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INSIDE

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Patient Experience, Not Just Satisfaction Scores, Tied to Quality

Patient satisfaction is a primary concern for quality leaders at hospitals, but it should be viewed as only one component in the overall patient experience, experts say. The broader patient experience is directly tied to quality and is far more useful for quality improvement, they say.

Satisfaction has always been only one component measured by tools such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey required by CMS for all hospitals in the United States. But over time, healthcare systems have either focused excessively on that one part or improperly used "satisfaction" to mean the entire patient experience, says **Jim Merlino**, MD, president and chief medical officer of Press Ganey's strategic consulting division.

> OVER TIME, HEALTHCARE SYSTEMS HAVE EITHER FOCUSED EXCESSIVELY ON THAT ONE PART OR IMPROPERLY USED "SATISFACTION" TO MEAN THE ENTIRE PATIENT EXPERIENCE.

"I cringe when I hear healthcare organizations say they're trying to improve patient satisfaction. No, you're trying to improve care delivery," Merlino says. "There are nine questions on the HCAHPS about how we communicate with patients, and we've seen that when nurses improve how they communicate with patients, falls go down, complications go down, pressure ulcers go down. When physicians communicate better, compliance with treatment goes up. There's no doubt that when we improve our communication patients are happier, but the bigger point is that we're touching

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on quality and safety there, and the overall delivery of patient care."

Healthcare organizations are coming to that realization more than in years past, Merlino says. Five years ago, hospitals focused on patient satisfaction as an end goal in itself, he says, whereas today more organizations are recognizing that satisfaction is only one metric in the overall assessment of quality of care delivery.

Merlino notes that a 2017 study of Press Ganey data found that when healthcare employees believe the organization prioritizes safety and quality, publicly reported quality of care and patient experience metrics are higher. *(That report is available online at: http://bit.ly/2rWkkEE.)* Likewise, the study found that when patient experience is rated highly, the hospital tends to have high marks in safety and quality.

"These relationships are absolutely real. Organizations and leaders are getting more sophisticated about how they see these connections, and the research is more supportive of that linkage," Merlino says.

Improve Overall Experience

Hospitals should make improving the patient experience — not solely patient satisfaction — a top priority for the organization, Merlino says — not as part of another initiative, but as a standalone objective. The patient experience also must be defined, he says, so that people don't assume you're just looking to get five stars on every survey.

"Make it clear that this is not about making people happy or satisfaction. It's fundamentally about how we deliver safe, high-quality care in an environment of patient-centeredness," he says.

Hospitals also must focus their metrics on the patient experience, Merlino says. There are so many metrics available and required these days that the ones truly determining the patient experience can be lost in the shuffle. Focus on the ones that indicate quality and safety when formulating strategies and prioritizing resources.

"As part of your data strategy, make sure you are correctly cascading it from board all the way down to the frontlines," Merlino says. "Use the scorecard correctly in front of the board and help the frontline staff understand what the performance elements are, how the things they do during the course of a work day impacts the numbers you're presenting to them."

Identify Experience Drivers

One challenge is identifying what actually affects the patient experience, notes **Carole Lambert**, vice president of practice optimization at Cooperative of American Physicians (CAP). Physician leadership is key, she says, so any effort to improve the experience must prioritize their involvement.

"I often say that if the physician doesn't want it, it's not going to happen. The physician needs to say, 'we're going to get this right, do things properly, communicate effectively, make sure our patients understand what we're trying to do to help them and what their responsibility is, and we're going to follow through,'" Lambert says. "That's a very important first step in creating the culture that will foster a good patient experience."

Lambert notes that the patient

experience can affect the hospital's reputation more quickly than ever before. All it takes is one patient who perceives a staff member being inattentive, dismissive, or exasperated (even if it is justified by the patient's behavior), to walk out of the hospital and immediately post a review on social media.

"In 90 seconds, you have a bad review and you will need to counter it with several good reviews to push it down. At the simplest level, that is the kind of thing that impacts the patient experience and your reputation in the community," she says. "You have to have staff who understand the bigger picture and that this isn't just about following an algorithm, and it isn't just smile training. It is about relentless attention to detail and the meaning of what we do."

Always Maintain Professionalism

It can be easy for healthcare staff to let their guard down around coworkers and forget that patients may perceive their casualness or familiarity in a negative way, Lambert says.

"We get very used to the environment and the work, becoming so comfortable that we forget what it may look like to people who are not used to it," she says. "We become informal in our appearance, how we speak to one another, forgetting that this is a business and people are coming in and for whom this is a new environment, and one in which they expect a level of professionalism and decorum."

Healthcare leaders must take responsibility for the message patients receive from their organizations and not make excuses, Lambert says. If a patient feels disrespected and poorly treated, it is not enough to point out that the staff were unusually busy that day and the patient just doesn't understand the pressure they were under at that time. The message sent to that patient was unacceptable, and hospital leadership should seek a solution, she says.

(CAP offers a Risk Management

Gender May Affect Patient Expectations

Men and women may have different ideas of what constitutes excellent care, according to a recent report from at the 2017 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS). Both want good clinical outcomes, of course, but when it comes to rating their experience with the hospital, the study suggests men want optimal pain management while women want good communication with the staff.

Researchers at the Cleveland Clinic analyzed survey results from 692 patients who had undergone total hip arthroplasty (THA) between November 2009 and January 2015, and both men and women had a mean age of 62. *(An abstract of the study is available online at: http://bit.ly/2tHahoi.)*

The men and women had comparable mean hospital satisfaction scores, and there were no significant differences in the grading of nurse communication, staff responsiveness, doctor communication, hospital environment, pain management, and communication about medication, the report says. However, when patient perception was further analyzed, researchers found a gender bias in the factors that influenced men's and women's perceptions of care.

Women's patient satisfaction was most influenced by staff responsiveness, followed by their communication with nurses and doctors. For men, the way their pain was managed had the strongest effect on their overall satisfaction with care.

"For post-THA patients who are men, the orthopedist should focus on optimizing pain management. For the post-THA patients who are women, orthopedists should optimize staff responsiveness, as well as focus on improving nurse communication and doctor communication," the study says.

The authors caution that this finding should not interfere with proper pain relief for women, noting that multiple studies have addressed differences in pain perception and management between different genders. One study compared pain management of acute musculoskeletal problems in the ED between women and men and found that treating physicians assessed women's pain level to be higher than that of men, even though medication administration was similar for both genders.

That study also found higher anxiety levels among women, which could explain the higher level of pain that was assessed. "In addition, other studies have also shown that women a higher prevalence of chronic pain from conditions such as headaches, temporomandibular joint disorder, fibromyalgia, irritable bowel syndrome, and arthritis, as well as experiencing greater postsurgical pain," the authors write. ■

Self-Assessment Kit that addresses patient experience considerations such as facility cleanliness, air and noise quality, availability of engaging and current reading materials, staff training and engagement, and complaint resolution. The kit is available online at: http://bit.ly/2tXxtTO.)

"A great way to start improving the patient experience is to listen for the clues about where you could do better. Be an alert for any phrases such as 'We always have trouble with…' or 'We never get this right...' or 'Why are we doing this again?' If you hear those things, you've found a problem to address," she says.

Hospital Strives to Improve

Thibodaux (LA) Regional Medical Center improved patient satisfaction by creating a culture of patient-centered excellence, starting when CEO **Greg Stock** joined the hospital in 2000 and wanted to better focus the mission of the hospital on patient-centered excellence.

Thibodaux promised to provide great clinical care, great emotional care, and to invest in great technology and processes.

Fulfilling those promises would require getting everyone at the hospital on board, and Stock knew that would be a challenge. He and the other hospital leaders expected some opposition to a grand plan such as that, partly because people knew it would require changes to how they currently operated, and partly because they doubted the conviction of hospital leadership.

They also knew the community would be skeptical of the plan, seeing it as either a grandiose idea that the small community hospital could not pull off, or just another empty marketing campaign.

The outside criticism could only be addressed with results, so the leadership team at Thibodaux focused internally, starting with its patient experience metrics. They were generally good, but Stock realized that he had been putting too much confidence in metrics that showed the hospital doing as well or slightly better than other health systems.

"That was a big mistake. Once I started to dig into the data, I could see all sorts of opportunities for improvements. The data was a real eye-opener, showing us how much we could improve and where," Stock says. "We challenged ourselves to perform at the highest level — not just in comparison to similar health systems, but comparing ourselves to organizations with some of the top numbers for satisfaction metrics, like Cleveland Clinic and Scottsdale Healthcare."

Thibodaux did that with three key strategies:

1. **Holding employees accountable for living up to behavioral standards during the workday.** Some employees were fired when they could not meet the behavioral expectations that came with the hospital's new vision. By the same token, senior leaders stress to managers that they must treat employees respectfully and in a way consistent with the hospital's values.

2. **Using data from employee satisfaction surveys to change behaviors.** Thibodaux uses satisfaction data with Six Sigma's process improvement methodology to change employee behaviors, operating on the premise that they won't change unless they know they need to change. Stock cites the example of one employee who was viewed by hospital administration as a great leader until they looked at his employee satisfaction metrics. The data revealed that his employees were largely dissatisfied with how he treated them, so the hospital showed him those metrics and encouraged him to change how he related to his staff, particularly how he recognized their contributions. The data helped him significantly improve his department's satisfaction metrics.

3. **Using patient satisfaction data as a measurement of the entire organization's progress.** Thibodaux leaders consciously try to avoid putting too much stock in the last set of patient satisfaction scores, always focusing on the next metrics. Stock says patient satisfaction excellence should be a constant stretch goal, rather than relaxing because you've achieved the marks you wanted.

Involve Patient in Plan

Any effort to improving the patient experience and patient satisfaction must start with the implementation of an evidence-based, collaborative care plan that involves both the patient and caregiver, says **Lori O'Brien**, MSN RN, senior clinical strategist and operations manager with Zynx Healthcare in Los Angeles. By fully engaging the patient and establishing patient-specific health goals and care plans, patients are more motivated to participate in the process and achieve established goals, she says.

Caregivers can guide the process to ensure continuous dialogue that addresses shifting needs, eliminates potential barriers, and provides patients with the specific tools

they need to ensure quality and cost-effective outcomes, she says.

"Clinicians know, based on a large amount of evidence, that the more that patients are engaged in their care the more likely that that costs will be reduced and clinical outcomes will be improved," O'Brien says. "By fully engaging the patient and establishing patient-specific health goals and developing individualized care plans, patients are more motivated to participate in the process and achieve established goals."

Some strategies to more fully engage patients include creating an environment that encourages patients to participate in developing their individualized care plan, she says. Clinicians should encourage dialogue on goal-setting and what that goal means to the patient and their health using their own words, she says.

"Clinicians should provide an evidence-based care plan for the patient to review to provide a starting point for discussion. It's important for the clinician to answer questions but remain neutral to enable patients to identify what steps or interventions will work for them to achieve their identified goals," she says. "Goals and interventions should be revisited at every encounter to reflect shifting needs."

Clinicians also must remember to tailor their communication styles, and their delivery of care to some extent, to the individual. Gender can affect patient expectations, for instance. One recent study found that men focused more on pain management, while women focused more on communication and staff responsiveness. *(For more on that study, see the story in this issue.)*

Avoid Information Overload

A typical barrier to patient engagement is providing too much information at one time. For example, identifying all of the self-management strategies and lifestyle changes for a patient newly diagnosed with Type 2 diabetes can be overwhelming, O'Brien notes.

"It may be better to focus on achieving a normal blood glucose level and medication adherence as the first priority and then focus on diet, weight loss, and exercise in subsequent visits to enable better comprehension and goal attainment," she says.

Another barrier is receiving information in a format that isn't personalized to a patient's learning style. All patient-directed information should be free of medical jargon and abbreviations, O'Brien says, and in a format and language that they can comprehend. Learning styles and preferences should be discussed initially and then re-evaluated for effectiveness and comprehension. *(See the story in this issue for more on how artificial intelligence may aid in this effort.)*

"Younger individuals will be more likely to access and learn information if it's in an electronic format that they can access at their convenience," she says. "Elderly individuals may prefer a face-to-face or telephone conversation and written information to reinforce goals and instructions. By facilitating goal-setting that is relevant and has a personal meaning, eliminating common barriers, and keeping the care plan meaningful and updated, patients are likely to stay more fully engaged and have a healthier future." ■

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AI Could Help Improve Care, Patient Satisfaction

Artificial intelligence (AI) is entering the field of medicine and may soon help improve quality of care and the patient experience, one expert says.

AI is beginning to capture the knowledge of clinicians and combine it with best evidence, and patient specific data, says **Guy Wood-Gush**, MD, a neurosurgeon and ophthalmic surgeon, and CEO of Deontics, a provider of artificial

intelligence for clinical pathways and clinical decision support systems.

"Prior technologies did not provide the capability to capture cognitive thinking that clinicians go through to manage complex clinical diagnosis and treatment, nor were patient preference taken into consideration," Wood-Gush says. "New measurements and performance payment are being put in place that considers patient experience and satisfaction."

AI also is responding to the need for transparency as patients want to know more about their care options, outcomes probabilities, and cost. This is especially true given the shifting insurance landscape and increasing health costs to individuals, he says.

"Patients want to explore what treatment options are available to them and if they are covered by their health plans. They want visibility to see where they are on their care journey and possible outcome scenarios in a simple, consumer-friendly way, avoiding medical jargon," Wood-Gush says. "Using the right AI technologies and delivering them on multiple platforms can engage a patient throughout their care lifecycle. Patients need to be able to make decisions that may be against recommended procedures, based on their personal preferences. These need to be accounted for in the technology platform and presented in a clear and explicit fashion."

Clinicians increasingly want technology to guide them through care treatment, especially in complex and overlapping disease cases, Wood-Gush says. These cases do not follow a single path and need to support nonlinear decision-making and argumentation, he says, and they need to be self-documenting such that results of a decision can be quantified. Then, the system can learn from decisions that are being made.

"A 'thinking' system that can augment clinician decision-making and provide outcome data, safety, quality, and cost, can become a learning health system over time as patterns are recognized and new best practices are established," he explains. "Given the overwhelming and ever-changing amount of clinical evidence, it is becoming impossible for a human to keep up with it and apply to best decision-making. Clinicians need technology that will allow them to make better and more accurate diagnoses and search through relevant data."

Ultimately, all constituents of the healthcare delivery process are focused on the same things — safety, quality, and cost control, Wood-Gush says. That calls for new, more advanced systems that can think like humans, manage mass amounts of data, and start to learn from experience, he says.

AI encompasses a broad set of different technical approaches and capabilities, which are complementary and capable of enabling these requirements. These include machine learning, knowledge representation, and reasoning, amongst others, and an ecosystem of small and large companies which represent all of these has now emerged capable of supplying very granular clinical decision support systems at the point of care, he explains.

"Machine learning and analytics technologies are becoming increasingly strong at recognizing patterns amongst data and highlighting diagnoses or probabilities of patients falling into different disease categories. Similarly, these technologies can evaluate outcomes data and feedback 'learning' to improve guidelines and treatment and patient management plans," he says. "Reasoning technologies or AI can contextualize data at the point of decision-making at the point of care, identifying possible courses of action and showing arguments from the evidence base — typically national guidelines and local protocols, but also analytics outputs, genomics, and proteomics — to allow the physician and the patient to understand the pros and cons of different courses of action."

AI will reason over the course of a patient's disease in a dynamic manner, much like the GPS in a car, Wood-Gush explains. As patients enter data about their conditions, like blood sugar readings for a diabetic, the advice continuously updates, engaging the patient in decision-making about their care, and allowing them to fully understand the consequences of different possible treatment options.

The AI also would inform the patient on whether the care being offered is compliant with best evidence, and it will take part in shared decision-making with their physician on a much more even-handed basis than is otherwise possible.

"As the technology is not a decision tree technology, but much more sophisticated, it is able to get away from step-by-step algorithms, which physicians hate as they do not represent real life and cannot handle anything other than very simple decisions," Wood-Gush says. "AI will improve the physician experience as well." ■

Social Determinants Affect Quality of Care, Outcomes

A Massachusetts accountable care organization (ACO) is using social determinants of health to shift how Medicaid care is delivered and dollars are spent — an initiative to take Medicaid payments into the hands of the providers themselves.

Community Care Cooperative (C3), a group of 13 federally qualified health centers (FQHCs) operating as an ACO, is building a model of care and associated systems and processes that integrate social determinants of health and behavioral health services with primary care to optimize health outcomes, says **Christina Severin**, president and CEO. The companies also will deploy a common technology platform across C3 health centers with a goal of unifying data aggregation, clinical stratification, and coding and documentation workflows across C3's FQHCs, which leverage a variety of electronic medical record platforms.

Massachusetts has long been at the forefront of innovative healthcare approaches, passing universal coverage in 2006. In November 2016, CMS and the state announced the renewal of Massachusetts' 1115 waiver, paving the way for work to restructure Medicaid delivery to support the move to ACOs and allow for innovative ways of addressing the social determinants of health. Massachusetts is the first and only state embedding social determinants of health into risk scores, ensuring that health-related social needs are recognized for the true effect that they have on an individual's cost of care.

According to a November 2016 study in the *American Journal of Public Health*, FQHCs provided a more cost-efficient setting for primary care for Medicaid patients. Those who received the majority of their primary care from FQHCs had lower use and spending than non-health center patients across all services, including 22% fewer visits and 24% lower total spending. *(An abstract of the study is available online at: http://bit.ly/2ucDMhj.)*

C3 is currently working with hospitals to reduce readmissions.

"The core philosophy of the program is that if we can lay eyes on physicians and caregivers while the patient is in a hospital bed, and establish a relationship, we can reduce readmissions by being part of discharge planning. We can ensure that the discharge planning includes the least restrictive community setting, for example," Severin says. "If the patient could be discharged to home but there are social determinants that might prevent that from happening, we can send someone to the patient's home for an assessment, provide an air conditioner, remove rugs, and make any other needed accommodations. We might also make the assessment that the home isn't the best option for this patient and bring that recommendation back to the hospital."

In addition, the C3 representative should be at the hospital bedside to establish a relationship before discharge, Severin says. That makes home visits more productive when the patient recognizes the representative and understands why he or she is visiting. The C3 representative generally works with the discharged patient for about 30 days, making sure basic needs are met and follow-up care is taking place as expected, and then assesses the next step for the patient. That might be inclusion in a general population health program, a more intensive population health program, or a specific program for an issue like diabetes or depression.

C3 also is looking at working with EDs to address patients who are admitted only because emergency staff determine the patient has no safe environment to which he or she can be discharged.

"Emergency department nurses responded so well when we suggested helping with these patients, because they admit them, appropriately, when they don't know if the patient has a home to go to, or whether they're going to be hungry at home or without any means for seeking follow-up care," Severin says. "We can help by making the necessary arrangements for the patient, taking that burden off the staff of the emergency department and spending money if we have to. We can get that person a refrigerator full of food, put them in an Uber to get them to the clinic — whatever it takes to get that person discharged in a safe and appropriate way."

Addressing social determinants of health is a key way that hospitals benefit from an ACO relationship, Severin says.

"You add value when patients and families feel supported throughout the patient experience, and particularly post-discharge, which can be a really stressful time

for patients and caregivers. Once you establish a meeting of the minds between an ACO and the hospital, that opens opportunities to do the programmatic work," Severin says. "The idea of doing this kind of intervention for every patient in the hospital is daunting, but that's not what has to be done. You can stratify inpatients so that you're focusing on those cases most likely to result in a readmission, the patients where the data analytics tell us there is the most risk and the most value." ■

NCQA Includes Population Health Management in Accreditation

The National Committee for Quality Assurance (NCQA) is including population health management (PHM) as a new category in its 2018 Health Plan Accreditation (HPA) standards and guidelines. The PHM category is a shift from evaluation of single-disease state toward a whole-person focus, NCQA says.

Within the PHM category, health plans must describe their strategy for addressing the needs of members, then demonstrate effective execution of that strategy.

The updated standards combine components of PHM such as wellness and complex case management, which were long-standing NCQA Accreditation requirements. The new PHM category also recognizes the important role of data analytics for identifying population needs, targeting resources to the right individuals and evaluating the impact of their strategy. This holistic approach allows removal of a number of outdated standards, such as siloed disease management and practice guidelines. Changes resulted in a net reduction of seven elements.

"NCQA recognizes the need for a population health focus on care management in which plans evaluate their membership and connect them to the care they need," the group said in a statement announcing the new category. "NCQA encourages aligning with the delivery system including accountable care entities, practitioners, and patient-centered medical homes to meet population heath goals."

More information on the NCQA health plan accreditation requirements is available online at: http://bit.ly/2vXRV3X. ■

High-needs Patients Require Focus to Avoid Readmissions

Hospitals can make significant headway in reducing readmissions by addressing high- needs patients, according to a new National Academy of Medicine (NAM) special publication, which notes that nearly half of the nation's spending on healthcare is driven by just 5% of patients.

Those patients can be identified long before discharge, making it possible to intervene early and reduce the likelihood of readmission, says **Peter Long**, PhD, chair of the planning committee for the NAM workshop series, and president and CEO of Blue Shield of California Foundation.

To improve health outcomes and curb spending in healthcare, hospitals need to identify these high-need patients and provide coordinated services through successful care models that link medical, behavioral, and community resources, the report says. The needs of this population extend beyond care for their physical ailments to social and behavioral services that are often central to their overall well-being, it says.

As a result, addressing clinical needs alone will not improve their health outcomes or reduce healthcare costs, according to the NAM publication, which summarizes presentations, discussions, and scientific literature from a three-part workshop series. *(The full report is available online at: http://bit.ly/2t8XbAJ.)*

New Quality Measures Needed

Common quality measures may not be enough to address high-needs patients, Long says.

"We think some of the quality measures in this are insufficient and misguided, so we're calling for appropriate assessing of outcomes and rethinking of what could be better

quality measures," Long says. "We have to take into account the heterogeneous population and their functional status in addition to their access to healthcare. This is an area where hospitals have deep insight to what those measures should be or could be."

The report examines the key characteristics of high-need patients, the use of a patient categorization scheme as a tool to inform and target care, promising care models and attributes to better serve high-needs patients, and areas of opportunity to support the spread and scale of evidence-based programs.

Understanding the characteristics of high-need patients is the first step in determining how to improve care, the report says, but consensus on those defining characteristics has been slow to evolve.

"Segmentation of the patient population and then applying different care models to those segments is a key concept, and some health systems are beginning to take that approach. That is a starting point that any hospital or health system could do today on their own," Long says. "We gave some examples based on claims data, but we think health systems themselves have much better data and do their own segmentation based on a number of factors like utilization and functional status."

NAM says three criteria could help define and identify this population: total accrued healthcare costs, intensity of care utilized for a given period of time, and functional limitations. Functional limitations include limitations in activities of daily living — such as dressing, bathing, self-feeding, and grooming — or limitations in instrumental activities of daily living that support an independent lifestyle — such as housework, shopping, managing money, taking medications, or using transportation.

Research indicates that high-needs individuals are disproportionately older, female, white, and less educated, the report notes. They also are more likely to be publicly insured, have fair-to-poor self-reported health, and be susceptible to lack of coordination within the healthcare system. Therefore, improving outcomes for this population requires assurance of attention to an individual's functional, social, and behavioral needs — largely through social and community services, NAM recommends.

"Understanding how to care effectively for high-needs patients requires ascertainment of the key factors driving the needs for of each individual. Because this patient population is heterogeneous, those factors will differ for different segments of the population," the report says. "Therefore, the use of a practical taxonomy that helps group individuals by the care they most need, as well as when, how, and how often they might need it, can inform decisions about how to serve these patients more effectively."

Care Models Identified

In the course of the meeting series that formed the basis of the report, a taxonomy working group identified for discussion the taxonomic elements that might help align high-needs patients with the care models that target their specific circumstances. While the success of even the best care model will depend on the particular needs and goals of the patient group a model intends to serve — which vary for different segments of high-needs patients — all successful care models aim to foster effectiveness across three domains: health and well-being, care utilization, and costs, the report notes. The planning committee identified 14 successful care models for high-needs patients and cross-referenced those to the segment(s) of the proposed taxonomy that could be served if health systems leaders match the needs of their patients to appropriate models within this menu of evidence-based approaches.

"A number of barriers currently prevent the spread or sustainability of successful care models, including the misalignment between financial incentives and the services necessary to care for high-needs patients, health system fragmentation, workforce training issues, and disparate data systems that cannot easily share needed information," NAM says.

The publication discusses these barriers as well as strategies for addressing them. NAM identified these opportunities for action and reform:

- Refining the starter taxonomy based on real-world use and experience to facilitate the matching of individual need and functional capacity to specific care programs.
- Integrating and coordinating the delivery of medical, social, and behavioral services to reduce the burdens on patients and caregivers.
- Developing approaches for spreading and scaling successful programs and for training the workforce capable of making these models successful.
- Promoting payment reform efforts that further incentivize the adoption of successful care models and the integration of medical and social services.
- Establishing a small set of proven quality measures appropriate for assessing outcomes, including return on investment, and continuously improving programs for high-needs individuals.
- Creating road maps and tools to help organizations adopt models of care suitable for their patient populations.

Find Key Drivers in Care Models

Long notes that while there are hundreds of models of care designed

to address high-needs patients — and the NAM report highlights 14 of the most well-known — the models need more study before any can be determined the best, he says, and it may be that there is no single model to adopt. Even care models that have proven success with some institutions can be difficult for any one hospital to adopt exactly as outlined, he says. A better strategy might be to identify what makes any model work and apply those concepts as appropriate in the hospital, which may not be exactly the way they were applied elsewhere, he says.

"Deconstruct that model into its component parts and you might find that it's really about improved communication — data sharing among different players, for instance," Long says. "Those elements can be applied without necessarily taking on the care model lock, stock, and barrel, which sometimes doesn't work because hospitals and health systems have unique characteristics."

Segmentation of a health system's patient population and developing a high-needs care model will require significant new and different data collection, as well as data flow, Long says.

"We don't underestimate the magnitude of what we're talking about for hospitals. When we say, 'you have to incorporate behavioral health and social risk factors,' we know that means incorporating a lot of new players, with different data and different systems," Long says. "We think data collection is going to be a challenge."

The move toward value-based care should be an impetus for improving the care of high-needs patients, Long says.

"As a hospital moves toward value-based care, they will need to improve the care of high-needs populations because they get a sum of money to produce an outcome. It reinforces the need for segmentation and providing a care model tailored to the needs of these patients," he says. "Value-based care is an accelerant to all of these care models." ■

SOURCE

- **Peter Long**, PhD, president and CEO, Blue Shield of California Foundation, San Francisco. Telephone: (415) 229-6080. Email: bscf@blueshieldcafoundation.org.

Readmissions More Common After Observation Stays

Patients often are readmitted to the hospital after an observation stay, according to recent research which suggests hospitals may want to target this population.

More patients are being treated under observation status rather than inpatient care because of the financial incentives from CMS and other payers, notes **Kumar Dharmarajan**, MD, assistant professor in the Section of Cardiovascular Medicine at Yale University School of Medicine in New Haven, CT, and an author of the study. Observation increasingly includes patients who might have been treated inpatient a few years ago, he says.

"Patients who would have been treated under inpatient status are being treated with an observation stay, and that is not the same level of care," he says. "We are seeing more of that shift from inpatient to observation status, so as that shift continues, we are seeing an increase in readmissions from the observation status population."

The research involved a nationally representative sample of Medicare fee-for-service beneficiaries aged 65 or over discharged after observation stays, ED treatment-and-discharge stays, and inpatient stays from 2006 to 2011. *(The full study report is available online at: http://bit.ly/2t0NIxk.)*

Thirty days after an observation stay, 2.9% of patients had another observation stay, 8.4% of them had an ED treatment and discharge, 11.2% had an inpatient stay, and 20.1% had any hospital revisit.

Focus on Transitional Care

"Revisit rates of 20% after observation stays suggest that patients who are older and receiving observation services are vulnerable to major adverse outcomes after discharge and may benefit from improved transitional and post-acute care," the authors wrote. "To date, focus on care transitions, post-hospital outpatient care, and corresponding outcomes in the USA has largely been applied to vulnerable older adults discharged from inpatient stays and, to a smaller extent, emergency

department stays. Little attention has been directed to improving outcomes after observation services."

Given that readmission rates after observation are comparable to those of inpatients, some of the same readmission reduction strategies could be applied, Dharmarajan says, such as facilitating access to outpatient providers, early and longitudinal follow-up, timely transmittal of information from hospitals to outpatient teams, outpatient availability of care management services, multidisciplinary team-based care, and home visits.

"Those are common-sense interventions from the perspective of the patients, but historically, hospitals were not held accountable financially for readmissions after discharge," Dharmarajan says. "That is changing now, not just because of readmission penalties, but also because of care bundles and other risk-sharing agreements. Hospitals are increasingly on the hook for post-discharge outcomes and it is becoming clear that it is not just inpatients that are a concern in this regard. We're seeing that observation status and discharge from the emergency department are signals of vulnerability, and many of those patients may benefit from transitions of care intervention."

Concerns Over Observation Status

The study results confirm concerns about how hospitals are using observation status, says **Mary Barton**, MD, vice president for performance measurement with the National Committee for Quality Assurance (NCQA) in Washington, DC. Patients who may be better treated as inpatients may instead go to observation status.

"Observation status is a decision made by the team treating the patient, so there can be huge differences in how that decision is made from hospital to hospital. It's not just the clinical status of that patient, but also what beds are available — all sorts of variables that come into play," Barton says. "When you're under pressure, the availability of an observation stay in the hospital puts a release valve on that decision-making. The theory may be that observation status is like an outpatient visit, but these study outcomes tell us that it's really more like inpatient hospitalization."

NCQA also has been studying observation stays and how they may apply to its all-cause readmission stays measure, Barton says.

"This data will be useful in showing why we need to include the all-cause readmission stays measure to include observation stays," she says. ■

SOURCE

- **Kumar Dharmarajan**, MD, assistant professor, Section of Cardiovascular Medicine, Yale University School of Medicine, New Haven, CT. Email: kumar.dharmarajan@yale.edu.

More Inpatient Spending Linked to Better Outcomes

High inpatient spending is linked to better patient outcomes, according to recent report.

A study in the *Journal of Health Economics* used ambulance referral patterns to examine treatment at different facilities and found that those treated at hospitals with greater amounts of care over three months after a medical emergency had better health outcomes than those treated at hospitals that provided less care.

Patients treated at hospitals that spend more on inpatient care than outpatient care also were more likely to survive one year after an emergency visit, the researchers found. *(An abstract of the study is available online at http://bit.ly/2vb8k7y.)*

"We discovered that downstream spending at skilled nursing facilities (SNFs) is a strong predictor of mortality," the authors wrote. "Our results highlight SNF admissions as a quality measure to complement the commonly used measure of hospital readmissions and suggest that in the search for waste in the U.S. healthcare, post-acute SNF care is a prime candidate." ■

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CE QUESTIONS

1. What does Carole Lambert cite as one potential problem with the patient experience?

a. It can be easy for healthcare staff to let their guard down around co-workers and forget that patients may perceive their casualness or familiarity in a negative way.
b. The out-of-pocket cost reflects poorly on the hospital.
c. Overly aggressive marketing in the community can backfire.
d. Poor signage can add to a patient's already high stress level.

2. In the recent report from the American Academy of Orthopaedic Surgeons Annual Meeting 2017, how did men and women differ in prioritizing their patient expectations?

a. Men were more focused on efficiency and women focused on pain control.
b. Men wanted optimal pain management while women wanted good communication with the staff.
c. Men prioritized cost control while women prioritized outcomes.
d. Men valued speed most and women valued infection control most.

3. A new National Academy of Medicine special publication notes that nearly half of the nation's spending on healthcare is driven by what percentage of patients?

a. 1%
b. 5%
c. 10%
d. 20%

4. According to a study co-authored by Kumar Dharmarajan, MD, what percentage of observation status patients had any hospital revisit 30 days after discharge?

a. 5.1%
b. 15.1%
c. 20.1%
d. 25.1%

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.