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INSIDE

Good Use of PEPPER Data Makes a Difference in Quality

Quality and performance data can be instrumental in improving healthcare, but it's what you do with that data that matters. Data from the Program for Evaluating Payment Patterns Electronic Report (PEPPER) includes a wealth of information about reimbursement errors, but you should know how to put it to good use in your compliance program.

PEPPER is a benchmarking tool containing hospital-specific data for 14 Diagnosis Related Groups (DRGs) and discharges that have been identified as at high risk for payment errors. The data is provided free of charge by TMF Health Quality Institute, under contract with CMS and is intended to reduce Medicare fee-for-service improper payments. PEPPER used to be distributed to hospitals by their state Medicare Quality Improvement Organization (QIO), but QIOs are no longer involved in providing reports.

> PEPPER IS A BENCHMARKING TOOL CONTAINING HOSPITAL-SPECIFIC DATA FOR 14 DIAGNOSIS RELATED GROUPS (DRGS) AND DISCHARGES THAT HAVE BEEN IDENTIFIED AS AT HIGH RISK FOR PAYMENT ERRORS

Data for different types of providers is released on different dates. TMF will release PEPPER data on several categories, including most hospitals, in April 2017.

(The release schedule and instructions for accessing your hospital's PEPPER data can be found at this link: http://bit.ly/2m4JAsJ.

More information is available at

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AUTHOR: Greg Freeman

EDITOR: Dana Spector
(404) 262-5470 (dspector@reliaslearning.com).

EDITOR: Jill Drachenberg
(404) 262-5508 (jdrachenberg@reliaslearning.com).

AHC EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

https://www.pepperresources.org/.)

Make the Most of PEPPER

The PEPPER report is not well understood by some hospital professionals and is not used as much as it could be for quality improvement, says **Deborah K. Hale**, CCS, CCDS, president and CEO of Administrative Consultant Service, a consulting company based in Shawnee, OK, that assists hospitals with clinical documentation improvement and compliance.

PEPPER data has been a useful resource for several years at Bluegrass Care Navigators in Lexington, KY, which provides palliative, hospice, and other care. The health system has two provider identification numbers, so Bluegrass could pull PEPPER reports on both and compare their performance internally between facilities, as well as to national averages, says **Eugenia Smither,** RN, BS, CHC, CHP, CHE, corporate compliance officer and vice president of compliance and quality improvement.

When Bluegrass first began using PEPPER data, Smither and her colleagues first took time to validate the data, ensuring it provided an accurate picture of their performance. That is a good practice with any data report on your performance, Smither says, but after a few years of working with PEPPER, they have enough confidence in the report that they forgo that step.

Smither notes that a good feature of the PEPPER report is the clear definition of numerator, denominators, exclusions, and other terms used to analyze the data. *(See the story in this issue for concerns about misunderstanding one section of the report.)*

Free Up Resources

One benefit of the PEPPER report is that it may provide reassurance that your performance is good enough in one area that it might not need as much compliance oversight as others.

"We were fortunate that we consistently don't fall into the areas that the contractor identifies as meaning you might need to audit yourselves," Smither says. "Most healthcare professionals have a lot of administrative duties that they didn't have before, so if you have an external entity tell you could probably spend less time in this area rather than more, that's always good. It's not that we ignore the issue, but we don't do continuous monitoring in those risk areas because of our scores."

That allows Smither and her colleagues to spend more time on other issues that need attention. A recent successful performance improvement project on meeting a national patient safety goal from The Joint Commission that involved oxygen safety might never have happened if the PEPPER data hadn't freed up resources, Smither says.

"We were able to do that project that particular year because when the PEPPER report came out, we scored pretty well," she says. "It's the same people who do both work, compliance and quality, so you have to use your resources wisely. If we had been at risk in one of the areas in the PEPPER report, we would have had to address that and try to put an improvement project in place."

A Closer Look at Early Discharges Ranking

Most hospitals should pay special attention to their rank regarding sepsis and in comparison, with urinary tract infection as the principal diagnosis when reviewing their PEPPER reports, says **Deborah K. Hale**, CCS, CCDS, president and CEO of Administrative Consultant Service, a consulting company based in Shawnee, OK.

Sepsis is the most frequent reason for admission of Medicare patients and it is a relatively high-paying diagnosis, Hale notes.

"It's on the forefront of everyone's minds, particularly in the emergency department, and CMS and several other payers have initiatives about early identification of sepsis and the appropriate treatment to reduce mortality and morbidity," she says. "Physicians have improved their documentation of sepsis, so consequently that increases the hospital's billing for sepsis. But Medicare Advantage and some of the big players in healthcare insurance are auditing those claims at an alarming rate and indiscriminately changing a well-documented and well-treated diagnosis of sepsis in the medical record to get out of paying the higher amount."

Hale cautions that a ranking in the 80th percentile should be a warning flag that you are likely to be audited and should spend a lot of time defending your documentation.

"You should be absolutely sure you have a system in place for defending these claims and not just chalk it up to the insurance companies doing their same old thing," Hale say. "That's what the insurers are hoping you'll do — just assume there's no use in fighting and give up."

One-day and same-day discharges also should get special attention. A high ranking in that area should prompt the hospital to investigate those discharges and make sure that they meet one of the exceptions allowed by CMS, Hale suggests. If not, improvement in utilization management is needed. ■

Report Aids Compliance

Providers are missing a big opportunity for quality improvement if they do not use the PEPPER data available to them, Smither says. There is no cost, and it provides a comparison group, along with thresholds for concern.

"It's a monitoring tool. For compliance, you have to have a plan in place and you have to evaluate where you are," Smither says. "You have an external benchmarking tool packaged with clear definitions and risk areas already identified for you, and you would be remiss in not using that gift."

Since all providers must have a compliance plan including certain elements, the PEPPER report can fulfill some of that obligation. One element is monitoring and evaluation, and the PEPPER report gives you both of those components, Smither says.

Some parts of the PEPPER report are less valuable than they were in recent years, Hale notes.

"Some of it is a little past its usefulness, given the changes we've seen in the necessity of admission and other issues," she says. "We have to evaluate some of those data sets a little differently because the report was designed before the two-midnight rule was implemented."

Dig Deep in PEPPER

To get the most of out the PEPPER data, Smither advises taking your time with it and digging deep.

"I usually read through the whole report one time and then go back to dissect it more in depth. You can't get everything out of it in the first read," Smither says. "This is not a report for light reading. It's a collection of data that you need to analyze."

Smither also spends time understanding the demographic components of the report, looking at how her patient population compares to that of the state, region, and country. Differences in patient population can shed light on your performance that does not meet the average when compared to those larger areas.

"For example, in southeastern Kentucky, there is not a lot of activity in the assisted living space, whereas nationally it is probably one of the fastest-growing areas," she says. "Everybody's population is different, so you have to consider how that affects those risk areas. It's presented as supplemental information in the report, but it's helpful when you analyze the report."

After reading the instructions and definitions, Hale suggests starting with the outlier report. The one-page outlier report is a summary of the data and understanding that first can give you a sense of what portions of the report you should study most closely, she

says. *(See the story on in this issue for advice on what areas to investigate.)*

Remember that the report is data and only highlights areas to investigate, Hale says. Do not assume that just because your PEPPER report has you in the 80th percentile, or even the 20th percentile, that you are making errors with DRG assignment or medical necessity, Hale says. Other factors could be in play.

"If a hospital ranks in the first 1,000, they should get a sense that their risk for audit is relatively high, either from the RAC with DRG accuracy, or the QIO with respect with to medical necessity of admission. That hospital should be particularly attuned to where they score the highest and are at highest risk an audit," Hale says. "It doesn't necessarily mean they're doing anything wrong. It could just be that they're doing a really good job of clinical documentation improvement and coding accuracy. That 80th percentile ranking might be something to be proud of."

Low Rank Not Always Good

You won't know that without internal auditing to make sure coding is accurate, Hale says. She also cautions that a ranking below the 20th percentile isn't always worthy of celebration. It could indicate that the hospital is being underpaid in that DRG group, necessitating improvement in coding and documentation. Without auditing your operation, you won't know if you are leaving money on the table.

"I often hear CFOs or compliance officers advise coding or case management that they should have a plan to bring their numbers into the average range. I think that's an unwise piece of advice," Hale says. "You want your admissions to be medically necessary, but you're going to have some short stay admissions. If you try to be average, you might be doing yourself and your patients a disservice."

Two-day stays data in the PEPPER report should be addressed carefully, Hale says. Two-day stays are now a benchmark of medical necessity, and those cases are not reviewed unless there is evidence of gaming, Hale says. To understand gaming, consider a scenario in which a hospital had been in the 80th percentile for same-day and one-day medical and surgical discharges, then those num-

Concern Over Accuracy of One PEPPER

One part of the PEPPER report may not be reliable, says **Deborah K. Hale**, CCS, CCDS, president and CEO of Administrative Consultant Service, a consulting company based in Shawnee, OK.

The concern is over the data relating to whether the hospital is frequently reporting just one secondary diagnosis that is considered a complication or comorbidity (CC), or major complication or comorbidity (MCC).

"That was what hospitals focused on in early days of DRGs because they got more money if they focused on assigning a case to the higher paying DRG with a complication or comorbidity, so they worked to find at least one CC because that amount of payment increase is significant," Hale says. "But as we move more into value-based purchasing, we know it's extremely important that we capture every condition that is reportable and supported by the record, so that we get credit for severity of illness for the risk adjustment process."

The explanation in the PEPPER report indicates that being in the 80th percentile means you have many cases with only one CC or MCC, which could suggest errors related to overcoding of unsubstantiated diagnoses. Cases with a single CC/MCC are at greater risk of review to potentially lower the DRG by disallowing the single condition that increased the DRG payment, Hale explains. However, the PEPPER report suggests that being in the 20th percentile could indicate that you are underreporting CC or MCC conditions.

In fact, the formula does not consider the volume of DRGs without CC or MCC, Hale says.

"For those in the 20th percentile for single CC or MCC, we believe a more accurate description would be that among cases with CC or MCC, the hospital has a greater percentage of those with multiple CC or MCC diagnoses," she says. "Therefore, rating at or below the 20th percentile in this measure could indicate the hospital is doing a good job of reporting all of the patient's significant conditions as they strive to achieve credit for risk adjustment."

The suggested audit intervention for this low outlier could send the hospital looking in the wrong direction for improvement opportunities, Hale explains. ■

ber dropped sharply and two-day stays increased proportionally.

"It might look like they decided to just keep patients longer. Maybe those patients don't need to be there and they are keeping them longer to avoid the appearance of an unnecessary admission," Hale says. "If that kind of thing were to appear in the data, that would be something the hospital definitely should consider."

Smither developed a dashboard for the organization's board of directors that provided the highlights of the PEPPER data.

"When you have such detail, the board wants the high-level information," Smither says. "I wanted them to see the variation among our providers, but also quickly understand where we were at risk and not at risk."

She used the graphs from the PEPPER report, but also melded that information to graphs with state and national information for comparison. She labeled each graph with a thumbs up or thumbs down. So, in one page they had all the information they needed for that risk area.

"When most compliance people talk to their board, the board is respectful and listen but they don't get down into the detail. The message I got from board members afterward was that they really liked the thumbs up or thumbs down, because it helped them get the point quickly," Smither says. "I explained in detail what the risk areas meant and gave them the background they needed, but the most salient points for them were the dashboard with the quick comparison and the thumbs up or down."

Smither notes that the PEPPER data is not publicly reported, so it is up to individual providers to share that information with others. She urges healthcare providers of all types to share the data so it can be used most effectively for comparisons.

"All providers have risk areas and if there is an opportunity to share this data the way you share other quality data, you should," Smither says. "The more the data is shared, the more valuable it becomes." ■

SOURCES

- **Deborah K. Hale**, CCS, CCDS, President and CEO, Administrative Consultant Service, Shawnee, OK. Telephone: (405) 878-0118. Email: dhale@acsteam.net.
- **Eugenia Smither**, RN, CHC, CHP, CHE, Corporate Compliance Officer and Vice President of Compliance and Quality Improvement, Bluegrass Care Navigators, Lexington, KY. Telephone: (859) 276-5344. Email: esmither@bgcarenav.org.

Johns Hopkins Shares Surgical Protocols with 750 Hospitals

Johns Hopkins has had success with using the Enhanced Recovery After Surgery (ERAS) protocols to improve post-op care, and now it is helping 750 hospitals adopt them.

ERAS protocols are multimodal perioperative care pathways designed to promote early recovery after surgical procedures by maintaining organ function and reducing the stress response following surgery. Advocates say ERAS can reduce complications, decrease lengths of stay in the hospital, and increase the overall patient experience. *(See the story in this issue for research on the effects of ERAS.)*

ERAS is used at the Johns Hopkins Hospital in Baltimore. The Johns Hopkins Armstrong Institute for Patient Safety and Quality, working with the American College of Surgeons (ACS), has been granted a multimillion dollar contract to implement ERAS protocols in 750 hospitals across the United States. The grant is funded by the Agency for Healthcare Research and Quality. Phase one is focusing on abdominal operations in colorectal surgery. Future projects will focus on bariatric surgery, orthopedic surgery, gynecology, and emergency general surgery.

ERAS is widely used in Europe and Canada, but American hospitals have been slow to adopt it, says **Michael Rosen**, MA, PhD, an associate professor of anesthesiology and critical care medicine at the Johns Hopkins University School of Medicine, and an associate professor with the Armstrong Institute. The program addresses many issues that top concerns for hospitals now, including readmission, complications, and cost effectiveness, he notes.

Hopkins began recruiting hospitals in March and will begin with the first cohort this summer.

Some hospitals are implementing pieces of ERAS but not the whole program, Rosen notes. The protocol challenges some widely held assumptions about what results in the best

recovery after surgery, so clinicians must understand the research behind it and the benefit if it is to be successfully introduced in a hospital, Rosen says. Though the goal is a quick and healthy recovery, he points out that ERAS does not affect just the post-op care of the patient.

"The protocols apply from the time the decision to have surgery is made to the days leading to surgery, pre-op, intra-op, recovery, step down, and discharge," Rosen says. "It affects the whole perioperative service line. So, adopting ERAS is more all-encompassing than programs that affect mainly the intraoperative time, for instance. Changes have to be made all along the continuum of care."

ERAS pathways are tailored for the particular type of surgery. The benefits of ERAS have been well proven in Europe, Rosen says. He strongly advocates adopting the program, but cautions that it is a significant commitment.

"It's a lot of work, a real challenge. Change in any organization is tough, and change in a healthcare organization is especially tough because it's technically and culturally complex." Rosen says. "Without a doubt, this involves a lot of work for hospitals. Our program is a 15-month cohort that starts with education and analysis, along with starting a team that ideally is led by surgeons, anesthesiologists, nurses, and administrators."

ERAS protocols are appropriate for all types of hospitals providing surgical services, Rosen says. Hospitals within the United States and Puerto Rico are eligible to participate. Participating hospitals will have access to leaders in ERAS, including representatives of surgery, anesthesiology, and nursing, along with prototype ERAS protocols developed for the five procedures based on up-to-date evidence review. They also will receive literature to support the protocols, tools and educational materials to facilitate implementation, quality improvement specialist support, and coaching calls to support hospital work.

To sign up or for more information, contact ACS at enhancedrecovery@facs.org. ■

ERAS Requires Coordinated Care, Best Practices

Enhanced Recovery After Surgery (ERAS) protocols result in major improvements in clinical outcomes and cost, reducing length of stay up to 50%, according to a recent analysis. The researchers call ERAS a good example of value-based care applied to surgery.

(An abstract of the report is available online at: http://bit.ly/2m482KY.)

ERAS started with colorectal surgery but has been to work with almost all major surgical specialties, the researchers note. It involves a team consisting of surgeons, anesthetists, an ERAS coordinator, and staff from units that care for the surgical patient. The care protocol is based on best practices and sometimes is contrary to traditional methods of care. For instance, the protocols call for switching from an overnight fast to having the patient drink carbohydrate drinks two hours before surgery.

The protocols also require minimally invasive approaches instead of large incisions, management of fluids to seek balance rather than large volumes of intravenous fluids, avoidance of or early removal of drains and tubes, early mobilization, and serving of drinks and food the day of the operation, the study notes.

The researchers concluded that ERAS protocols have reduced length of hospital stay by 30% to 50%, with reductions in complications. Readmissions and costs also were reduced.

They also noted the importance of auditing process compliance and patient outcomes. ■

Behavioral Healthcare in ED Improved with Telepsychiatry

Quality of care for behavioral health patients in the ED has been dramatically improved at Rideout Regional Medical Center in Marysville, CA, with a program that aims to get professional help to people in need as soon as possible. In addition, the ED dramatically reduced its length of stay for these

patients.

By serving mentally ill patients better, the hospital also benefits with less overcrowding in the ED, decreased violence from frustrated patients, and less need to warehouse patients until a doctor can see them.

Prior to implementing a program that involves telepsychiatry services, the Rideout ED struggled with the same issue seen in most hospitals across the country. Patients needing behavioral healthcare appeared in the ED often and would be cleared medically, but they then had to wait until a psychiatrist could see them, and that meant keeping them in the ED and dealing with disruptions or even violence from some patients, says **Theresa Hyer**, RN, director of emergency services at Rideout. Simply finding space for them to wait also was an issue and some would stay for days until they could be admitted to a mental health facility.

"Patients sat and waited and didn't get a true mental health assessment from a psychiatrist until they were admitted to a facility," Hyer says. "We did our best, but it wasn't good for the patient and it was a functional problem for the ED."

Admission Was Default Plan

That was the situation in most EDs, says **Scott Zeller**, MD, vice president of psychiatry with CEP America, a company based in Emeryville, CA, that provides staffing and other services to EDs across the country. Zeller is the former chief of psychiatric emergency services of the Alameda Health System in California, where he led one of the busiest psychiatric EDs in the country, and he is past president of the American Association for Emergency Psychiatry.

"I find this strange and frustrating because this is the only illness where the default treatment plan is admission," Zeller says. "But if you go to the ED with an asthma attack, they're going to give you the treatment you need and send you home. We should be treating people in the ED and resolving their problems in the emergency setting, just like any other emergency."

Most psychiatric emergencies can be resolved within 24 hours, Zeller says. The lack of beds, leading to backup and long waits, is because of the automatic decision to admit the patient, he says.

"If you admitted everybody who came to the hospital with chest pain, you'd run out of beds very quickly. But only 10-15% are admitted," Zeller says. "There are similar numbers with psychiatry indicating that if you get these patients the help they need in the emergency setting, you'll end up admitting only 20-30%."

Rideout addressed the problem by making it possible for patients to be evaluated without delay by county mental health workers in the ED, and when necessary the patient can receive a full mental health assessment in the ED through telemedicine. The hospital contracted with a company that provides access to psychiatrists at all hours through telemedicine.

"The ED had become just a holding ground for psychiatric patients. Instead of waiting for that elusive mental health bed, we now use our county health workers to start the behavioral screening, and then if they need to, the patient can talk to a psychiatrist within minutes rather than waiting for a bed they might not even need," Hyer says. "They might be able to get the patients on medications that will clear them and they don't even need to be admitted."

Patient Put on Right Pathway

The county mental health workers and the telepsychiatry provider also work to develop a plan for a safe discharge back home, another process that previously would not have begun until the patient reached a mental health facility.

Hyer says the effects have been significant.

"It has taken between three and five hours off the length of stay for every single mental health patient, but on top of that is has improved the quality of care big time for those patients," she says. "The mother of a long-time psychiatric patient came up to me and told me that she had never seen treatment like and just raved about the care he received in our emergency room. She said it was unlike anything she had ever seen before, and he had been to quite a few really well-known healthcare organizations."

The improvement in turnaround time to discharge is a major benefit for the ED, Hyer says. The effect is felt throughout the ED because fewer mental health patients waiting in the ED means more staff, space, and other resources are available.

"Each one of those people require a sitter to stay with them to make sure they're safe and the staff are safe, so all the resources are affected when you decrease length of stay," Hyer says. "But the best part about this is that it's

really treating the human needs of the psychiatric patient. A lot times an emergency room will come up with ways to push people through quicker, but it's not always getting them what they need. This gets you both benefits."

County Workers Vital to Success

The program relies on building a good relationship with county mental health workers, Hyer says. She encouraged and empowered them to assess and treat mental health patients with the same approach that the ED provides for physical illness or injury — timely assessment, treatment, and discharge or on to the appropriate place. Urgency is warranted sometimes because a person on the edge of a psychotic episode may actually need care just as quickly as someone having a heart attack.

"They see the patients the second they come through the door and get telepsychiatry involved right off the bat," Hyer says. "These are master's-level mental health professionals and they focus on spotting the patient with a mental health issue and providing care as quickly as possible, which is a big turnaround from when we had to just hold on to them a while, sometimes a long while."

The county workers created a three-way pathway they use to make decisions from the beginning about how they will try to help the patient. They place each patient on a clinical pathway intended to result in the patient being discharged home, sent to a psychiatric bed, or given a medical bed because there are physical conditions also needing care.

Zeller says providing mental health access as quickly as possible changes everything.

"If you can get a psychiatrist to a patient with a psychiatric emergency quickly, you're going to change the course of what's happening and their chance of being able to go home goes through the roof," Zeller says. "You're giving them better care and taking a strain off the system."

ED Not Best Setting for Some

Getting the patient out of the ED as soon as possible can be the best quality care, even though the hospital benefits as well, Zeller says. A typical ED setting can be a bad place for a person with psychiatric issues to stay a while, he says.

"If you're having paranoid hallucinations or are despondent and suicidal, two very common diagnoses, being in a noisy, confining ED is not going to be helpful for you and might make your situation much worse," Zeller says. "The noises, sounds of people in pain, people rushing by, police present, lots of blinking lights and strange buzzers. In many cases, getting them out of that environment as soon as possible is in their best interest."

The program has improved quality of care without the hospital investing much money, Hyer notes. The telepsychiatry service's monthly fee is the biggest expense, with a fee for each encounter with a psychiatrist. The county pays their mental health workers and for some psychiatric care. The program has been in place for less than a year, so the financial benefit hasn't been formally calculated yet.

"The win for the hospital is that even though there are some expenses, beds are opened up," Hyer says. "Our normal turnaround time for a medical patient is only 140 to 150 minutes, so you can imagine how many times we could have moved a patient through a bed that a single mental health patient is occupying for four or five days." ■

SOURCES

- **Theresa Hyer**, RN, Director of Emergency Services, Rideout Regional Medical Center, Marysville, CA. Telephone: (530) 749-4515. Email: thyer@frhg.org.
- **Scott Zeller**, MD, Vice President of Psychiatry, CEP America, Emeryville, CA. Telephone: (510) 350-2777.

Hospitals Collaborate to Reduce Aspirational Pneumonia

The two hospitals in Jefferson County, WI, both had higher readmission rates than the state average, so they decided to collaborate and look for the cause and a solution. They were surprised at what they found.

About 45% of their readmissions were from aspirational

pneumonia, a rate that surprised everyone. A team of professionals from both hospitals set out to investigate the issue and found that much of the problem was related to communication, says **Sharon Olson**, supervisor of the Aging & Disability Resource Center of Jefferson County in Jefferson, WI.

They conducted a survey of area nursing homes and assisted living facilities which found that the most commonly cited problem was poor communication between the hospital and their facilities. In addition, about half of those surveyed said they would welcome more education on how to prevent aspirational pneumonia.

The hospitals decided to develop a training program for aspiration pneumonia. The Safe Swallowing program provided education on what the condition is, how to make food for someone at risk, and how to help the person while eating. *(The program is available online at: http://bit.ly/2lUBLFQ.)*

They offered the program to nursing homes and assisted-living facilities in the community and it was well received. Olson and her colleagues presented the program to managers at the facilities as a train-the-trainer initiative. Both hospitals began to see their readmission rates improve.

"We started getting calls from people in the community who were concerned about the people they cared for, so we put together a presentation that was attended by about 20 people," she says. "We are in the process now of creating some modules to build on the original training, and that will be available online." ■

SOURCE

- **Sharon Olson**, Supervisor, Aging & Disability Resource Center of Jefferson County, Jefferson, WI. Telephone: (920) 674-8139. Email: sharono@jeffersoncountywi.gov.

$1.3 Million from Big Data QI

A Maryland hospital has gone from losing $1.2 million in quality-based reimbursement in one year to gaining $1.3 million the next year, after implementing several quality improvement initiatives using big data.

In the first year after the Maryland Health Services Cost Review Commission (HSCRC) initiated payment adjustments to state hospitals' rates according to their performance on a set of quality indicators, Western Maryland Health System in Cumberland ended up ranked 46th out of 46 hospitals.

With one 205-bed hospital that provides care in a rural area across West Virginia, Pennsylvania, and Maryland, Western Maryland already was struggling and decreased reimbursement would only worsen its situation. Looking for a solution, in 2010 Western Maryland was one of 10 Maryland hospitals that volunteered to participate in a demonstration project called Total Patient Revenue (TPR), a model that provided fixed revenue for all inpatient and outpatient services provided in the hospital.

The goal was to encourage the hospital to provide the most appropriate care in the most appropriate setting, says **Susan Mays**, vice president of Dimensional Insight, a data analytics company in Burlington, MA, that assisted Western Maryland with developing quality improvements by mining its data. *(For more on the use of big data, see "Time to Use Big Data for Quality Improvement," HPR, February 2017, pp.13-17.)*

Western Maryland lost $1.2 million in revenue in 2012 due to its low performance on core measures, patient satisfaction, and potentially preventable conditions, so the hospital launched several initiatives for improvement. The hospital wanted to emphasize value over volume, reduce admissions and readmissions, provide care in the most appropriate location, improve chronic care delivery, reduce variation in quality, and reduce utilization rates in the ED, inpatient department, an ancillary services.

Better use of data was necessary for any of that to happen, Mays says, so the hospital adopted software that would allow it to extract data on a continual basis, showing quality performance in real time rather than looking backward. Western Maryland also began tracking potentially preventable conditions, which allowed it to reduce the number of patients who acquired preventable conditions while in the hospital. When a patient was diagnosed with a hospital-acquired condition, clinicians used big data analytics to search for previous patients with the same diagnosis and other factors that were similar, determining which order sets had

worked best on those patients.

"They developed a dashboard of quality indicators for their clinicians and quality leaders, using a series of metrics, and were able to report those metrics on a daily basis instead of the historical method of doing chart reviews, sending them out to a quality organization, and getting them back two months later," Mays says. "This was near real time, bringing all this information to them when the patient presents, giving providers a heads-up and the opportunity impact utilization and outcomes while the patient is in house."

Hospital leaders had known for some time that the data for its daily readmission reports were calculated differently than the data used by the state to determine reimbursement rates, setting the hospital up for unnecessary penalties. To fix that, the hospital's director of quality initiatives manually corrected the data in an Excel spreadsheet, which was time-consuming and inefficient. As part of the quality initiatives, that process was automated to produce more accurate data, Mays says.

BETTER USE OF BIG DATA HELPED THE HOSPITAL LOWER ITS READMISSION RATE TO 11.72%, BELOW THE STATE AVERAGE OF 13.9%.

Western Maryland also developed a care coordination team responsible for following up on high-utilization patients after discharge, using a call list of patients who met specific criteria for outreach. The hospital discovered discrepancies in discharge information between systems, so it created a discharge discrepancy report that could be used to resolve inconsistencies. Care managers also began reviewing mismatches during morning huddles, Mays says.

"Providing more data integrity and making it possible to reconcile those discrepancies gave the care managers much more ability to make sure people didn't slip through the cracks and not receive the kind of discharge follow-up that keep people from being readmitted," Mays says. "It was an example of how issues with data and data analytics can put a hospital's best efforts in an area like this at a disadvantage if those issues are not addressed."

The hospital also created a discharge clinic that patients could visit to ensure they understood their medications and were taking them appropriately.

Better use of big data helped the hospital lower its readmission rate to 11.72%, below the state average of 13.9%. Western Maryland also went from last place to first place in the state rankings of hospitals based on quality-based reimbursement measures. ■

Parent-reported Errors May Not Make It to Medical Record

Parents notice a significant number of medical errors but their reports sometimes do not make it into the medical record, according to a recent study.

Researchers from Harvard Medical School and Boston Children's Hospital surveyed parents, doctors, and nurses about the care of hospitalized children and looked at the medical records. They found that error rates were almost 16% higher when family reports were included, as opposed to just the clinician reports, and the rate of adverse events was almost 10% higher.

Twenty-six percent of the families reported a total of 255 incidents, with the researchers classifying 132 incidents as safety concerns, 102 as quality issues unrelated to safety, and 21 involving other problems.

The errors and adverse events reported by parents sometimes were not entered the medical record, with 49% of family-reported errors and 24% of family-reported adverse events not documented.

Hospital incident reports were even less reliable. Family-reported error rates were five times higher than hospital incident report rates, and adverse event rates were nearly three times higher than the incident report figures. ■

Maternity Quality Improving, Early Electives Almost Gone

Efforts to reduce the rate of early elective deliveries have been a huge success, with the rate declining to just 1.9%, according to the latest report from The Leapfrog Group, a Washington DC-based nonprofit representing employers and other purchasers. That rate is the lowest since Leapfrog began collecting maternity care quality data.

That means the procedure criticized as unhealthy for both mother and child has been practically eliminated, after rates reached 17% in 2010.

The rate of episiotomies has fallen to 9.6%, lower than the 13% first reported in 2012, but still a long way from Leapfrog's target of 5% or less. About 25.8% of births are cesarean sections, the same from the previous year but close to the target rate of 23.9% or lower.

Leapfrog reports that 45% of reporting hospitals are meeting target rates for episiotomies, and 37% are meeting the group's standard for cesarean sections.

These are some other findings in the 2017 Maternity Care Report:

- Cesarean section rates can be higher in some states. Cesareans on low-risk, first-time mothers with a single baby in the head-down position at term made up a higher percentage of births in Eastern and Southern states, but Western states tended to have lower rates.
- Hospital type does not affect maternity care quality. Leapfrog compared teaching hospitals to non-teaching hospitals, and urban to rural hospitals, but found the maternity quality performance data to be nearly identical.

(The full report is available online at http://bit.ly/2mad3Sx.) ■

Rude Parents Can Affect Quality of Care

Clinicians may unknowingly lower the quality of care after a pediatric patient's parents are rude, according to a recent study.

"Rudeness has robust, deleterious effects on the performance of medical teams," the authors concluded.

Researchers studied 39 teams of clinicians who worked in a neonatal ICU, conducting simulations that included the care of both full-term and newborn babies.

One group of clinicians were exposed to rudeness in the form of a mother criticizing the overall quality of the facility, saying they should have taken the baby to another hospital where they would receive better care. The mother did not directly criticize the clinicians working with her child.

The other group had parents who made neutral comments during their child's care.

Another two teams of clinicians were exposed to the rude parent, but one had undergone a preventive mode of therapy called cognitive bias modification, which addresses how people may unconsciously focus on the positive or negative of interactions.

That therapy was provided before the exposure to the rude parent. The other group underwent post-exposure narrative therapy, in which the counselor encourages the person to discuss the event and find skill sets to address problems.

Two independent judges evaluated each team's performance with a questionnaire. The researchers found that clinicians exposed to rudeness performed worse on diagnostic and intervention measures. Teamwork also was adversely affected.

The effects of the two therapy options varied significantly. Cognitive bias modification successfully mitigated the negative effects of the rudeness in almost every instance, but the narrative therapy after the event had no significant effect, the researchers said.

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

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CE QUESTIONS

1. **According to Deborah K. Hale, CCS, CCDS, why is a low rank on a PEPPER report not necessarily a good thing?**

   a. It could indicate that the hospital is being underpaid in that DRG group.
   b. It could indicate that the data is inaccurate.
   c. It could indicate that the hospital cherry-picked the submitted data.
   d. It could indicate that there is not enough competition in their region for a comparison.

2. **What do the Enhanced Recovery After Surgery (ERAS) protocols affect?**

   a. Only the post-op period.
   b. Only the intraoperative period.
   c. Only the post-op period and the intraoperative period.
   d. The entire continuum of care for a surgical patient.

3. **Which is true of the ERAS protocols?**

   a. They are tailored for the particular type of surgery.
   B. They apply only gynecologic and bariatric surgery.
   C. The must be licensed for use.
   D. They have not been widely adopted anywhere.

4. **How did the program to improve treatment of behavioral health patients at Rideout Regional Medical Center in Marysville, CA, affect their length of stay?**

   a. It decreased by three to five hours.
   b. It decreased by 90 minutes.
   c. It had no effect on length of stay.
   d. It increased length of stay slightly.

CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.