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INSIDE

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Competition Improves Physician Quality, But Tread Carefully

The idea of using physician performance data to spur individual competition among their peers is a tried and true quality improvement strategy, but it has been used enough now to show its strengths and weaknesses. Showing a doctor where he or she stands in comparison to others can be effective, but if you go about in a ham-handed way it can backfire and just cause problems for everyone involved.

The latest confirmation of the strategy's usefulness was in a recent *Journal of the American Medical Association* study, which found that electronic "behavioral interventions" comparing a physician's performance to others were effective in decreasing the inappropriate prescription of antibiotics. *(See more on that study later in this issue.)*

Hospitals can use the strategy on a departmental or physician group level before addressing individual performance, says **Richard E. McClead Jr.,** MD, associate chief medical officer at Nationwide Children's Hospital in Columbus, OH. McClead also is co-editor-in-chief of the journal *Pediatric Quality and Safety*. He cites an example of working with the gastroenterology department to improve management of celiac disease, which includes a number of process measures.

> "HOSPITALS CAN USE THE STRATEGY ON A DEPARTMENTAL OR PHYSICIAN GROUP LEVEL BEFORE ADDRESSING INDIVIDUAL PERFORMANCE."

At McClead's hospital, they initially track how the section is performing on a particular measure, in order to get the group engaged in the processes and outcome measures that need to improve. Then they break the information down by physician and provide that information to the entire section, but not with names attached. Each physician is provided with a coded

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letter or number to match with the posted data, so that they can identify their own scores and see where they stand against the others.

Resistance is to be expected in the early stages, with doctors questioning the validity of the data. *(See the story later in this issue for more on that initial resistance.)* That resistance is likely to persist unless the hospital promotes transparency, not just in this improvement effort but throughout the hospital, McClead says.

"We see over time that they gain confidence in the process and then we can reveal each other's data and be very transparent with it," McClead says. "But my experience has been that gaining their confidence is difficult to do in an institution that does not have a culture of transparency. Doctors don't like to be an outlier, so that's a real motivation, but if you don't have a culture of transparency they start questioning the validity of the data and respond with all the excuses for why their scores are lower."

Show Validity of Data

It is important to acknowledge that physicians treat patients of different acuity, as well as other factors that can affect a quality score, McClead says. But if the data are presented in the most transparent way possible and with an emphasis on quality improvement, most physicians will accept that the data is valid. The hospital must stress that the scores are not a way to find "bad" doctors and punish or embarrass them, but rather an effort to help them improve, he says.

"We had one outlier physician who challenged the data at first, and then when he saw everyone's data he realized he could improve his performance," McClead says. "He went to the QI leader in his department, sat down, shut the door, and said 'OK, tell me what I'm doing wrong here so I can fix this.'"

Physicians are driven to change their performance primarily by two factors: competition and money, says **David Friend**, MD, MBA, chief transformation officer and managing director of the Center for Healthcare Excellence & Innovation with BDO USA, a Chicago-based consulting company. He previously was chair of the clinical affairs committee at the University of Connecticut in Storrs.

Friend used both in quality improvement efforts at the university, which includes the UConn John Dempsey Hospital and the UConn School of Medicine. Efforts to improve outcomes often involved encouraging competition between individual physicians and also against other institutions. Physicians are, by and large, a very competitive bunch because they had to compete to get good grades, get in to medical school, earn the best internships, and stand out among their peers, Friend notes.

Public Recognition Matters

One effort began with declaring that UConn John Dempsey was going to be the safest hospital in the state and comparing outcomes data to other hospitals. That created competition among the hospital's physicians on a hospital level, with UConn's physicians working together to beat the other facilities. That was successful, and the physicians were proud to say they worked at the safest hospital in the state.

Awards and recognition are important to physicians, much

Electronic Prodding Changes Behaviors

Physicians are influenced to change their behaviors when the electronic medical record tells them they are out of step with their peers, according to a recent study in the *Journal of the American Medical Association*.

Researchers from the University of Southern California and several hospitals studied 248 physicians in 77 primary care practices, first giving them a primer on the proper prescribing of antibiotics for acute respiratory tract infections. Three different interventions were provided. The first was suggested alternatives to antibiotic treatment, and the second was the option to write a note justifying the antibiotic prescription. Both came up in the medical record when the physician entered an antibiotic prescription.

The third intervention was a monthly emailed "peer comparison" that compared their rate of antibiotic prescriptions to that of top performers with the lowest rate of improper prescriptions. The emails were direct in labeling the physicians top performers or not top performers.

The first intervention had no effect. The second had some effect, but the peer comparisons helped reduce unwarranted prescriptions from an average 20% to 4% over the 18-month study period.

An abstract of the study is available online at http://bit.ly/2a3W3Hs. ■

more so than many hospital administrators realize, Friend says. It is easy to assume that physicians are highly accomplished, well-paid professionals who don't need a pat on the back or a little plaque to feel good about themselves, he says. But they do value those gestures.

"I don't think most people realize that, and it is absolutely essential. Physicians are driven by a desire to excel and they want that recognition. They crave it," Friend says. "Peer recognition means everything to physicians and if you don't include that, you are omitting one of the most powerful tools in a quality improvement program."

Failing to focus on positive aspects with praise, incentives, and recognition will make the effort look punitive, like you are looking for the failures and encouraging physicians to be "RVU slaves," just working to create good data instead of good medicine. Friend recalls working with the hospital's urologists to determine the amount of mesh used in procedures and what was the optimal amount. There was a wide disparity, with some physicians using 10 times the mesh that others used in the same procedure, with no difference in results.

"When we said we were going to give a prize for the best outcome, including the proper use of mesh, immediately the worst performer became the best performer," Friend says. "This motivation to excel is far more effective than punitive systems or these overloaded programs with hundreds of metrics that nobody understands."

Financial rewards also make a difference, Friend says. The reward doesn't have to be huge to have an effect. Even a modest financial reward tells the physician that the hospital values the efforts to improve and acknowledges that those efforts save money for the hospital, he says.

Choose Objectives Carefully

Friend cautions that you must make physicians responsible only for the factors they can control. Including performance measures that they cannot control will only frustrate them and make the whole experience a negative one. They also must be completely objective measures; any subjectivity will result in physicians arguing that the data are inaccurate.

Also, be careful not to overburden physicians with too many goals at once. Determine which factor is most essential to the outcome improvement and have them focus on that, Friend says.

"If I tell a world-class runner to focus not just on getting to the finish line as fast as he can, but also to smile for the cameras, count the pebbles on the track, and sing a song, he isn't going to win the race," Friend says. "People do best when they focus on one thing."

Physicians also need sufficient notice of any initiative that will affect their public image, standing within the hospital, or their compensation, says **Karen Meador**, MD, managing director of the BDO Center for Healthcare Excellence & Innovation. Meador is working with one-third of the New York state providers participating in state-sponsored Medicaid reform efforts (DSRIP), which include physician alignment and care coordination incentives.

"If something is imposed on them and they feel like they didn't have an opportunity to influence the design or what quality metrics were chosen, there is going to be a lot more resistance," Meador says. "Bring the physicians together early on and explain what you're planning, here's why, how it's going to benefit them, and get

their input. Let them help determine what metrics are most relevant."

Patient Satisfaction Complicates Metrics

When selecting metrics and goals, Meador says you have to be careful not to omit those that seem obvious. If a certain metric is crucial to outcomes but seems so obvious that you don't include it in the initiative, you can inadvertently cause physicians to neglect that metric or even sacrifice it to make the stated metric better, she says.

Quality initiatives based on physician competition must acknowledge that there will always be those who rank as the lowest performers, Meador says. If everyone is providing high-quality care, the hospital should acknowledge that those ranking lowest are not providing poor-quality care.

Patient satisfaction measurements can complicate physician outcome measures, Meador notes. In some cases, doing the right thing in terms of good medicine and best practices will not make the patient happy. An example is refusing to prescribe antibiotics for a common cold or prescribing too many narcotics to a pain patient.

Any physician quality initiative must account for this conflict, Meador says. Otherwise, physicians get frustrated and lose confidence in the quality improvement effort.

"I know a number of physicians who say they feel this struggle because the patient says the doctor doesn't appreciate his pain and won't prescribe what he wants," Meador says. "They debate whether to stick to what they think is right or risk having the patient give a really low satisfaction score. When the incentives for a good ranking are really strong, that's difficult." ■

SOURCES

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Be Ready for Challenges to Data Reliability

Data transparency is one of the most effective mechanisms for incentivizing physician behavior change, but one of the first reactions to unveiling physicians' performance among their peers usually is to question the validity and source of the data, says **Kelly Tiberio**, manager of GE Healthcare Camden Group, a consulting company based in Los Angeles.

"In my experience, if physicians don't trust the data being presented, you've already lost your ability to engage them in a meaningful discussion," Tiberio says. "A well-designed dashboard with clear methodological assumptions will keep the discussion factual and objective."

Quality professionals will have better luck with physician acceptance if they involve physicians early on in the performance measure selection and definition process, Tiberio says. Compliance measures that physicians have not bought into will likely not be effective measures of success.

Tiberio says there are two schools of thought on providing performance data to physicians, and both are valid. One option is to rip off the Band-Aid and embrace the potential political strife that ensues. The other is ease the physicians into the data first with blinded performance dashboards, allowing them time to digest the data in a neutral state. When there is acceptance of the methods used and understanding of individual performance related to peers, with some window of time for improvement, hospital leadership can transition the report to an unblinded one.

Defensive Reaction Expected

When confronted with evidence that they seem to be underperforming — especially when that evidence is also seen by their peers — it is a natural reaction for physicians to become defensive. In many cases, their reaction is warranted, Tiberio notes.

For instance, perhaps they deal with higher acuity patients than their peers and the best practices against which they are being evaluated don't account for the complexity of all patient care situations.

"While standardization of care is typically its purpose, a physician compliance plan must also incorporate enough flexibility such that physicians aren't penalized for complex patient exceptions," she says. "Ideally, the measure being tracked can be adjusted to evaluate and adjust for patient acuity."

When the data is presented ef-

fectively, it can bring out the best in physicians. Tiberio recently worked with a health system in the Northeast that presented a physician performance report to its orthopedic medical staff and saw a sudden increase in collaboration. While the spirit of competitiveness can motivate behavior change, Tiberio says physicians ultimately want to provide excellent patient care and are driven by evidence-based medicine and best practice. Presented with the right data in the right way, the result may be more collaboration than competition, she says.

"Variation in compliance rates stimulates valuable discussion among physicians who fall on either end of the performance spectrum, helping them to understand and adopt new care delivery practices that will ultimately benefit their patients," she says.

Financial incentives, such as shared savings programs, are another means to incentivize behavior change, but Tiberio says that in her experience, quality of care and patient outcomes need to be the drivers of an incentive program in order for it to be sustainable and patient-centric.

Support from C-suite executives is crucial to the development, dissemination, and messaging of physician-level dashboards, Tiberio notes. There also should be a physician leader who will be a champion for physician engagement and performance improvement.

"At a minimum, this individual should act as a liaison between the medical staff and hospital administration, emphasizing important strategic imperatives on behalf of the hospital while advocating for physicians' interests," Tiberio says. ■

SOURCE

- **Kelly Tiberio**, Manager, GE Healthcare Camden Group, Los Angeles. Telephone: (310) 320-3990.

Tactical Teams Get Results for Hospital

Tactical quality improvement teams have helped a Georgia hospital reduce complications and length of stay so much that the savings amounted to more than $12 million over one year.

Beginning in 2012, DeKalb Medical Center in Decatur, GA, developed a clinical leadership model that relies heavily on collaboration between physicians, hospital operations staff, and Six Sigma Black Belt project leaders serving on tactical teams that address particular key performance indicators (KPIs), says **Ellen Hargett**, RN, CPHQ, LSSBB, director of quality and process improvement. The tactical teams meet monthly and prioritize strategies for driving improvement.

DeKalb Medical simultaneously developed a dashboard that analyzes outcomes for KPIs, like length of stay or mortality, and compares the health system's performance to national standards each month. They also created a clinical leadership model that uses data to identify opportunities and facilitate processes for improvement.

"Prior to this time we had reported our quality performance to the board of directors in the context of performance measures, core measures, CMS-required public reporting. There really weren't the global outcome measures that reflect an organization's overall performance," Hargett says. "So while we were doing well on those process measures and publicly reported measures, we weren't doing so well on the bigger issues like complications, mortality, and length of stay."

More Physician Involvement

The clinical leadership model and tactical teams were designed particularly to get physicians more involved in quality improvement, Hargett says. Significant support came from DeKalb Medical's physician hospital organization (PHO), which comprises the employed physicians and those who work primarily at the hospital. The PHO negotiates the doctors' fee contracts with payers.

"The PHO really stepped up and said it would compensate physicians for their time on these tactical teams," Hargett says. "It's not a huge amount of money but it is enough to respect their time and maximize how we use them."

From 2014-2015 these tactical teams have been able to reduce complications and length of stay, resulting in financial savings of $12,473,116. Mortality reductions netted 104 lives saved.

The Quality Department worked with outside analysts from Truven Health to develop a whole system measure dashboard called the Big Dot Dashboard. KPIs are displayed as Observed to Expected (O/E) Ratios, which enable the hospital to compare its performance to a national standard each month. Each KPI on the dashboard has a tactical team comprised of three or four physicians, an equal number of operations leaders, and one of the hospital's two Lean Six Sigma black belts.

Drill Deep for Drivers

The challenges included hospitalist scheduling patterns and weekend

inefficiencies. For example, DeKalb Medical determined that patients admitted through its ED on Wednesdays actually had a 1.7 average opportunity days per discharge. This type of analysis by the Lean Six Sigma black belt enabled the LOS tactical team to target improvement strategies resulting in an overall 61% reduction of opportunity days per discharge.

The complications tactical team began by drilling down to isolate possible drivers for the complication rates, says **Sarah Kalaf**, BSN, RN, CPHQ, performance improvement coordinator at DeKalb Medical and the facilitator for the tactical team. The team analyzed complications from various perspectives, first looking for potential factors that drive the complication rate up, such as particular physicians with a higher rate of accidental puncture during surgery.

"We found that we were not finding any particular trends that way, so we decided to go back to the 'old school' method of doing quality," Kalaf says. "We isolated our top complications and did a deep dive into the medical record reviews. Having the physicians on that team was excellent because they could do the record review instead of someone like me doing a one-page summary that they reviewed."

The complications team involved several departments in its investigation. The Quality Department coordinated medical record reviews, physicians contributed clinical expertise, and Health Information Management focused on documentation and coding opportunities.

"We found that what was driving a majority of our complications was documentation and coding," Kalaf says. "For example, there was no difference documented between an inherent puncture that is an intentional part of the procedure and a true accidental puncture and laceration."

Another example was postoperative respiratory failure. The tactical team found that patients with a history of chronic obstructive pulmonary disease or sleep apnea needed to be on the ventilator for a few hours longer than other patients, but that reason was not documented clearly, so it was coded as postoperative respiratory failure instead of continued postoperative vent management.

The hospital made improvements in documentation, coding, and clinical, resulting in a 55% improvement in the complications O/E.

"It was trying to find that low-hanging fruit that doesn't necessarily involve clinical practice change — which Ellen and I like to call the 'sexy part of quality' — but rather the non-sexy, like looking at documentation and coding," Kalaf says.

Watch the E and the O

Tactical team members have developed an ability to look for system issues and scrutinize the "expected" as much as the "observed," Kalaf says. They learned that when using an O/E metric, you should give as much attention to the "expected" as the "observed." This can be a motivator for improved documentation when physicians recognize that their words drive coding, which drives "expected," Kalaf explains.

Hargett says DeKalb Medical's experience yielded key lessons for other facilities. First, she says, it is crucial for physicians to feel they are part of the process and not just the targets to be "fixed." Prior to this culture change, the hospital approached many metrics as a "doctor problem."

"A lot of our assumptions were that we could find a doctor who was driving the problem or who was performing worse," Hargett says. "Now we approach virtually every metric as an organizational system output, versus a doctor problem. We know that our system is supporting every standard of care, so we have look at the system first. The majority of the improvements we have put in place were system issues, so it is a fundamental difference in our approach."

Another lesson was that hospital committees should be evaluated for their return on investment (ROI). Too many hospital committees, quality-focused or otherwise, are created with good intentions but then drain resources without accomplishing much, Hargett says.

"A lot of times, you see that you can get a better ROI by going to a team approach with very focused data analysis to target strategies," Hargett says. "We've really worked on how well we maximize our resources, and I would encourage other institutions to do the same. Rather than being additional work, this is productive work that should take the place of inefficient work."

For these quality improvements, DeKalb Medical received the 2016 Truven Health Advantage Award for Performance Improvement and Efficiency at the Truven Health Analytics Advantage Conference on April 27 in Dallas, TX. ■

SOURCES

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'Clean It Like You Mean It' Improves Quality, Reduces Costs

A nursing-led program designed to get clinicians to follow best practices at a New York City hospital has significantly reduced the incidence of central line-associated bloodstream infections (CLABSIs) in neonatal, pediatric, and pediatric cardiac intensive care settings.

The "Clean It Like You Mean It!" program at Morgan Stanley Children's Hospital, part of the NewYork-Presbyterian system, sought to limit CLABSIs because they are largely preventable if nurses and other clinicians follow the proper protocols, says **Regan Morimoto**, RN, CCRN, clinical nurse II at the hospital and one of the program leaders.

The program team consisted of Morimoto and another nurse from the pediatric intensive care unit (PICU), one nurse from the pediatric cardiac intensive care unit (PCICU), and one from the neonatal intensive care unit (NICU). They had the full support of management but carried out all the tasks in the initiative. They also were available around the clock for consultation.

"If a PICU nurse in the middle of the night saw a line that had some redness or was starting to get clotted, we would get a text or a picture. I could advise the nurse and the next day I could check it and talk to an attending about why it hadn't been pulled yet," Morimoto says. "The totally open communication among the staff was very important."

The program used continuous education sessions, central line maintenance protocol, weekly surveillance, and a good dose of cheerleading by nurse champions to reduce CLABSIs. After a year, the results were impressive:

- The NICU CLABSI rate increased by 55%. *(The NICU did not fully participate in the program. The result lends more support to the effectiveness of the program.)*
- The PICU CLABSI rate decreased by 21%.
- The pediatric cardiac intensive care unit CLABSI rate decreased by 100% to zero.

> "THE FIRST CHALLENGE WAS GETTING BUY-IN FROM THE NURSES."

- The average length of stay (LOS) decreased by 4% (1.11 days) in the NICU and by 35% (4.87 days) in the PICU since 2013. It increased by 2% (0.32 days) in the PCICU.
- The total number of CLABSIs for all units decreased by 25%.
- These outcomes resulted in a fiscal effect of $37,134 over nine months, with a projected annual savings of $99,024.

Not Always an Easy Path

The first challenge was getting buy-in from the nurses, Morimoto says. They were all for reducing infections, but were wary about slowing the pace in the unit to scrub hubs on medication pumps and syringe lines.

The effort kicked off with a travelling CLABSI Carnival that visited each nursing unit in January and February 2014, providing cupcakes and freebies to get the nurses involved. The CLABSI Carnival appeared again during the hospital's Nurses' Week celebration. The project team met with more than 100 nurses and gave hands-on demonstrations of "Scrub the Hub" — the central message in the project encouraging nurses to pay extra attention to this detail with central lines. Nurses answered trivia questions on central line care, reviewed central line dressings and changes, learned about the use of alcohol-impregnated caps on needleless ports, and reviewed central line change policy and central line care.

Nurses took well to the effort as long as they felt their voices were heard when they wanted a central line pulled or had other input, Morimoto says.

"One of the first things we instituted was a two-person line dressing change, which was difficult because we don't have resources nurses. That meant you had to pull a nurse who had their own workload to come watch you change the dressing," Morimoto says. "But we thought it was very important to have another set of eyes, someone to speak up and say 'you might not be sterile anymore.'"

The next hurdle involved residents and rotating staff. Residents start every two weeks, requiring that fresh education each time. In addition, some residents were coming off rotations where they had been instructed to order central line cultures but now had to be taught not to in the ICUs.

Plus, they had to tell parents that the child would have a needlestick instead of using the central line.

The nursing team went to the fellows overseeing the residents and presented the CLABSI project, which resulted in better understanding when residents arrived for ICU rotations and better compliance during their stays. Afterward, a nurse disagreeing with a resident could call the fellow to make the final decision.

With the program originating with the ICU nurses, compliance was not immediate in other departments.

"We would leave our kid in radiology and they would come back with everything that was in the peripheral line now running through the central line with the same tubing. That was just horrifying to us," Morimoto says. "We thought about going to the doctors, but instead we went to the nurses and begged them to be accountable for what's going on with those lines. We would even send primed, brand-new, fresh lines done by us to them if they needed that, but we ended up getting good cooperation from the other nurses."

Some services, like oncology, were resistant to the CLABSI project and did not want to change practices when a patient moved from the floor to the ICU. But attending physicians in the ICU stood up for the project and explained that there is no data to support daily central line cultures if the parent consents to peripheral cultures.

Reminder Hangtags on IV Poles

The "Clean It Like You Mean It!" program used a variety of methods to keep the message in front of nurses and reinforce the CLABSI prevention best practices. The team developed "Scrub the Hub" IV pole hangtags for all patients with central lines.

CLABSI prevention posters were placed in all three units, and the team provided CLABSI prevention education in groups and one-on-one.

The team also conducted weekly central line surveillance for 32 weeks, assessing more than 300 central lines for appearance, needleless caps, central line sites, and dressings.

> "CLABSI PREVENTION POSTERS WERE PLACED IN ALL THREE UNITS, AND THE TEAM PROVIDED CLABSI PREVENTION EDUCATION IN GROUPS AND ONE-ON-ONE."

At one point the team decided to take a break from taking blood cultures off the central line to see if contamination from nurse error had any influence on the CLABSI rate.

The policy at the hospital was not to take cultures from central lines, but doctors were ordering them because that option popped up when entering orders in the electronic record. The nursing team did not have the authority to stop the central line cultures, but they went to a critical care quality and safety meeting with all the attending physicians.

"We just asked if they would do what we want for a little while and just stop that practice so we can see if it makes any difference," Morimoto says. "Because the CDC's gold standard is to use peripheral lines for blood culturing, they were willing to stand behind us. We actually had some great results from not accessing our central lines and that was information we use to validate this change."

The program was funded mostly with a $10,000 grant from the American Association of Critical-Care Nurses, with a good portion of those funds covering the off-duty time of nurses spent on the project. The hospital spent $2,752, with 25% of those funds spent on posters, 25% on staff gift giveaways, 22% on educational material, 12% on food, 9% on printed water bottles, and 7% on team shirts.

Morimoto suggests that any nurse-centric quality improvement project will be most successful if it originates or at least is driven by the nurses themselves.

"Ultimately we are the stopgap at the bedside and the last person who can ensure that we're doing everything right," Morimoto says. "I'm lucky to work in an ICU where our nurses feel empowered and don't have any trouble saying 'no' to a doctor. The project succeeded in large part because the nurses cared and took ownership." ■

SOURCE

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Oregon Targets Data Overload, Develops Strategies

It's one of the most common complaints among healthcare quality professionals: There are so many metrics and so much data to compile. How can we ever keep up?

A group in Oregon is hearing the pleas and trying to find a solution. The Portland-based Collaborative for Health Information Technology in Oregon (CHITO), a nonprofit which includes healthcare organizations and related groups addressing data needs, recently investigated the problem of data overload in the state and found strategies that could help nationwide.

The group recently issued a report, "Aligning Health Measurement in Oregon," which is a result of months of collaborative research to study and develop recommendations around a proliferation of hundreds of overlapping — and sometimes competing — state, federal, and commercial healthcare quality reporting initiatives and mandates.

(The report is available online at http://bit.ly/29Ut2QH.)

The following are some highlights from the report:

- There are more than 420 reporting measures in Oregon from various state, federal, and commercial healthcare programs and initiatives.
- Many quality incentive programs have mixed results as they are not tied to best practices, are siloed among dozens of sponsors, and the results are not always available to the public.
- "Previous efforts to align measures were well-intentioned but had little success, in part because those involved did not have the authority and resources to implement changes," according to the report authors.

"The quantity of reporting requirements is just overwhelming," says **Andy Davidson**, president & CEO of the Oregon Association of Hospitals and Health Systems, a member of CHITO. "There is not only the state and federal payers, but even within those there can be subsets. The variability is huge just with the government plans, and then there are the commercial payers."

> "WE THINK THERE NEEDS TO BE A PUBLIC/PRIVATE EFFORT THAT DEVELOPS OREGON-SPECIFIC GOALS. WE THINK THERE NEEDS TO BE A LIMITED SET OF MEASURES THAT ALIGN WITH THOSE GOALS."

A key finding of the study was that metrics are siloed far more than the CHITO group expected, Davidson says. The lack of access to many of the measurement results also was a concern.

"We think there needs to be a public/private effort that develops Oregon-specific goals. We think there needs to be a limited set of measures that align with those goals," Davidson says. "That may mean we replace some existing measure sets."

Part of the problem, Davidson says, is that so many measures are developed for narrow healthcare groups and localities. In its 2015 assessment of its own measurement efforts, CMS analyzed more than 700 measures across 25 programs and found that only half of the measures were shared across programs, and that nearly half of the measures were developed locally.

"What the healthcare community can clearly see now is that though each effort may cite the Triple Aim or the National Quality Strategy — or both — as a guidepost in their work, that has not prevented measure sets from proliferating to a nearly unsustainable degree," the CHITO report says.

The good news is that there are existing frameworks that might help address the problem. Recent national-scale initiatives, such as the dashboard proposed by the Center for Healthcare Transparency, or the framework for a Culture of Health developed by the Robert Wood Johnson Foundation, are two examples to consider, the report says.

Their recommendations reflect an attempt to balance the immediately feasible with aspirational measurement; to include measures that are broadly applicable and measures which target specific populations and challenges.

The Oregon experience is not unique, Davidson says, but it illustrates the challenges posed by

the overload of metrics and hints at what can happen if the healthcare industry does not find a solution.

He notes that some healthcare organizations have to hold office space open for the constant flow of chart reviewers sent by the payers.

Other healthcare providers have reported that document overload adds five minutes of administrative work for every patient, Davidson says.

"We're really concerned about burnout and organizational focus on improvement and patient safety," Davidson says. "People are spread thin, and ultimately we are concerned if that if we layer more and more metrics on people we can take the system backward. I don't say that lightly." ■

AHA Analysis Says Star Ratings Inaccurate

A new analysis from the American Hospital Association (AHA) concludes that there are fundamental design flaws in the CMS star ratings.

The flaws may make the star ratings invalid for comparing hospital quality, the report says. The analysis was conducted by **Francis Vella**, PhD, chair of the Department of Economics at Georgetown University in Washington, DC. *(Vella's analysis is available online at http://bit.ly/2aJi5kA.)*

Rick Pollack, AHA president and CEO, issued a statement saying the analysis was troubling.

"As currently designed, CMS's star hospital ratings program is not up to the task of providing the public with meaningful and accurate assessments of hospital performance," Pollack said. "Patients need reliable information to make important choices regarding their healthcare. And hospitals and health systems need reliable information so that they can continue to improve the quality of the care delivered. CMS star ratings misses the mark on both accounts."

Vella's analysis specified the following problems with the star ratings:

- There is a wide variation in the number of measures and categories used to identify the star ratings across hospitals. Different hospitals are rated using a number of different measures, which can bias the results, irrespective of their actual performance.
- The methodology is not well constructed. The estimation aspect gives the impression of being rigorous and objective, but actually is highly dependent on choice of measures and the weighting scheme is entirely subjective and highly determinant of the final outcomes.
- Ignoring other social determinants of quality outcomes (such as location of hospital, race, income, and patient composition) potentially biases the results. Two or more identical hospitals could have very different outcomes depending on the type of patient they have, where they are located, the type of health issues they typically face, and multiple other factors.
- The use of a star system implies that substantial differences in quality may exist across hospitals when they do not.

AHA's statement accompanying the analysis urges CMS to make substantial changes in the star ratings system before making it public. ■

One Third of Patients Injured in Rehab Hospitals

Almost a third of patients in rehab hospitals suffer a medication error or some other type of preventable harm during their stay, according to a recent report from the Department of Health and Human Services (HHS).

HHS had doctors review medical records of 417 randomly selected Medicare patients who stayed in U.S. rehabilitation facilities in March 2012. They concluded that nearly half of the 158 incidents they spotted among 417 patients were clearly or likely preventable.

The events ranged from a temporary injury to an adverse event that led to a longer stay at the facility, permanent disability, or death. Of those suffering an adverse event at the rehab hospital, almost a quarter had to be admitted to an acute care hospital. The researchers determined that those hospitalizations cost about $7.7 million for the month analyzed.

Most of the harm was caused by substandard treatment, inadequate monitoring, and failure to provide needed care, the physician reviewers concluded. Just under half, 46%, were related to medication errors. Many of those cases involved bleeding from gastric ulcers related to the use of blood thinners, and a loss of consciousness related to narcotic painkillers.

Forty percent of the cases

were caused by a lack of proper monitoring, leading to falls, bedsores, constipation, and other problems. HHS noted that the incidence of adverse events in rehab hospitals is similar to that of acute care facilities. It recommended that the Agency for Healthcare Research and Quality and CMS create and disseminate a list of potential adverse events in rehab hospitals as part of an overall campaign to raise awareness.

The HHS report is available online at http://bit.ly/2a3QoAV. ■

EHRs May Not Affect Patient Safety Negatively

Recent research suggests concerns over how electronic health records (EHRs) may affect patient safety may be overblown.

The report from researchers at Harvard Medical School in Boston, MA, addresses the concerns that have long been associated with EHRs. Some healthcare professionals have worried that the introduction of EHRs to a facility can hamper patient safety by slowing work flow as clinicians learn to use them. In addition, there has been concern about design faults and the inevitable technical problems.

The Harvard study acknowledges these concerns but comes down on the side of the EHRs. Unadjusted 30-day mortality did not change significantly in the study hospitals before and after EHR implementation. The average unadjusted 30-day mortality in the pre-implementation period was 6.74% , compared with 7.15% in the post-implementation, the report said. That small increase was not statistically significant.

The authors say they began the research expecting to see an increase in negative patient safety outcomes

"Contrary to that hypothesis, we found that before and after a discrete 'go live' date for EHR implementation across 17 hospitals, there was no evidence of a significant or consistent negative association between EHR implementation and short term mortality, readmissions, or adverse events," the authors reported.

The study is available online at http://bit.ly/2aD1ah1. ■

HHS May Change HCAHPS for Pain Care

HHS is proposing a change to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to address complaints that healthcare providers were penalized if they appropriately limited pain medications.

The HCAHPS survey targets patient satisfaction, but clinicians have reported that they get poor ratings from patients who sought pain medication. The clinicians were left with the choice of taking a hit on HCAHPS or giving into the patients' demands.

"Many clinicians report feeling pressure to overprescribe opioids because scores on the HCAHPS survey pain management questions are tied to Medicare payments to hospitals," according to the HHS announcement. "But those payments currently have a very limited connection to the pain management questions on the HCAHPS survey. In order to mitigate even the perception that there is financial pressure to overprescribe opioids, the CMS is proposing to remove the HCAHPS survey pain management questions from the hospital payment scoring calculation. This means that hospitals would continue to use the questions to survey patients about their inpatient pain management experience, but these questions would not affect the level of payment hospitals receive."

The proposal was part of several new actions the department is taking to combat the nation's opioid epidemic. The actions include expanding access to buprenorphine, a medication to treat opioid use disorder, a proposal to eliminate any potential financial incentive for doctors to prescribe opioids based on patient experience survey questions, and a requirement for Indian Health Service prescribers and pharmacists to check state Prescription Drug Monitoring Program (PDMP) databases before prescribing or dispensing opioids for pain.

In addition, the department is launching more than a dozen new scientific studies on opioid misuse and pain treatment and soliciting feedback to improve and expand prescriber education and training programs. ■

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CE QUESTIONS

1. What does Richard E. McClead Jr., MD, say is necessary for successfully using individual physician outcomes data to improve outcomes?

a. A culture of transparency
b. Support from the community
c. Physician approval to conduct the program
d. A tiered reporting system

2. What does Ellen Hargett, RN, CPHQ, LSSBB, advise regarding the Observed to Expected (O/E) ratios of key performance indicators?

a. Give as much attention to the "expected" as the "observed."
b. Focus on the "observed" and pay little attention to the "expected."
c. Do not rely on O/E measures as a quality metric.
d. Allow physicians to assess the value of O/E ratios.

3. How did the "Clean It Like You Mean It!" team members at Morgan Stanley Children's Hospital address the problem of patients returning from other departments with compromised central lines?

a. They went to physicians in those departments.
b. They went to the nurses in those departments.
c. They went to administration.
d. They went to the nurses' union representative.

4. What does Andy Davidson say is one reason for the overload of metrics in Oregon?

a. Many measures are developed for narrow healthcare groups and localities.
b. More than half of the metrics are duplicates.
c. At least a third of the metrics are outdated.
d. Not enough measures are developed for narrow healthcare groups and localities.