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INSIDE

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Improve Best Practices Adoption With Acceleration Strategies

Adopting best practices is key to improving quality of care, but once those ideal strategies are identified, it can take an agonizingly long time to actually get an organization to start using them consistently. Some healthcare organizations are finding ways to cut down that long introduction period, which can mean achieving improvements years sooner.

Even when the healthcare community settles on best practices for any particular area of concern, it takes an average 17 years from publication of research findings until they are widely used, according to one report. *(An abstract of the report is available at: https://bit.ly/2I6OWgI.)*

That was way too long for healthcare leaders such as **Michael H. Kanter**, MD, a research scientist with Southern California Permanente Medical Group, and chair of clinical science and professor at the Kaiser Permanente School of Medicine in Pasadena, CA. Kanter previously was executive vice president and chief quality officer for The Permanente Federation and medical director of quality and clinical analysis for the Southern California Permanente Medical Group.

> TO SPEED THE ADOPTION OF BEST PRACTICES, KAISER PERMANENTE DOES NOT TRY TO REPLICATE DATA SUPPORTING NEW APPROACHES BEFORE IMPLEMENTING THEM.

Kanter and his colleagues looked for ways to implement best practices in months, not years or even a decade. One of the implementation methods Kaiser Permanente uses for best practices is the E-SCOPE (Evidence Scanning for Clinical, Operational, and Practice Efficiencies) system. The program is designed to facilitate the most rapid identification and implementation of

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new evidence-based practices by using systematic evidence searches to first recognize them, then using accelerated decision-making with Kaiser Permanente to get them in use.

"We scan the literature, systematically looking for practices that will improve quality, reduce costs, improve satisfaction. A lot of organizations have a more passive approach, waiting until their doctors discover something or they hear about it at a quality meeting," Kanter says. "We try to get at it earlier with a scan that pulls evidence-based abstracts that are reviewed by a group of physicians who determine their initial validity. Then, they are reviewed by senior leadership who determines if the practices have actually been deployed in a system or not."

Best Practices Deployed Quickly

If they have and the practices seem promising, they are taken to chief stakeholders who would implement the best practices, Kanter says. The changes can involve direct clinical care or operational issues. He recalls one instance in which E-SCOPE identified an article about steam sterilizer practices that were efficient and created a smaller carbon footprint, so they were taken to operating room managers. The practices were soon adopted.

Kaiser Permanente employs a project manager who works with hospital units to encourage rapid adoption once the chief stakeholders accept the changes, Kanter explains. Another example involved weight loss interventions that were shown in 2015 to reduce severity of psoriasis symptoms. Through the rapid implementation using E-SCOPE, the health system offered weight reduction options to 18,000 psoriasis patients in only eight months. *(See the sidebar on page 75 for more on Kaiser Permanente's strategies for rapid implementation of best practices.)*

"A lot of the best practices we have already implemented, so we're looking for the ones we haven't. With a relatively small resource allocation, we have put in about 25 practices," Kanter says. "Some of them have been very impactful while the impact of some, like the steam sterilizers, has been relatively modest. But those were relatively easy to do, so the return is still worthwhile."

To speed the adoption of best practices, Kaiser Permanente does not bother replicating the results of published research or measuring the impact in a small trial implementation, Kanter explains.

"One of thing things organizations do is trying pilots, doing some new practice and then measuring to see if it worked as intended. That takes a lot of resources and can be problematic because you need a control group and have to account for measurement artifacts and bias," he says. "We don't try to reprove the evidence if it's already been published and accepted as legitimate by our stakeholders. That's a major philosophical change that makes it scaleable."

Move to Virtual Cardiac Rehab

In another example, Kaiser Permanente found evidence that virtual cardiac rehab works as well

as traditional cardiac rehab, which many patients forgo because it is expensive and requires frequent visits to a hospital or clinic. The health system deployed a program that uses remote connections so the patient can participate from home. As a result, the participation level among cardiac patients has greatly increased, Kanter says.

The rapid adoption of best practices depends on clinicians accepting their validity, and Kanter notes that there sometimes can be pushback.

For instance, some leaders may question whether the patient demographics or other factors are different in a meaningful way. The E-SCOPE program tries to minimize those concerns with reviews by clinical leaders who look for those potential issues before recommending adoption of the best practices, he explains.

"There also will be occasions where people just feel overwhelmed by the changes being pushed on them and feel like they can't take this on right now, even if they don't dispute the value of the best practices we've identified," Kanter says.

"In that case, we have enough to focus on that we can move on to the next one and look at what we implement rather than getting bogged down in what we don't. We've not allocated a lot of resources to this yet, but we've deployed a lot of improvements for our 4.5 million members."

The E-SCOPE program delivers about 100 abstracts a month for Kanter and his assistant to consider. That's a lot to keep up with, he says, even though the algorithm was tweaked to narrow the results down to the abstracts most likely to be useful.

Medical Education, Embedded Researchers Improve Best Practice Implementation

Michael H. Kanter, MD, a research scientist with Southern California Permanente Medical Group, and chair of clinical science and professor at the Kaiser Permanente School of Medicine in Pasadena, CA, and a colleague recently summarized the efforts to improve best practices adoption that were reported at Kaiser Permanente's 2019 National Quality Conference.

In addition to the E-SCOPE (Evidence Scanning for Clinical, Operational, and Practice Efficiencies) system that identifies new best practices, Kaiser Permanente created a medical education program to encourage the adoption of quality improvement initiatives. At the time of its report, Kaiser Permanente had more than 130 ongoing quality improvement projects.

More than 5,000 physicians had received Maintenance of Certification credit for the projects, the report says.

"New ways of educating future clinicians will embed quality improvement into the medical school curriculum from day one. The KP School of Medicine just received preliminary accreditation from the Liaison Committee for Medical Education and will be accepting its first class to start in 2020," they reported.

"As part of the curriculum, students will be required to perform scholarly work, which may include quality improvement projects," the report says.

"Other medical schools also promote such activities, although the KP system is perhaps uniquely suited to excel in this arena because of our integration, access to data, and ability to spread and scale good practices."

Kaiser Permanente also uses embedded researchers in quality improvement projects.

"In this case, researchers join quality improvement teams from the beginning and bring their analytic skills to the project. This participation improves the rigor with which the project is conducted and evaluated, and increases the likelihood of publication and spread," the report says.

"Organizations can also bring this same discipline to study the spread of best practices. By more precisely understanding the factors that improve the identification and spread of these practices, we can continue to improve care."

The report is available online at: https://bit.ly/2WCM9oU. ■

"We found that pharmacy and drug therapy are areas in which we don't have that much opportunity, possibly just because of how our system is structured with very good pharmacists who do a good job of keeping up with improvements there," Kanter says.

"So we look less thoroughly at drug issues in the literature, and that narrows down the abstracts we have to review. Other systems may have a different experience depending on their own particular strengths."

The biggest barriers to adopting best practices are time and organizational culture, says **Jane Carmody**, DNP, MBA, RN, program officer with The John A. Hartford Foundation (JAHF), a nonprofit, nonpartisan organization in New York City that works to improve conditions for the care of older adults in the healthcare system. She previously was chief nurse of a large health system in the Midwest.

"I'm a firm believer that you have to have a process for introducing best practices, or it just won't work," Carmody says.

"Particularly in a health system, you will have so many different areas of expertise and specialties, and all of them will be monitoring their areas for new developments and best practices."

Carmody has seen success with first creating a large interest group of individuals who are seeking to improve care, which should include the chief medical officer and chief nurse.

They help create the urgency that can guide others to a rapid implementation, she says.

"You aren't going to create change by telling people this is the best way to do it and you need to start doing it this way right now," she says.

"You have to recognize the influence of the culture and the emotion that can come with change. Some people may feel like everything is new again and they're novices now, whereas yesterday they were the experts. That can increase their resistance."

One strategy is to minimize the feeling of change so that people feel more like you are asking them to do what they are already doing in a slightly different way, rather than having them feel like they must do something completely different, Carmody suggests.

It also is important to ensure that the available technology matches and supports what you are asking people to do, she says.

Best practice implementation can be derailed if you push the potential benefits only to have people find that the electronic medical record or other tools make it difficult or impossible for them carry out your instructions.

"Sometimes, if it's a good idea, you don't have to push it very hard. People will say, 'Oh, yes, that makes sense,' and it will go viral on its own," Carmody says.

"When that happens, you have to make sure you are prepared to support that implementation and not let that enthusiasm go to waste."

Networks Have an Advantage

Hospital networks and other cooperating facilities have a leg up when it comes to discovering and implementing best practices, notes **Troy Polan**, chief technology officer with Excelera, a specialty pharmacy network based in Minneapolis, MN.

Polan leads data collection for the 23 health systems that are part of the Excelera network.

Like many hospital networks, Excelera members have a formal structure of communication, committees, and collaboration to both identify best practices and implement them systemwide, he says.

"One benefit is that best practices are not unique to one facility ... because [facilities] are collaborating on them," Polan says.

"An example is how in the last six months, there have been new migraine meds coming to market, so we've had a few members who thought we should get together to talk about protocols and exactly how to manage these medications in certain populations," he says.

We have a few members who are working to sort that out and share it with the rest of the network."

Rapid adoption of the best practices is baked into the process, Polan says.

"By working together rapidly, the implementation of best practices can be a lot more dynamic than perhaps seeing a presentation by someone and trying to figure out how to do this," he says.

"Because there is a dialogue and the consideration of how other groups will implement this," Polan says, "there is an inherent dynamism that you don't get when you just present an idea to people and they have to determine how that process that worked somewhere else also can work for them."

Organizations tend to have more trouble implementing broader, wide-ranging best practices, Polan notes.

The narrower the focus, the more rapidly the best practices can

be absorbed into an organization's operations, he says, whereas expansive cultural changes can take much more time.

"It's hard to change a lot of things at once," Polan says.

"An incremental change or a well-defined change in a limited portion of your organization usually can be implemented much more quickly in a healthcare setting. As organizations become more receptive to learning from each other, there is great potential for improvement across the entire country and the healthcare community." ■

SOURCES

- Jane Carmody, Program Officer, The John A. Hartford Foundation, New York City. Phone: (212) 832-7788.
- Michael H. Kanter, MD, Research Scientist, Southern California Permanente Medical Group, Pasadena, CA. Phone: (510) 267-7449.
- Troy Polan, Chief Technology Officer, Excelera, Minneapolis. Phone: (612) 293-0378.

Hospital Reduces Invasive Procedures, Uses Escalation Huddles

Dixie Regional Medical Center, part of the Intermountain Healthcare system in St. George, UT, is reporting success with a program called POKE that significantly reduces the number of invasive procedures patients must undergo while hospitalized.

The hospital also is seeing success with the use of escalation huddles to enhance communication among clinicians, administrators, and other hospital leaders.

POKE, which stands for "Prevent pain and Organisms from sKin and catheter Entry," was created in 2008 to minimize infections and other consequences of invasive procedures in the neonatal intensive care unit (NICU), says **R. Erick Ridout**, MD, a neonatologist with Intermountain Healthcare in Salt Lake City. The idea was based on the reasoning that with fewer pokes of any sort, there should be fewer ill effects.

Since the program began, the hospital has eliminated 11,000 pokes, and NICU length of stay has fallen by 21%. Associated costs have dropped by 28%.

"The foundation of POKE is having the right leaders in place and nursing buy-in. Extreme humility goes a long way, subjugating ego and flattening the hierarchy at the bedside so that the only person at the bedside who outranks everyone else in the room is the patient," Ridout says. "Everyone has a voice and all voices are valued. Leaders speak last."

Eliminating Unneeded Patient Pokes

In addition to monitoring how often patients are poked for blood draws and other needs, and minimizing that wherever possible, POKE also factors in to how the environment is structured and how work processes are designed, Ridout notes. The goal always is to add value and not waste resources, he says.

With POKE, Intermountain wanted to identify all the care the patient was receiving and eliminate that which did not add value, Ridout explains.

"The giant hurdle we have in healthcare is that we are finding a tremendous amount of care that patients experience just doesn't add value. Tests are being done that don't help and may harm," Ridout says. "But physicians are used to carrying out those tests and getting that data, and when they lose that, that's where the pushback comes in."

The changes have to be implemented in a way that illustrates the benefits to the patient, he says.

"The result was that we were able to decrease length of stay and hospital-acquired infections so that our babies have extraordinary outcomes and go home sooner. We're deploying this laterally throughout our NICUs at Intermountain and also are taking it outside our system."

Better to Pull Than Push

POKE is successful in part because Intermountain has encouraged units to "pull" the effort to them, rather than a central authority "pushing" it on them, Ridout explains. That approach is always more effective in continuous quality improvement, he notes.

"We want folks to self-determine where they want to go and then just need the tools and someone to come in and coach them. You coach them to be experts and world-class experts," Ridout says. "You get that pull by having a compelling story and data to demonstrate it. The people that are interested will pull you in, and then eventually you get a critical mass where everyone wants to do it, and it might even be required by regulation."

POKE also benefits from the way Intermountain erases the lines between facility, physicians, and nursing, explains **Jeannette Cutner**, BSN, RN, nurse manager with Dixie Regional Medical Center. Traditionally, those three groups have had different concerns and levels of influence, with the disparities getting in the way of best practice implementation, Cutner explains.

"We had physicians and nursing become one and working with the facility. Instead of physicians telling staff what to do or the physicians not even knowing what the staff were trying to accomplish, we did it in lockstep," Cutner explains.

"Others are still struggling to adopt something two or three years later, when we have it as soon as we educate to it because everyone has a voice at the table. Everyone understands their role and everyone else's role, too, so you don't have physicians pushing for change without understanding the heavy lifting that will be required of the nurses to make that happen."

Intermountain also conducts a survey of facilities to identify units that are ready for change, looking for evidence that they have the right mindset with psychological safety and a culture of accountability.

"When you identify the units that are ready in that way, you can take big ideas to them and implement them well," Cutner says.

"The units that are struggling will have a hard time adopting something this big, so they have to work on their culture first. The culture work has to be up front, and then they can adopt whatever you present them for best practices."

Escalation Huddles Improve Communication

Another example of best practice implementation is Intermountain's escalation huddles, which were started four years ago. The health system's Continuous Improvement Team oversaw 652,080 huddles in the first year, Cutner says.

Playing off the huddle concept used by many hospitals, Intermountain facilities first started with each charge nurse organizing a huddle at 6 a.m. every day with incoming and outgoing shift nurses. They discuss their goals and challenges for the day.

"It was done with little success on our unit. Charge nurses work 12-hour shifts, three or two days a week, and they don't necessarily have the 60,000-foot view, but they do know how to run a floor for 12 hours," Cutner explains.

"That's what they're really good at, but we wanted the huddle to be much broader so we could talk about elevating the culture of our unit and the principles of zero harm."

Intermountain changed the huddle procedure so that tiered escalation huddles start with frontline caregivers — Tier 1 — huddling at 8:45 a.m., followed by five other tiers of management and leadership, up to Tier 6, the executive leadership team, at 10 a.m. The discussions occur around huddle whiteboards showing metrics and other information.

Nurses Encouraged to Speak Up

The tiered huddles provide a communication channel from the frontline staff all the way up to the C-suite and back down again, Cutner explains. Ideas, strategies, concerns, and needs are effectively communicated up and down the line, she says.

Ridout and Cutner huddle every day at 9 a.m., and that huddle is repeated at 9 p.m. by the nurse practitioner and charge nurse. "We found that it adds tremendous value for the staff. They enjoy the huddle, and it has dramatically impacted the culture of our unit," Cutner says. "The huddles might focus on praise, gratitude, zero harm techniques — whatever is hot, we talk about it every 12 hours from a global perspective and take it to the bedside."

Cutner recalls how the huddles helped address a common problem in healthcare: the nurse who is aware of a dangerous situation but afraid to speak up. The issue was addressed in labor and delivery huddles, with Cutner requesting that the hospitalists ask the nurses every day, "How are you going to help me keep my patients safe today?"

"The nurses were quiet and hesitant in the beginning, but then they started responding with 'I will use SBAR [Situation, Background,

Assessment, Recommendation], I will stop and resolve, I will speak up when I see a patient safety issue.' Then the physician would reply with, 'You promise me?'" Cutner explains.

"Just putting it out on the table made the zero-harm principles real and viable. Even if the nurse was hesitant or 23 years old and inexperienced, that nurse felt more comfortable speaking up to tell the physician in the moment because he or she had told the nurse that morning that that input was not just OK but desired and expected." ■

SOURCES

- **Jeannette Cutner**, BSN, RN, Nurse Manager, Dixie Regional Medical Center, St. George, UT. Phone: (435) 251-1000.
- **R. Erick Ridout**, MD, Neonatologist, Intermountain Healthcare, Salt Lake City. Phone: (435) 251-5200.

Duplicate Medical Records Reduced, Improving Patient Safety

Many hospitals and health systems have a duplicate medical record rate that can threaten patient safety by fragmenting the data available to clinicians. Reducing the number of duplicates can improve patient safety.

Northwell Health, based in New York City, recently addressed the problem of duplicate records. With 23 hospitals and more than 600 physician practices, patient records were being duplicated at the rate of 700 per day, explains **Keely Aarnes**, PMP, associate vice president for business operations. Leaders were aware of the problem, but there was a backlog of about 200,000 duplicate records.

Northwell addressed the duplicates with manual intervention using algorithms and deterministic logic, but was able to clear only about 300 a day.

While they considered that a huge win, the constant creation of duplicates meant they were being created at a faster rate than they could be resolved, Aarnes says. And there was still the backlog.

The health system then used an outside company to start addressing the low-hanging fruit, the duplicate records that could be quickly identified and resolved, while Northwell also ramped up its manual intervention by incentivizing employees to work on the duplicate backlog from home.

"It took us about 18 months to get through that. The outsourcing helped us reduce the inflow, and we moved people around to allocate resources in a way that helped reduce the backlog," Aarnes says.

The progress was encouraging, but the duplicate rate was still unacceptable, she says.

At that point, Northwell sought a software solution that could address the duplicates more effectively. (Northwell used Auto-Steward from Verato, based in McLean, VA. Similar software systems are available from Occam in Hanover Park, IL, and Imprivata in Lexington, MA.)

Adding the software solution resolved 87% of the duplicate records and provides quick resolution of most of the duplicates generated every day.

It is effective largely because it has access to databases beyond those in the Northwell health system, Aarnes explains.

"All we can compare a record to is the data we have, which is very limited," says Aarnes.

"But the software has a referential data set of 300 million-plus lives; it can access not just identity but things like outdated information and previous addresses that we don't have," she explains. "That kind of information can help resolve whether two records are, in fact, the same patient or not the same patient." ■

SOURCE

- **Keely Aarnes**, PMP, Associate Vice President, Business Operations, Northwell Health, New York City. Phone: (888) 321-3627.

Nursing Innovation Underutilized, Can Be Leveraged for Career Advancement

Nurses are gaining more stature as potential leaders in healthcare, and much of the innovation in healthcare will come from nurses in the future, says **Antonia M. Villarruel**, PhD, RN, FAAN, professor and Margaret Bond Simon Dean of Nursing, senior fellow at the Leonard Davis Institute of

Health Economics at the University of Pennsylvania School of Nursing in Philadelphia.

Hospitals should work to leverage the innovative potential of nurses, and nurses in the quality field should look for opportunities to advance their careers through this increasingly available pathway, Villarruel says.

"Nurses have a role to play, and we have the expertise. When you're thinking of quality assurance and quality improvement, nurses can have a significant influence," she says. "Nurses' roles at the patient level get recognized, but we need to be elevated to leadership at the level where system changes can happen. Quality improvement is where people look to make system-level changes and organizations should look to involve nurse leaders in those efforts."

A recent report from BDO and the University of Pennsylvania School of Nursing addresses how clinical and industry leaders are leveraging nurse innovation. BDO provides this summary of the findings:

• "Nursing innovation has yet to be fully unleashed, including institutionally, regulatory-wise, and policy-wise." BDO says only 46% of business leaders report their C-suite includes a representative with a nursing background. Less than one-third say they have a nursing leader whose primary responsibility is innovation.

• "Nurses will gain a seat at the leadership table." Having nurse innovators in advanced leadership by 2025 is considered very important by 57% of leaders, and 81% say it is very important to have nurses as decision-makers on strategic planning teams.

• "Unleashing nurse-led innovation will create positive ROI." Nurses will play a critical role in transforming care by 2025, BDO says. They will have the most opportunity to influence care in chronic care management, mental health, and population health. *(The report is available online at: https://bit.ly/317fQh5.)*

The survey results indicate that healthcare leaders are recognizing the value of innovative nurse leaders, but their organizations have not yet fully installed them in leadership positions, says **Karen Meador**, MD, managing director of the BDO Center for Healthcare Excellence & Innovation in New York City.

"There is an opportunity for more of these institutions to put nurses in these innovator leadership roles. It may not necessarily have the title 'innovation' in it, but any healthcare leader needs to be innovating on an ongoing basis," Meador says.

"Only 7% of CEOs are nurses, and if there is a chief innovation officer, only 8% are nurses. Not having a nurse in an innovative leadership position means they are missing out on the unique perspective that a nurse brings to the table."

Villarruel notes that the survey found the most valuable skills for nurse innovators are design thinking, clinical acumen, and the interface of clinical acumen and technology. Nurses with these skills will be positioned to advance their careers in quality improvement, she says.

"Innovation is needed to keep moving quality improvement to the next level and address the current challenges," Villarruel says.

"Healthcare organizations are recognizing that having the right nurses in the leadership roles will be beneficial to the goals of the organization, so innovative nurses with the right skill sets will be in demand."

Meador adds that quality improvement professionals with a nursing background and the desired skill sets should seek recognition and strive for leadership positions.

"A lot of quality improvement professionals are already doing this work and demonstrating these needed skills, but I think it's time to take the covers off and really show what it is you're doing to improve patient quality and safety," Meador says. ■

SOURCES

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- **Antonia M. Villarruel**, PhD, RN, FAAN, Professor and Margaret Bond Simon Dean of Nursing, Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania School of Nursing, Philadelphia. Phone: (215) 898-8283. Email: nursingdean@nursing.upenn.edu.

Leapfrog Says Patient Safety Measures Improving; Maternity Not So Much

A recent report from the Leapfrog Group — a nonprofit organization that aims to improve healthcare quality by increasing hospital transparency — and Johns Hopkins found that poor hospital performance on 16 patient safety measures caused more than 161,000 deaths annually, a decrease from 2016.

The Spring 2019 Leapfrog Hospital Safety Grades updates the group's estimate of deaths due to errors, accidents, injuries, and infections, breaking them down by the A through F scores Leapfrog assigns to hospitals.

An analysis of 2,600 hospitals found that when compared to A hospitals, there was a 92% greater risk of avoidable death at D and F hospitals.

There was an 88% greater risk of avoidable death at C hospitals and a 35% greater risk at B hospitals.

"Even A hospitals are not perfectly safe, but researchers found they are getting safer," the Leapfrog report says.

"If all hospitals had an avoidable death rate equivalent to 'A' hospitals, 50,000 lives would have been saved, versus 33,000 lives that would have been saved by 'A' level performance in 2016."

Leapfrog estimates that 160,000 lives are lost each year to avoidable medical errors. That is down from the group's estimate of 205,000 avoidable deaths annually in 2016.

(The report is available online at: https://bit.ly/2WNecia.)

Hospitals Focused on Regulations

The report suggests that healthcare organizations are still struggling to address patient safety and quality, says **Stanley Pestotnik**, MS, RPh, vice president of patient safety products at Health Catalyst, a healthcare data analytics company based in Salt Lake City. "A lot of organizations chase regulatory measures and get focused on the regulatory aspect of healthcare, what is required for reporting — and in doing that, they unintentionally separate safety from quality," he says.

"As we move into this higher reliability organization paradigm, we need to be preoccupied with safety and other failures. If you take a myopic view of this from a regulatory standpoint, you lose this connectivity."

Culture also plays a pivotal role and tends to be undervalued in some healthcare organizations, Pestotnik says.

"We also need to be able to measure more accurately events that are occurring, and not just those that have to be reported from a regulatory standpoint, but all events that cause harm. As part of that, we have to understand the culture at the unit level because that is where the culture lives," he says.

"Those organizations that have a good culture of safety usually do a good job of providing quality care and have limited safety events," Pestotnik adds.

"I think that's what Leapfrog is trying to do here, showing that the A hospitals are doing much better than the other grades with preventable deaths, and that validates the accomplishments that got them the A grade."

Maternity Report Not Encouraging

Leapfrog also recently released its 2019 Maternity Care Report. Based on data voluntarily submitted by more than 2,000 U.S. hospitals, it shows how those hospitals adhere to best practices in cesarean sections, early elective delivery, and episiotomy rates. The group says only 20% of the reporting hospitals are fully in compliance with Leapfrog's standards on those issues.

(The report is available online at: https://bit.ly/2W18gB2.)

These are the main findings of the report:

- The average rate of early elective deliveries was 1.5% in 2018, the lowest rate since 2010 when the rate was first measured at 17%. The current 1.5% is well below Leapfrog's target of 5%.
- Episiotomy rates were at 6.9% in 2018, down from 7.8% in 2017. Leapfrog's target is 5% or less.
- The average rate of nulliparous, term, singleton, vertex (NTSV) cesarean births is not changing. It has been about 26 since 2015, deviating only by one-tenth of a percentage each year since. The 2018 rate is 26.1%, and Leapfrog's target is 23.9%. ■

SOURCE

- **Stanley Pestotnik**, MS, RPh, Vice President of Patient Safety Products, Health Catalyst, Salt Lake City. Phone: (855) 309-6800.

Hospital Improves Care, Reduces Readmissions Related to Sepsis

As Medicare's Bundled Payments for Care Improvement Advanced (BPCI Advanced) model continues to incentivize the transition toward value-based care, hospitals are innovating with new services and capabilities to meet its goals.

CHA Hollywood Presbyterian Medical Center (CHA HPMC) in Los Angeles designed and implemented a post-acute care program that allows sepsis patients on Medicare

to continue receiving high-quality care during a 90-day period after discharge.

Early results indicate that the program is successfully meeting its objectives with improved quality measures, reduced readmission rates, and enhanced patient and physician satisfaction while contributing to cost reductions, says **Jamie Chang**, MD, MBA, FACEP, chief clinical operations officer.

Chang notes that patients who are 65 and older are especially susceptible to sepsis. CHA HPMC's Continuing Care Program is designed to encourage the patient's recovery at home and help him or her stay healthy and avoid readmission, he says.

CHA HPMC relies on data to identify the priority areas for intervention during the post-acute period, providing patient navigators, case managers, a 24/7 nurse triage line and support services, and other assistance. The program also relies on a comprehensive data and performance management platform.

Outcomes measures from CHA HPMC's Continuing Care Program have demonstrated its success with lower readmission rates and improved CMS quality measures.

Fourth-quarter 2018 data show that the sepsis population increased in overall case volume by 17%, but the 30-day readmission rate went down from 32% to 25%, Chang says.

The 90-day readmission rate was reduced from 40% to 34%, and the 90-day utilization rate for skilled nursing facilities and inpatient rehabilitation facilities decreased from 57% to 48%.

The program resulted in cost savings of 14% below the Medicare target price for sepsis episodes of care, he says.

Internal and External Specialists

CHA HPMC created the Continuing Care Program by assembling a multidisciplinary team of internal hospital resources and external specialists to collaborate on delivering effective post-acute care for sepsis patients, Chang explains. The team includes representatives from case management, social work, nursing, pharmacy, quality, and coding.

"Our vendor partners include technology companies to provide patient tracking and notification systems, a team of patient navigators who engage patients at bedside and also at home, an on-campus care transitions clinic, SNF [skilled nursing facility] specialists, and a comprehensive data and performance management platform," Chang says.

"In addition, we contracted with multiple community physicians to support our efforts to reduce the cost of care, with gain-sharing agreements per CMS guidelines."

This multidisciplinary team spent several weeks working together to design the detailed workflows, operations, and communication strategy for the program, Chang says. Then, they went live with executing the plans in October 2018, and continue to meet every week to refine operations in an effort to continuously improve.

CHA HPMC was accepted in the first cohort of hospitals to participate in BPCI Advanced, Chang notes. This bundled payment program created the incentives for the hospital to invest in the technology, services, and resources required to establish an effective post-acute care program to reduce the cost of care after discharge.

"More broadly, CHA HPMC recognizes that hospitals are operating during a period of transition from fee-for-service to value-based reimbursement. As more financial risk for the cost of care is transferred to hospital providers, we understand that there needs to be increasing attention to the costs that are incurred not just during the acute hospital encounter, but also the costs of care after discharge," he says.

"Specifically, as traditional Medicare tests innovative payment models, we recognize that this change to value-based reimbursement is inevitable for this population. The only decision for hospitals is whether or not they will adapt and be ready for this change before it becomes mandatory."

Cost of Care Difficult to Determine

The hospital's initial challenge was having little to no visibility into the cost of care for patients after discharge from the hospital, Chang says. While they had a lot of data on the cost of care during the acute inpatient encounter, they did not know what costs were being incurred by Medicare after the patient left the hospital.

"Since we were now faced with financial liability for these costs after discharge, we needed to partner with a vendor to help us understand where these costs were being incurred so we could effectively manage them," he says.

"This intelligence about post-acute spending was critical to helping us identify which physicians and post-acute facilities to focus our attention and efforts to align incentives for success in the program."

Another challenge has been physician adoption for the innovative program. Physicians were skeptical about why the hospital was investing in so many resources to proactively manage these patients after discharge.

"We overcame this obstacle by directly contracting with physicians to incentivize them to partner with us on reducing costs of care, and then providing regular performance updates so they could have more visibility into what healthcare expenditures were being incurred by their patients," Chang says. "Just providing this data was very illuminating to physicians, who otherwise had very little insight into the cost of care being incurred by their patients."

SNF Cooperation Lacking

The other major challenge has been cooperation with post-acute facilities such as SNFs because the objective has been to reduce spending in these sites of care.

"We have been able to overcome these obstacles by establishing a narrow network of post-acute facilities who understand that healthcare reimbursement is changing, and so are willing to collaborate with us on this effort," Chang says.

"These early adopter post-acute facilities realize that aligning themselves with acute care hospitals and working together to coordinate transitions of care is good for patient care, and will ensure that these post-acute facilities are relevant in the market in the future."

Readmissions Decreased, Savings Improved

Chang says the hospital has demonstrated through the Continuing Care Program that it is able to deliver higher-quality care to patients in terms of both patient satisfaction and improvements in outcome measures. Comparing 2017 with Q4 2018, Chang cites these results:

• **90-Day Readmission Rate:** Across all patients included in seven selected bundles, CHA HPMC improved this metric from 40% to 31%.

• **Cost Savings:** For patients admitted with a diagnosis of sepsis, the hospital achieved cost reductions that are 14% below the target price that CMS has set for CHA HPMC for this population of patients. CHA HPMC projects that it will receive a $3 million reconciliation payment annually for this bundle alone, helping fund program expenses and also generate incremental net revenue for the hospital.

• **Improvement in CMS Quality Star Rating Measures:** By participating in the program, CHA HPMC has been able to use the anticipated reconciliation payments to fund the services, technology, and capabilities to improve overall hospital quality. Specifically, the reduction in the 30-day readmission rate for congestive heart failure (40% to 11%), pneumonia (12% to 9%), and acute myocardial infarction (28% to 18%) directly improves its CMS Star Rating and its performance in the CMS Hospital Readmissions Reduction Program.

"While delivering higher-quality care to our patients, we are able to achieve this at a lower overall cost to Medicare, indicating that this would be a sustainable model of care for the future," Chang says.

"Implementing a post-acute program to provide care for patients after discharge requires additional resources, technology, and services that hospitals have not traditionally invested in. Innovative payment models, such as BPCI Advanced, can help to finance the change that is required for us to deliver higher-quality care." ■

SOURCE

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CE QUESTIONS

1. **What does Michael H. Kanter, MD, say is one way that E-SCOPE facilitates rapid adoption of best practices?**
   a. The hospital does not try to replicate the data supporting best practices before implementing them.
   b. The program includes penalties for employees who do not participate.
   c. The hospital uses an accelerated methodology for replicating the data supporting best practices.
   d. The program limits how many people can be involved in the implementation of best practices.
2. **About how many abstracts does the E-SCOPE program deliver per month for Kanter and his assistant to consider?**
   a. 25
   b. 50
   c. 100
   d. 150
3. **How much have NICU readmissions at Dixie Regional Medical Center in St. George, UT, dropped since it began a program called POKE?**
   a. 7%
   b. 12%
   c. 28%
   d. 41%
4. **Northwell Health, based in New York City, was generating about 700 duplicate medical records per day. In its first effort to use algorithms and deterministic logic to resolve the duplicates, about how many were they able to clear up each day?**
   a. 100
   b. 300
   c. 500
   d. 700

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.