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INSIDE

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Governance by Experts, Aligned Goals Critical to Successful Quality Improvement

Never forget the fundamental elements of a successful quality improvement program, experts say, even as your attention may be drawn away by complex data analysis. The basic, essential elements of quality improvement are necessary for any initiative to succeed.

Governance in decision-making can be an important component of any successful quality improvement program, says **Leslie M. Jurecko**, MD, MBA, senior vice president for quality, safety, and experience at Spectrum Health, based in Grand Rapids, MI. This can mean deferring to experts with more knowledge, which often will be those most directly involved with the issue, she says. Spectrum operates under a governance structure that includes about 100 expert teams that determine the proper clinical pathways for multiple subjects such as sepsis, wounds, and heart failure.

"You need a governance structure around those decisions, meaning those closest to the front line need to decide the best practice and also how to hold people accountable to that practice," Jurecko says. "That gets the front line engaged, because they are not decisions handed down from on high by executives who don't actually care for these patients."

NEVER FORGET THE FUNDAMENTAL ELEMENTS OF A SUCCESSFUL QUALITY IMPROVEMENT PROGRAM.

However, governance-by-expert teams is not always easy to achieve. Jurecko notes that it can be challenging to gather subject matter experts in a room at the same time to discuss quality issues. Simply scheduling

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different people at the hospital for a meeting can be difficult, but then the quality improvement department has to provide them with useful data.

"We also have to provide them a quality improvement specialist who understands improvement methodology," Jurecko explains. "We have to have a clinical nurse specialist and often a pharmacist. Even if physicians are leading the discussion, this is still a team effort. Just getting all of those critical roles and multidisciplinary representatives together can be a challenge because no one has any extra time for meetings."

Spectrum addresses some of those challenges with virtual meetings and other technology that does not require gathering everyone in person, Jurecko says.

Aligned goal-setting can be critical to the success of quality improvement projects, Jurecko notes. "A key to good quality improvement is clarification and simplification of goals. Often in a physician leadership structure, they will have certain goals they want to achieve; a corporate structure will have other goals. In a risk-based reimbursement agreement, there will be still other goals," Jurecko says. "Finding the alignment and simplifying the message around all of these different goals is going to be very important for the future. Healthcare systems that can do that are going to make providers a lot happier. Right now, they are getting disparate messages coming at them from all different angles, both internally and externally."

At Spectrum, Jurecko tries to align any incentive goals with its quality system goals, its risk-based reimbursement agreement, and the system's ongoing professional practice evaluations. Those practice evaluations summarize data to assess a practitioner's clinical competence and professional behavior.

"All of that has to align so that we don't have four or five different goal-setting systems coming at our frontline physicians," Jurecko says.

Shared ownership is another crucial component of successful quality improvement programs, Jurecko says. Quality cannot just live in the quality improvement department; rather, it must be a focus of the entire hospital, a culture in which everyone feels responsible for improving quality.

"Even if you name a chief quality officer and give them a big team of folks, that is not what is going to drive improvement," Jurecko explains. "You need shared ownership across physician leaders and operational leaders so they see quality as their number two job, right behind ... caring for patients. They have to see quality as the way to improve their performance in their number one job."

Successful quality improvement programs also employ specific improvement methodology to issues, which requires training in that discipline, Jurecko says. Not all quality department employees are sufficiently trained on how to apply change management to a project.

"There are physicians who are interested, but that's another challenge to find the time required to teach them and give them the tools that will allow them to lead these projects most effectively," she says.

A review of the most successful quality improvement programs will show that they all include a robust process improvement process, says **Kristen Geissler**, managing director with Berkeley Research Group in Baltimore.

"This means they are not just looking at numbers and putting them in a report," she explains. "They are actually doing something with those numbers, actively engaging a multidisciplinary group to find better processes, removing variations and waste."

Leadership support also is essential, she says. Quality improvements will not be successful without hospital or health system leadership endorsing the effort and holding the organization accountable for reaching high expectations of quality.

"It also is critical to be a data-driven organization," Geissler says. "If you can't measure it, you can't improve it. That is especially true in healthcare quality improvement."

Most of these essential elements are dependent on the organization's culture, she notes. Without the right culture, even the best quality improvement efforts can stall.

"We've seen organizations that have a great process improvement program on paper, but the culture isn't there down through the frontline staff to encourage them to think about how to do things better and even to raise their hands when they see concerning issues related to patient care," Geissler says.

The culture can be more important than the size of the quality department or the available resources, Geissler notes. "Hospitals that have very small quality shops can still manage to have very good quality scores. We've seen hospitals with very large quality shops that don't have great quality scores," she says. "The culture can be the link. Even if you have a large quality department, and you're throwing a lot of money and effort at a problem, it can all be wasted if the people caring for patients don't have the mindset to receive your efforts in the right way and apply those improvements."

WITHOUT THE RIGHT CULTURE, EVEN THE BEST QUALITY IMPROVEMENT EFFORTS CAN STALL.

Leadership rounds can be effective in promoting the right culture, but Geissler says the way in which leadership rounds are conducted can be a bellwether for the success of a quality improvement program.

Some leaders participate in the rounds but see them only as a way to check off a box for interacting with staff, Geissler says.

Others may round at inopportune times or move through too quickly, with little or no interaction with staff and patients. "With the organizations that don't have an effective, engaged leadership rounding process, that often is an indicator of issues that lead to lower quality scores and lower employee support of quality improvement projects," Geissler notes.

Conflicting data also can undermine quality improvement efforts, she says. It is not uncommon for one set of data to show a quality rate that conflicts with another set of data. Presenting both data sets to frontline staff can undermine improvement projects, she says.

A better approach is to designate a data steward who can sort through the conflicting data and present a uniform picture of where the hospital stands.

"Otherwise, you run the risk of people latching on to one set of data or other, and then you have people running in different directions or forming a different idea of the seriousness of the issue," Geissler cautions. ■

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Hospital Improves Acute Care for Elders With Dedicated Unit

A Massachusetts-based health system is reporting positive results from an initiative designed to improve care for geriatric patients and increase the use of advance care planning.

Baystate Health's Acute Care for Elders (ACE) model of care is a designated unit that includes staff trained on mobility, rationalizing, medication, early discharge planning, and early recognition and treatment of dementia, according to **Maura J. Brennan**, MD, division chief for geriatrics and palliative care with Baystate Health.

The ACE model of care first emerged in the 1990s.[1] As defined by the author of one study, an ACE unit "includes principles of a prepared environment that encourages safe patient self-care, a set of clinical guidelines for bedside care by nurses and other health professionals to prevent patient disability and restore self-care lost by the acute illness, and planning for transitions of care and medical care. By applying a structured process, an interdisciplinary team completes a geriatric assessment, follows clinical guidelines, and initiates plans for care transitions in concert with the patient and family."[2]

ACE is a medical acute care unit. There are not different levels of service; beds and services are billed as acute care. End-of-life beds on the unit are not hospice beds; rather, they are used for patients who are expected to die before discharge who were previously scattered over the hospital.

The Baystate Health ACE program began when Brennan was conducting grand rounds and reviewed a paper on the success of such programs. The vice chair of medicine asked why Baystate was not running such a program if they were so successful.

Brennan received enthusiastic support from the hospital's quality department, which recruited and trained a team. Quality improvement staff also provided "basic quality 101 training" to Brennan's entire division, she says.

"Everyone from the secretarial staff up to me learned what a run chart and a PDSA cycle are," Brennan says. "We began a pilot on a medical unit where we used typical ACE criteria on about eight patients. A member of our group was from decision support and finance. He became very enthusiastic about participating in meaningful change rather than just crunching numbers somewhere."

Initial funding for the program included some modest support from a Health Resources & Services Administration grant, philanthropy, the hospital, and the medical practices group. (Today, the program largely is baked into operations.)

Over 18 months, the hospital studied length of stay, costs, use of restraints, falls, and other criteria, showing enough improvement to win the hospital president's annual safety award. That led to enough support that the pilot project was expanded to become a full ACE unit, despite budgetary restraints. The unit includes 34 beds, with additional space dedicated to patients at the end of life.

One the biggest challenges is to keep patients mobile, Brennan says. The staff tried walking patients regularly, but Brennan found the staff members were too busy with their primary duties to regularly mobilize patients. Volunteers helped walk patients until leaders became concerned that home care and post-acute rehab services were affected by patients not moving around enough while in the hospital.

"That prompted a hospitalwide interest in improving mobilization. That allowed us to get approval for patient mobility technicians," Brennan explains. "We're now tracking and recording distances in ways that we hadn't before. It seems like mobility shouldn't be so challenging but it was one of the toughest nuts to crack." Part of the impetus for improving mobility hospitalwide was that Baystate is an accountable care organization and shares the risk of post-acute costs. That makes it easier to address issues that affect more than one silo in the hospital, Brennan explains.

After the first year, ACE unit patients' length of stay was almost one full day shorter than other patients, and there were measurable gains in patient safety. Complication and delirium rates decreased by 30% to 50%, and falls were reduced by 50%.

Use of restraints was virtually eliminated, and 17% more patients returned home rather than discharging to another facility. More than 500 medication changes resulted from the ACE team's recommendations. Approximately 60 nurses and 50 physicians were trained in the ACE program.[3] The ACE unit also leads other departments in patient satisfaction scores.

A team approach is necessary to see good results from the ACE unit, Brennan says. However, one should not assume everyone's idea of teamwork is the same.

"We talk about teamwork a lot in healthcare but I think it's not always

seen the same way as we see it in geriatrics. You might have a physician who thinks teamwork is the doctor making the calls and everyone else doing as he says," Brennan says. "Truly grasping teamwork and building processes in which everyone is equally valued and can see their successes is important."

Hospital quality leaders interested in establishing an ACE unit should remember that it requires a genuine interdisciplinary approach. Care is provided in a less hierarchical way, with a focus on the need to treat basic geriatric and palliative care needs while also addressing medical concerns. "It's a classic quality improvement win because it is an example of eliminating the quality waste," Brennan says. "If you get rid of the unnecessary drugs, eliminate falls and restraints, you're improving the care of the patient, and you're also going to save money. You can do better by doing the right thing, which was surprising to a number of people who thought this was going to be more expensive." ■

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Cameras Help Monitor Compliance, Reduce Patient Falls

A health system based in Florida has found using cameras can improve compliance with quality and safety efforts, especially when the camera includes a speaker for communicating with people.

Cameras already were in use for security purposes at Lee Health's facilities, but leaders recently decided to start using a type of camera that includes a speaker, according to **Sean Owens**, director of security technology and non-acute care. In one use, the cameras are employed as "sitter cams."

Previously, the health system paid a retired nurse to sit at a patient's bedside when the patient need to be watched constantly for falls or other risks. The paid sitters were hard to staff because they were needed on short notice — and they were expensive.

Lee Health changed to a system in which the same sitters were stationed in a room with monitors for cameras watching several patients at once. The cameras do not record anything in a patient room, but the observer can summon help immediately to any room. "Not only did we see a reduction in falls, but we were able to expand our monitoring of at-risk patients," Owens reports. "Patients who were only borderline fall risks before might not have gotten a sitter because ... they didn't meet the clinical criteria for requiring one."

Beyond preventing falls, Lee Health uses cameras to monitor a particular stairwell that staff, patients, and visitors used for convenience despite multiple efforts by the hospital to stop the habit. The high volume of traffic in the stairwell was thought to be a safety hazard, with a high risk of trips and falls. Administrators declared the stairway off limits, even though no one could lock the doors for fire safety reasons.

Previously, leaders tried signage, admonitions from supervisors, and even stationing security officers at the exits to remind people of the policy. None of that worked, so administrators installed a camera with a speaker, triggered by motion, in the stairwell. "Imagine you're in the stairwell and you hear a recorded announcement that this is an emergency exit only. The message even guides you to the proper exit — nothing authoritative or scolding," Owens explains. "Within the first week of implementing it, that message was enough to change their behavior instantly. We had complete compliance moving forward."

The camera system also can help with infant abductions, Owens notes. The National Center for Missing and Exploited Children, which tracks infant abductions, indicates that people looking to abduct an infant usually will hang out around obstetrical units for some time, watching staff and patients as they wait for the right opportunity.[1]

"We debuted a camera that uses video motion analytics for loitering. Anyone who spends an extended amount of time in an area will trigger a notification to our security operations center so we can make contact

with that person and ensure everything is all right," Owens says. "We're able to home in on the human behavior that really matters to us."

Similarly, Lee Health was able to address a problem with transients and drug abuse in a hospital parking lot. An exterior camera uses motion video analytics in the area to detect anyone loitering on the property after hours, triggering a recorded message telling them they are being watched and to leave.

"There has been a complete turnaround in that location. We have had almost complete compliance just by using the audio," Owens says.

Other than patient safety, hospitals also can use cameras to monitor compliance with handwashing and other infection control policies.[2] Here, the camera typically is oriented to capture only the handwashing sink or other work station, with no coverage of patients so as to protect their privacy. Most hospitals using this approach have recorded the video to be reviewed later for compliance, sending feedback and metrics as soon as possible.

In one study, a door sensor triggered the camera to start recording a handwashing station, and the video was sent to a third-party vendor who assessed compliance and sent feedback to the unit.[2] ■

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Stroke Care Lessons Learned From Award-Winning Hospitals

Five hospitals that are part of CHI Franciscan Health, based in Tacoma, WA, recently received awards for their commitment to providing high-quality stroke care to patients. The experiences of these facilities hold lessons that can be replicated in other organizations.

The American Stroke Association has recognized Highline Medical Center, St. Joseph Medical Center, St. Anthony Hospital, Harrison Medical Center, and St. Clare Hospital for their efforts to meet quality measures related to the proper use of medications and other stroke treatments.[1]

The hospitals focused on nationally recognized guidelines and the latest scientific research to improve stroke care, says **Christina Bradley**, BSN, RN, stroke coordinator at CHI Franciscan. Hospitals throughout the system implemented changes recently, such as extending the time window for when stroke patients can receive emergent treatment.

In recent years, the practice has been able to provide emergent care up to six hours from the last time the patient was known to be without symptoms. However, recent research supports extending that time to 24 hours with a few caveats, Bradley explains.

"CHI is extending that time frame at St. Joseph and is in the process of moving that time frame out to other facilities as well," she says.

The health system also is working on shortening the time of arrival to the administration of tissue plasminogen activator (tPA). The

faster a stroke patient receives tPA, the better the outcome.

"We're also working on swallow screening, making sure patients are safe to swallow," Bradley says.

He notes that some stroke patients may struggle to swallow. To improve this process, Bradley says CHI Franciscan is working on improving the screening performed by nursing staff and speech therapists. "All of these things have shown improved outcomes, including decreased disability and an increased number of patients who can go home instead of having to go to some type of facility," Bradley explains.

The American Stroke Association's Get With The Guidelines-Stroke program is supported by published studies demonstrating its success in improving patient outcomes. The association says that more than 2,000 hospitals have entered more than 5 million patient records into the Get With The Guidelines-Stroke database since the program began in 2003.[2]

Implementing the stroke best practices changes was not as simple as sending a memo with the new protocol, Bradley says. CHI began with gathering a group of stakeholders at St. Joseph to create a pilot program.

"It wasn't enough to agree that this should be our new path. We had to have conversations about how to make things work logistically," Bradley explains. She notes certain changes included things like making sure stroke patients go immediately in for a CT scan when they arrive at a facility.

"There was a lot of behind-the-scenes work done with all the stakeholders from emergency, imaging, neuro-interventional radiology, pharmacy," she adds. "There were a lot of people involved."

That work took a few months before the pilot could be launched at one hospital, Bradley notes. A key is making sure all the right people are involved. Otherwise, the process can be bogged down if a department or key player in the stroke treatment process balks at what the task group is doing or does not provide the necessary support, Bradley says.

In the pilot at St. Joseph, CHI Franciscan has achieved faster times in several parts of the stroke treatment process — the time from arrival to CT scan, the time to receiving imaging results, and the time to administer tPA.

"We've gotten better at breaking our records for how quickly we can give the tPA. Everyone is getting involved and making it a team effort," Bradley reports. "We've also seen on the back end patients have lesser disability and more patients who can be discharged home with no or very little disability. Seeing those patients go home and able to resume their lives with their families has been very rewarding."

CHI Franciscan is expanding its stroke efforts to include better communication with EMS personnel, with representatives attending base station meetings and using other opportunities to educate them on stroke protocols and how to best work with hospital teams. Another project involves increasing the number of people who call 911 with potential stroke symptoms who actually go to the hospital.

"We see through triage people maybe not taking it seriously and not realizing that stroke is an emergency, if they come to the hospital at all. Our goal is to improve the percentage of people who follow through and get to the hospital through EMS," Bradley says. "Going to the hospital with EMS is the best option for the patient because everything gets lined up, EMS can call us ahead of time, and the outcome of patients is better. That is one of our biggest goals going forward."

The stroke improvement efforts at any single hospital are multiplied through the CHI Franciscan system, notes **Dennis Wang**, MD, stroke specialist. This is a substantial benefit for improving the quality of care for the largest number of patients in a fast way, he says.

"In a network of hospitals, everything is more uniform and standardized. We can work with EMS to encourage them to communicate with us quickly and in the same manner, no matter what hospital they are going to. Then, the treatment process is the same at all the hospitals," Wang says.

He adds that because each facility uses the same radiology group, there is uniformity even in that process.

"If the patient has to be transferred to another facility, the images are already available," Wang notes. "All the information is in the same chart that we share." ■

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Moving From Hospital Quality Improvement to C-Suite: How It Happens

Many quality improvement professionals would like to move into a C-suite position one day, but the path from quality to hospital executive is not always clear. A quality professional in Kansas has made that transition successfully, noting her background in quality, safety, and compliance will serve her well in the new position.

Melanie Urban, RN, BSN, HACP, recently was named administrator of the University of Kansas Health System Pawnee Valley Campus in Larned after serving as director of patient quality services at HaysMed, another hospital in the university system, for 10 years. During her 26-year career, Urban has served as a director of quality, accreditation, and infection prevention, as well as a risk manager, case manager, and acute care nurse. She also has worked in utilization review and discharge planning.

"I built my career and got a lot of department experience underneath me. Then, about five years ago, our focus in the organization really started moving to a higher level of safety, quality, and patient experience," Urban says. "I started shedding some of the departments underneath me to start building up the quality program." Urban says her background in quality improvement helped position her well for the administrator role when it became available, but she says it was no accident. Urban always saw quality as the vital link to all aspects of healthcare and worked to gain the experience that she thought would lead to an executive position.

"I always tell people I worked in quality when quality wasn't cool. Fifteen years ago, a lot of people didn't even know what it was, thought it was just a lot of measuring and checking boxes," Urban recalls. "I think it's come to the forefront now, and it absolutely is the focus of the system now."

The University of Kansas Health System acquired HaysMed in 2017, and that is when Urban saw an opportunity to move up. The university health system wanted to provide all Kansans with the same kind of care they provide their own patients, and they were a little further along with that quality approach than HaysMed, Urban says.

"As we transitioned into the system, I started focusing mainly on quality, accreditation, and patient safety," Urban says. "I lost some of the other departments that had reported to me because we needed to devote more time to quality if we were going to fit into the University of Kansas Health System's approach to quality of care. We developed score cards that were very transparent on patient harm and associated score cards just to set the bar and get people motivated."

Urban led HaysMed in changing its entire mindset about quality improvement and patient safety. Previously, the hospital had focused on rates. However, with Urban's direction and support from the health system, the hospital started adhering more to the idea that one incident of a patient fall or other harm is too many.

"We started motivating people to know when their last fall was, to the day, so that we could encourage and celebrate when we go 30 days, 60 days, 90 days without a particular form of harm happening," Urban says.

Urban says she had her eyes on a leadership role for some time before the opportunity arose. HaysMed had begun working with the Pawnee Valley campus of the health system in 2009, and Urban frequently visited the campus in a quality and risk management role.

The University of Kansas Health System Pawnee Valley Campus, formerly Pawnee Valley Community Hospital, is a 22-bed critical access hospital.

"I fell in love with the organization and thought that was the size of

an organization I could be an administrator for. It was something that fit my skill set and what I enjoyed doing," Urban says. "I started trying to help as much as I could here on the Pawnee Valley campus and become someone they could depend on."

Urban started working on her master's degree in healthcare administration two years ago and is about halfway through her program. She also joined the American College of Healthcare Executives (ACHE), which helps healthcare directors who want to move on to CEO, administrator, and similar roles. Urban participated in several of the group's webinars and other activities as she prepared herself for leadership.

"I wish I had finished my master's degree before this position became available ... I always encourage people to get a master's degree in something that would lead to an executive position if that is their eventual goal," Urban says. "I also made sure I spent a lot of time with the vice presidents at HaysMed to learn and watch."

Reaching a top leadership position is not something that typically happens without the person striving for it in a purposeful way. It is rare that someone in quality will be cruising along with no particular effort to advance and then be tapped out of the blue to take a role like hospital administrator, Urban notes.

"You have to have a target and create a plan for getting yourself there. I let people know that I was interested," Urban says. "The administrator at HaysMed and our vice presidents knew, which is helpful because they can start grooming you for the position you want. They start seeing you in that role because they know you're interested."

Other hospital leaders may be surprisingly helpful once you voice your desires to take on a similar role, Urban says. They probably will provide more useful feedback and direct you to career advancement opportunities that eventually could lead to your desired position.

"Even during my evaluations, they would provide feedback on my current position but then also add advice about how to proceed if I want to reach a senior leadership role," Urban says. "It's important to let people know what you're interested in. You might receive more assistance and encouragement than you anticipated."

One benefit for Urban was the location of Pawnee Valley Campus, about an hour south of HaysMed. Urban's husband farms in the HaysMed community, so taking a leadership role in any hospital farther away would have been a family hardship. But even living an hour away was a hurdle in the beginning.

The health system originally wanted an administrator for Pawnee Valley Campus who lived closer to the hospital, but they relented after losing a few administrators who fit that criteria but did not last long because they viewed the position as a stepping stone or because they just didn't fit with the organization.

"Five years ago, I had conversations with them about this position, but they were wanting me to move here, so I had to just let it go," Urban says. "I think they realized that it was more important to find the right person vs. the person who was willing to live there."

When the position became available again, Urban applied and did so without relying solely on the groundwork she had laid over the years. Rather than working only through her connections and assuming the relationships she had cultivated would win her the role, Urban applied for the position as if she were an outside person.

Urban used the ACHE résumé assistance toolkit, studied, and participated in practice interviews, even though the interviewers would be people with whom she already had close working relationships.

"I decided I was going to lay out all my cards and do everything I could to go after this position," Urban says. "I formally applied, with cover letters and treating everyone as if I were applying from outside the health system and not acting as if I had some inside line to this because of the people I knew. I wanted them to take me seriously and not just keep me in their side pocket as someone they could hire if the other person they hired didn't work out."

She was interviewed nine times, including a whole day of interviews with leaders at Pawnee Valley Campus, community member interviews with her and her husband, and an interview with the health system CEO.

"I feel like I earned the position. You want to come in here knowing that you are the one [leaders] wanted in this position so you feel supported," Urban says. "I feel extremely supported throughout the system and here in this facility. I was in a position at HaysMed where I could build relationships here. Now, I try to capitalize on that."

Urban says her background in quality will shape her role as administrator at Pawnee Valley Campus. Such a background clarifies what is important as an administrator.

"Some administrators think it is all about business and financials. They spend a lot of time in their office. That's not how I see it or how the health system sees it," Urban says. "I've made patient care the priority. My focus is on seeing what's going on in the organization and measuring it. I'm all about looking at patient outcomes and measures because that

tells you the true north of how your organization is doing."

The focus on quality helps Urban make decisions for the organization that will put the patient first.

"Historically, we have seen administrators in organizations who were accounting- or business-driven and maybe don't see that aspect as clearly as I do," Urban says. "I wanted to come down here and spend more time making sure that we were meeting all our goals for sepsis bundles, stroke, chest pain, [and] patient outcomes ... they just needed someone to keep that quality focus at the forefront because that is what is going to make this facility successful."

Urban also wants to improve employee engagement, which she says is vital to improving quality and safety and measuring the right patient safety and quality factors.

Further, she wants to emphasize communication about those quality measures with the facility staff as well as within the health system.

"Communication has not always been a strong point here but it is important. If people know the purpose behind things and are included in the decision-making, then your outcomes are better," she says. "We want to keep the medical staff, the hospital staff, and myself all in line as an organization and moving toward the same goals. You set goals with your strategic plan but also with your quality measures."

Urban encourages quality professionals interested in leadership positions to set a goal and stick with it. Landing an administrator or similar role may take time.

However, Urban recommends using that time wisely so as to be prepared when the opportunity arises.

"Stick with it," Urban says. "I'm probably more prepared now than I ever imagined I could be. Even if you're not in an administrator position now, you can be confident that you will be that much better prepared when the time comes." ■

SOURCE

- **Melanie Urban**, RN, BSN, HACP, Administrator, University of Kansas Health System Pawnee Valley Campus, Larned. Phone: (620) 265-8663. Email: melanie.urban@haysmed.com.

Government Moving to More Risk Arrangements Based on Quality

The Center for Medicare & Medicaid Innovation (CMMI) wants 100% of providers in upside/downside by 2025 and is using the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model, primary care models, and (increasingly) more mandatory models to get there.

This pressure from the government will put quality directors in a position to highlight their work and play an important role in the organization's future financial success, says **Dave Terry**, CEO and co-founder of Archway Health, a company in Watertown, MA, that helps hospitals with bundled payments.

"[CMMI] said last winter that their goal is to move 100% of Medicare providers into some type of meaningful up and downside risk arrangement, which is a pretty big deal. Previously, under the Obama administration, they were looking for value-based contracts, but those could be upside or downside. A lot of providers chose just upside only," Terry explains. "The current team is focused on moving providers to real risk arrangements because you only see improvements in performance, quality, and costs when there is a downside component to the contracts."

BPCI Advanced is a model that covers services within a 90-day clinical episode, with a clinical episode defined as beginning with an inpatient admission for an inpatient procedure or the start of the outpatient procedure. Such an episode continues for 90 days after discharge or the procedure. Good performance on quality measures and costs results in increased revenue — the upside — but money can be lost if goals are not met — the downside.

BPCI Advanced qualifies as an Advanced Alternative Payment Model under the Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act. Healthcare providers can choose to participate in up to 29 inpatient clinical episodes and three outpatient clinical episodes.[1]

All alternative payment models include a quality improvement component. Quality professionals will become increasingly important as their organizations explore the options and move forward, Terry says. No matter what model is used, quality metrics will be crucial to seeking the upside rewards of the model.

"If the provider organization isn't able to demonstrate with real data that they are improving on quality,

the reimbursement will be impacted," Terry says. "I think that's a pretty big deal for quality professionals." ■

REFERENCE

1. Centers for Medicare & Medicaid Services. BPCI Advanced. Available at: http://bit.ly/2lDIPsp. Accessed Sept. 4, 2019.

Report Shows Potential Value of PCMH Model

Hospital leaders can make the business case for patient-centered medical homes (PCMH) by using recent research from the National Committee for Quality Assurance (NCQA) in Washington, DC.

NCQA reports that PCMH can increase annual revenue — and perhaps a great deal, depending on the payment model. Improvement measures are dependent on a practice's patient population.[1]

Milliman prepared the report for NCQA, aiming to help health systems that might be interested in leveraging PCMH to improve quality and reduce costs, says **Michael Barr**, MD, executive vice president of the NCQA Quality Measurement and Research Group. Payers increasingly are interested in value-based care, and PCMH can be an effective approach, he argues.

"The challenge to date has been that there are so many different models of reimbursement and delivery. The PCMH model is not a one-size-fits-all option," Barr says. "The question has been how a hospital leader can assess these different options and determine what makes the most sense for their organization. We wanted to look at hypothetical scenarios for how PCMH would affect a practice. The hospital leaders can take that information to make their case."

The NCQA Patient-Centered Medical Home Recognition program requires practice management processes and patient care quality metrics that address both high-cost chronic care patients and overall patient satisfaction. Currently, about 13,000 primary care physician practices have NCQA recognition.[2]

Milliman studied several models of PCMH, including the costs of implementing it and the potential benefits. "They found that in all of the different models, there would be an increase in revenue of between 2% and 20% for a hypothetical practice of 10 primary care clinicians and 20,000 unique commercial members," Barr reports. "In the early days of the PCMH efforts, there was great interest by large employers, health plans, and payers, and they offered incentives to keep it going. Some of those incentives are still around, but this paper shows that even in the absence of those incentives, practices should look closely at this model."

The report authors note that, aside from being "the right thing to do" for primary care, the PCMH model "provided organizations a clear 'roadmap' for primary care transformation. PCMH recognition was particularly helpful for those organizations that had less experience with the concepts of this advanced primary care model prior to recognition."[1]

The research should be useful in understanding the potential financial benefits from PCMH, Barr says, which will be helpful for quality professionals who support the approach because of the benefits to patient care. "If a health system is thinking about using a program that has been well studied to help improve the delivery of primary care, this model has not only been shown to improve quality but now we're seeing in these various models that you can see an increase in revenue above and beyond the cost of implementation," Barr says. "I see significant growth opportunities for primary care and transforming the way primary care is delivered." ■

REFERENCES

1. National Committee for Quality Assurance. White paper: The business case for PCMH. Available at: http://bit.ly/2lzIR4H. Accessed Sept. 4, 2019.
2. National Committee for Quality Assurance. Patient-Centered Medical Home (PCMH). Available at: http://bit.ly/2jZDBad. Accessed Sept. 4, 2019.

CE OBJECTIVES

After completing this activity, participants will 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.

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CE QUESTIONS

1. **In the stroke program pilot at CHI Franciscan's St. Joseph Medical Center, what was one of the improvements?**
   a. Faster time through triage
   b. Faster time from arrival to CT scan
   c. Lower costs for the hospital
   d. Lower out-of-pocket costs for the patient

2. **How did Christina Bradley, BSN, RN, stroke coordinator at CHI Franciscan, begin implementing improvements in stroke care?**
   a. She gathered a group of stakeholders to begin discussing the improvements.
   b. She asked the CEO to issue a directive mandating employees to follow the new policies.
   c. She created a reading group for research related to stroke care.
   d. She organized a seminar on the best practices for stroke care.

3. **What was one factor that led to improved mobility for geriatric patients at Baystate Health in Springfield, MA?**
   a. Clinicians were encouraged to walk with patients.
   b. Family members were encouraged to walk with patients.
   c. Fall risk guidelines were eased to allow more patients to walk.
   d. The hospital allocated resources to encourage walking.

4. **How did Melanie Urban, RN, BSN, HACP, become administrator of the University of Kansas Health System Pawnee Valley Campus in Larned?**
   a. She worked specifically toward that goal for several years and formally applied when the position became available.
   b. She was one of the few people available in the health system to take the role and did not seek it out.
   c. She had worked in another state until the position became available and did not have any connections to the organization.
   d. She was recommended by a university contact but had to be talked into taking the position.