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Is 'non-pay for non-performance' a wave of the future of health care?

The flipside of P4P takes root as nine California hospitals are fined

Just when hospital leadership was getting used to the pay-for-performance (P4P) concept, it seems that they will now have to adapt to another new reality that might well be called "non-pay for non-performance."

The first inkling the industry had of such a trend came in the form of an announcement several months ago from the Centers for Medicare & Medicaid Services (CMS) that it would cease reimbursement for certain preventable hospital-acquired infections **(See "CMS unveils proposed list of 'no-payment' conditions," *Healthcare Benchmarks and Quality Improvement*, August 2007, p. 85.)** Now, the California Department of Public Health (CDPH) has taken this approach a step further by fining nine hospitals $25,000 each for patient safety violations.

Here is a summary of the hospitals and their violations:

• Enloe Medical Center, Chico: Failure to develop and implement policies and procedures for the safe and effective administration of medications known to cause cardiac arrhythmias.

• Feather River Hospital, Paradise: Failure to develop and implement policies and procedures to ensure safe food handling practices and failure to develop policies to ensure medication is safely used.

Key Points

- Failing to follow proper safety procedures can cost you big bucks.
- Experts predict financial penalties for poor safety will become more common in the future.
- Hospital association supports the move, as long as new public health power is not abused.

• Garden Grove Hospital & Medical Center, Garden Grove: Failure to develop and implement written policies and procedures to ensure the safe and effective use of medications with black box warnings.

• Glendale Memorial Hospital and Health Center, Glendale: Failure to ensure that medications dispensed for patient care were administered as ordered and in accordance with facility-approved protocols.

• Hanford Community Hospital, Hanford: Failure to have written policies and procedures for the establishment of a safe and effective system for the distribution, dispensing, and use for patient care of biologicals.

• Kaiser Foundation Hospital, Santa Clara: Failure to provide patient safety by ensuring that written policies and procedures for the distribution of all drugs were developed and implemented to ensure the safe use of medications.

• Martin Luther King-Harbor Hospital, Los Angeles: Failure to ensure specialty consultation by a physician, ongoing medical evaluation, medically stabilizing treatment, and physician intervention to ensure prompt transfer to a higher level of care for a patient who presented to the emergency department. Also, failure to ensure prompt nursing assessments and medical care for a patient who presented to the emergency room, and failure to ensure the availability of competent and appropriate nurse staffing resources so that patients could receive prompt treatment.

• Saint Agnes Medical Center, Fresno: Failure to have the proper policies and procedures for the administration of medications, and failure to ensure that registered nurses were appropriately trained.

• Universal Health Services of Rancho Springs: Failure to provide adequate on-call physician coverage to meet the needs of patients receiving emergency care in the emergency department.

(Additional information about each of the violations can be found at the CDPH web site: www.cdph.ca.gov/Pages/default.aspx.)

The "administrative penalties" are the first to be issued by CDPH under new authority granted by Health and Safety Code section 1280.1 (Senate Bill 1312, Statutes of 2006, Chapter 895), which was signed by Gov. Arnold Schwarzenegger last year and took effect Jan. 1, 2007. The law allows CDPH to impose administrative penalties with a maximum fine of $25,000 per violation that constitutes "immediate jeopardy to a patient's health and safety."

"We believe this is just one of many enforcement tools and other tools we can use to improve the quality of care that is delivered to patients every day in the state of California," says **Kathleen Billingsley**, deputy director of the Center for Healthcare Quality at the California Department of Public Health, which oversees licensing and certification. "We believe it will help motivate and stimulate improvement."

There are several ways such violations can come to the attention of the department, Billingsley explains. "We have 500 health facility evaluator nurses out in the field investigating; we oversee 6,000 facilities," she notes. "Half our bud-

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Safety expert blames poor flow for many errors

The recent fining of nine California hospitals for patient safety violations underscores just how high a cost health care facilities might pay for safety shortcomings, and puts an even greater emphasis on identifying new causes of errors and their solutions.

According to one expert, a key factor that contributes to reduced quality of care; reduced patient safety; and overworked and disgruntled nurses, doctors, and administrators is the lack of managing patient flow — in particular, poorly controlling the timing of elective (scheduled) admissions, which then results in periodic episodes of high stress on the entire system.

"What we have found is that patient demand is extremely variable," says **Eugene Litvak**, PhD, co-founder and director of the Program for the Management of Variability in Health Care Delivery at Boston University, and a professor of health care and operations management. "One day the hospital is under stress, and another day its resources may not all be utilized."

What is behind this variability? Hospitals, Litvak explains, have three main portals:

- admission through the ED, which accounts for more than 50% of all admissions;
- elective surgery, which represents a much smaller percentage; and
- transfers.

The logical assumption would be that the ED holds the key to solving this problem, but that's not the case, Litvak argues. "We have found that elective admissions are more variable than admission through the ED," he says. "In other words, it's easier to predict when somebody will break a leg than when the hospital will schedule an elective surgery."

Peak demand equals stress

The way hospitals are staffed today, these periods of peak demand cannot be addressed adequately, says Litvak. "About 40 years ago we used to staff up to peak; today, nobody can afford to do that." With staff levels well below what is needed to meet peak demand, he says when that peak demand occurs, the hospital and staff are under great stress.

This relates directly to the problems in California, he asserts. "Not having beds available to move patients up from the ED is cited as the No. 1 reason why EDs are overcrowded, and California experiences that full-scale," he says. "In two of those hospitals, problems arose because people were waiting in the ED too long — and when you have a peak in scheduled admissions, all the beds are taken away," Litvak explains.

"On top of that, all the nurses are under stress," he continues. "What happens? Nurses under stress are known as one of the major sources of medical errors and sentinel events."

More resources not the solution

The solution, says Litvak, lies not in gaining additional resources, but in better allocating them. "If you reduce the number and frequency of peaks and valleys, you will dramatically increase revenue, improve your nurse staffing, and dramatically improve your quality of care," he argues.

"Bed occupancy can jump from 25% to 80% in one day, and yet you have fixed staffing; how can you ask your nurse to perform quality care if she is overburdened?

"The solution is to smooth those artificial peaks," he says.

He and his colleagues suggest changing the scheduling of elective admissions so they fall evenly across all workdays. To accomplish this, he says, you need to get your CEO involved. "If he's not, forget about it," he says.

But why should surgeons agree to change their way of operation? "As soon as you smooth out the peaks and valleys, the number of surgeries performed increases dramatically, so the surgeons benefit dramatically," Litvak says. "You also need to make sure that ancillary services like physical therapy are available on weekends."

And what about the financial penalties for hospital safety violations? Does Litvak think this will be a growing trend? "I think it will happen if hospitals do nothing," he predicts.

[For more information on Dr. Litvak's approach to patient flow, as well as studies quantifying his results, go to www.patientflowtechnology.com. He can also be reached via phone at: (617) 358-4547.] ■

get is funded by CMS, and we conduct certification surveys on their behalf. The other half of our budget is for state licensing; we actually do state surveys as well, using our own state requirements."

Violations, she continues, can be found in either of these types of investigations — or, her department can receive complaints, which in turn

would be investigated.

Hospital reaction mixed

While a number of the fined facilities quietly took their "medicine," a few are reportedly appealing the levies. For example, the *San Francisco Chronicle* recently reported that Kaiser Permanente had appealed its fine. The case involved the death of an infant with a rare metabolic disorder that was allegedly due to the incorrect weight on a packaged mixture of nutritional supplements. The hospital was cited and fined for a situation that put patients "in immediate jeopardy, although its plan for correction had been approved by the federal government," according to the paper.

On the other hand, Garden Grove said that it had immediately developed a plan of corrective action that was approved by the state the following day. Glendale, in a prepared statement, said: "In collaboration with the California Department of Public Health, we have conducted a thorough investigation of this incident and taken appropriate action to protect all patients' safety while in our facility. We are working closely with our medical staff, nurses, pharmacists, and hospital leadership, as well as with the appropriate agencies to ensure that all requirements of licensure are continuously met."

"I believe my discussions with the hospitals with respect to the issuance of administrative penalties have been very cordial and positive, although some will be filing appeals," says Billingsley. "I do know that in cases of immediate jeopardy, all hospitals have resolved the situations, and we have found them incredibly responsive and they have done the right thing."

CHA supports law

In fact, the California Hospital Association (CHA) came out in favor of the new legislation. "We knew the department needed to have some basis to cite hospitals that was more than just a slap on the wrist, and by the time the legislation got through all the committees, we were supportive of the bill," says **Dorel Harms**, RN, senior vice president of clinical services. "There were concerns on the part of a lot of people, including some hospitals, that we needed to improve quality, and there had been safety issues, but all the department could do was write out a form and come back and see if the policies had been instituted. This new law more or less gets the attention of everyone."

That's not to say that the CHA is in total agreement with all of the fines. "Some of the language had to do with immediate jeopardy or the possibility of jeopardy," says Harms. "We understand that in some cases there was harm, but in others there was no harm anyone could detect — and some errors did not seem to warrant a $25,000 fine."

Harms says she knows the department is looking carefully at each case and is trying to be fair to the hospitals, but says that "it does seem a little bit over the edge in some instances." Still, she says, she is "not opposed in principle" to the fines.

Right or wrong, are such financial penalties for poor safety and quality the wave of the future? "I think it will be interesting to see how that unfolds in the next year or so," offers Billingsley.

Harms is a bit more certain. "Yes, I do believe it will be a growing trend," she predicts. "It all has to do with pay for performance. I know that legislatures statewide and nationally are supportive of not paying for inadequate service." **(In another recent development, The Leapfrog Group reports that more than half the hospitals participating in its survey have agreed not to charge for "Never Events." See the article, p. 7.)**

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Six Sigma CAP initiative reduces mortalities

Enables staff to make required process changes

A Six Sigma performance improvement project in community-acquired pneumonia (CAP) at Mercy Medical Center has decreased mortality rates from 6.7% in 2003 to 3.5% in 2006, or a 47.8% reduction.

The program also reduced the mean length of

Key Points

- Compliance Joint Commission CAP core measures improved by 70% to 90%.
- Methodology helps team identify critical processes and key stakeholders, and to track results.
- Early positive data, proactive education efforts help sway initially reluctant physicians.

stay (LOS) from 5.9 days to 5.1 days and saved more than $300,000. In order to achieve these improvements, staff raised compliance scores for each Joint Commission core measure for CAP to between 70% and 90%.

The results were measured in 670 CAP patients who were admitted during the baseline period of fiscal year 2003, and the 1,550 CAP patients who were admitted during the study period. The staff at Mercy Medical in Des Moines, IA, credit their success to the standardization of treatment and the statistical identification of the appropriate processes to target.

"Six Sigma was the P.I. methodology our hospital had adopted," explains **Karen Gamerdinger**, RN, MSN, pulmonary case manager. However, while there were many such projects implemented in the hospital, "we were the first," she adds.

Targeting core measures

The CAP core measures targeted, says Gamerdinger, were:

- Oxygenation assessment within 24 hours;
- Blood cultures before antibiotic dose;
- Antibiotics within four hours of arrival at the hospital;
- Antibiotic regimen consistent with guidelines;
- Screening and administration of influenza and pneumococcal vaccine;
- Smoking cessation advice or counseling for those who smoke or did so in the previous year.

"Those were the core measures at the time of the study," clarifies **Neil Horning**, MD, medical director of the pulmonary care improvement team. "They continue to be adjusted by The Joint Commission."

The pulmonary care improvement team, he continues, included himself and Gamerdinger, the facility's Six Sigma Master Black Belt, the chief nursing officer, the ED medical director, ED and floor nurses, a representative from the finance department, and a pharmacist.

A focused intervention

One of the main benefits of Six Sigma, says Horning, was that it enabled the team to conduct a "focused intervention."

"It gave us a couple of important tools to be able to really dive in and look at what was going wrong and at what the critical processes were; to measure statistically where we could make important changes; what kind of interventions could help; and who the important people were who could make this happen and get back to us," he explains.

In this case, the most important place identified was the ED, and the person was the director. With his assistance, says Horning, "we were able to get data back more quickly, we moved faster, and we knew where we were and were not making improvement — what we should and should not be doing."

What else led them to the ED? "One of the main reasons was the ED director knew that 80% of our patients came through the ED, and four of the six core measures had to be met before they left. So that was the key," Gamerdinger explains.

"From our baseline analysis, we found that in those patients who had pneumonia admission standard orders their LOS was almost a full day less," she adds. "Switching from IV to oral medication also had a strong correlation with [shorter] LOS."

Revising orders

Accordingly, the team revised the ED orders to incorporate the appropriate guidelines and to make sure they were initiated in the department. "Prior to this, our compliance had only been 40%," says Gamerdinger. "Having the medical director from the ED function as a process owner meant he was able to give timely feedback to the doctors who were deficient."

Educating the physicians about the new orders also was critical, says Horning. "We let them know the orders were available, made them easy to locate, and tried to make them as easy as possible to use," he says. "We worked with the ED physicians to change the orders, and make some requested adjustments."

Before these orders, physicians had a number of different choices about things that could hap-

pen on the floor, he adds. "There were almost too many choices; the form was too cluttered, and we had tried to pack too many things in," he says. "All you really had to do was to make the diagnosis and to order the correct antibiotic."

When it was discovered through chart audits (control charts were used to monitor variation in CAP admission order use) that a specific physician was not using the form, Gamerdinger would send an e-mail to the ED director telling him which patients had gone through without proper orders. "She developed a pretty simple chart for them so they could see at a glance the percentage of use by each doctor," notes Horning. The director would then go directly to the physician and point out their performance.

To track other results, descriptive statistics were used for data analysis of core measures, LOS, and mortality.

Getting docs on board

As with many QI projects, getting physicians on board was a challenge. "Some physicians have a problem with standardized forms no matter what they are, although that is a minority," notes Horning. "Compliance was lower at the beginning because some doctors didn't know about them and their easy availability."

Letters were sent out to the doctors telling them about the new form, and the ease of availability soon became evident. In the ED, the new form was made part of all standardized admission order forms. "On the floors where [CAP] patients were admitted frequently, they were in the chart at room-side," says Horning. "We also brought them to the doctors' offices."

In addition, the medical executive committee and the administration made it clear they expected the form to be used for every patient. "Once we had data we were able to take them to the medical staff and administration; after we showed them the data, they endorsed the use of that order form for all patients with CAP," Gamerdinger explains.

In addition, says Horning, "Six Sigma was a hospital-wide QI initiative, so that gave some weight and importance to our project. The implication was that this was important to the administration, and that it should happen correctly."

He adds that using Six Sigma processes is not by itself a guarantee of success. "Six Sigma is used in a lot of hospitals — without success in some," he notes. "What's important here is that this was a QI initiative where the administration presented it as something they believed would improve quality of care — that it was not just a cost-saving initiative. Also, in some hospitals, it is used in a punitive way, but not in ours. The attitude was, 'Let's all pull together and make things more efficient for everyone at the hospital.'"

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Docs, paramedics using new two-way video link

Puts hospital physicians 'inside the ambulance'

Physicians at the University Medical Center (UMC) in Tucson, AZ, a level I trauma center, and the city's 17 paramedic units are participating in a pilot program for what its proponents say is a worldwide first — a two-way video system that enables them to see and communicate with each other in real-time as the patient is being treated and brought to the hospital.

Some of the units also have cameras on the outside of their vehicles, which enable those using the system to see what's happening at the accident scene as well.

The videoconferencing system uses the city's safety and public works wireless Internet system to connect the video cameras installed both in the paramedic units and in the hospital. The cameras can be manipulated at both ends of the system, so not only can the doctors view the patients and the paramedics, but the paramedics can see the physicians through a computer monitor on the walls of their vehicles.

The project, funded by a $1.6 million federal grant and matching funds from the city of Tucson, is an extension of the Southern Arizona Teletrauma and Telepresence Program. The program provides live videoconferencing, telemetry, digital X-rays, and ultrasounds to the trauma physicians at UMC, as well as to rural emergency departments and nurses in the southern part of

Key Points

- Visuals of patients and accident scene help docs communicate with paramedics.
- Some paramedics are resentful of the 'big brother' aspects of the new system.
- City of Tucson matches federal grant in order to make program a reality.

the state.

"When I got here (several years ago) the grant for the telemedicine/ER link had been under way, with some funds from the Department of Transportation," recalls **Rifat Latifi**, MD, interim medical director of UMC's level 1 trauma center. "But somehow, things were kind of quiet. We helped reinvigorate the process; we wrote [a request for proposal] and did the other things we needed to do."

The three partners in the project, he explains, are the Tucson Fire Department, the Tucson Department of Transportation, and UMC. "We had a number of people present bids, and, ultimately, we picked the equipment from General Devices, which is based in Ridgefield, NJ. We thought at that time that they were the best at providing real access to the patient, as well as vital signs."

A real 'first'

Is this truly the first system of its kind in the world? "To my knowledge, this is true," says Latifi. "A few others have tried it before, but they did not succeed."

With the pilot program, which began in August, "we have access to the patient, to the paramedics, and to everything outside and inside the ambulance," says Latifi. "And once we know what's going on, we share that knowledge with the paramedics."

Why is it so important to have a system such as this? "In Europe they send the [trauma] docs out to pick patients up at the scene," Latifi notes. "We do not have enough physicians to do that, so this is basically an extension of manpower to the scene of the accident."

The system will improve quality on a couple of different levels, says Latifi. "Patient care will get better," he predicts, noting the immediacy of treatment. "Number two, the cohesiveness of the team — the pre-hospital and hospital providers — will be much better. Any time a team works better, the patient receives better quality of care." Theoretically, observers note, such a system can also reduce potential liability by reducing errors.

Some mixed emotions

Lafiti concedes that the system has been met "with mixed emotions" by the paramedics, because some feel people are now looking over their shoulders.

"We need to do a better job overall to educate them that this is not a 'big brother is watching you' concept, but that we are just trying to be more helpful," he explains. "If you have a really sick patient trying to die on you and your colleague is driving the ambulance at 70 miles per hour and you are there in the back, you feel pretty lonely. The new system will remove the loneliness, and make physicians more a part of the team." Patient privacy (and more specifically HIPAA), on the other hand, should not be an issue because the city will not have access to the videos.

There are a few other "bugs" that need to be worked out of the system, Ratifi adds. "We had some issues with the [sound of the] voice initially, but we are getting used to it, as we are the whole system," he says. "All of a sudden we are seeing inside the ambulance. We see the patient come in. We have to adjust our concentration, since now we can also see and not just hear, and that will take some time."

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Majority of hospitals won't bill for 'never events'

Survey shows commitment to 'doing the right thing'

The Washington, DC-based Leapfrog Group reports that 52% of the hospitals responding

to its Hospital Quality and Safety Survey say that they have adopted the "Leapfrog Never Events" policy. This policy includes the following actions that the hospitals pledge to take whenever these medical errors — rare though they may be — occur:

- Apologize to the patient and/or family affected by the never event;
- Report the event to at least one of the following agencies: The Joint Commission, a state reporting program for medical errors, a patient safety organization;
- Perform a root cause analysis, consistent with instructions from the chosen reporting agency;
- Waive all costs directly related to the serious reportable adverse event.

This year, 1,285 hospitals reported for the first time on their adherence to the Leapfrog Never Events policy. These "never events" follow the 28 "serious reportable events" outlined by the National Quality Forum, which includes errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, and discharging an infant to the wrong person.

According to Leapfrog, hospitals that agree to the policy are twice as likely to have scored full points on the Leapfrog Safe Practices Score (SPS) than those hospitals that have not.

The SPS asks hospitals how well they implement 27 of the NQF's Safe Practices; 33% of hospitals who commit to the Leapfrog Never Events policy have scored full points on the SPS, but only 17% of those that did not commit to the policy did the same.

Leapfrog also found that the rate of adoption differed by hospital size, with a higher rate of adoption among smaller hospitals. Here is the breakdown:

- 59% of small hospitals (1-100 beds);
- 53% of medium hospitals (101-250 beds);
- 48% of large hospitals (251+ beds).

A 'positive sign'

"We think that [these results are] a very positive sign," says **Rachel Weissburg**, program associate with The Leapfrog Group. "We hope and think that other hospitals are going to respond to that kind of leadership."

She adds that asking hospitals to submit to what may be normal customer service principles in other industries "is radical" in health care.

Key Points

- Policy also includes apologies, reporting events to agencies such as The Joint Commission.
- What are considered normal customer service practices in other industries are 'radical' in health care.
- Risk manager says 'doing the right thing' also can help reduce your hospital's liability exposure.

As for the willingness of hospitals to forego charging for services when such events occur, Weissburg admits to being surprised that she has not had much negative feedback. "I thought I would hear a lot more complaints," she says.

That may be because some hospital leaders, such as Children's National Medical Center in Washington, DC, already had been pursuing a similar policy.

"We've been writing off bills for over 10 years, but our practice has evolved to where we are doing it more frequently," says **Mary Anne Hilliard**, Esq., BSN, CPHRM, the hospital's chief risk counsel.

Hilliard says this increased frequency began about five years ago, but that the scope of bill write-offs is broader than just "never events." "Whenever there is a serious, unexpected error," she says, "we try to do the right thing. We investigate, we disclose, and where appropriate, we apologize, and write the bill off if we find we have caused harm." Such a practice, she adds, is simply a case of "doing the right thing."

Practice is rewarded

Hilliard says that Children's National has definitely benefited from this policy. "It's absolutely had a positive impact [in terms of minimizing] litigation," she asserts. "These cases are much more likely to settle; I believe we have saved hundreds of thousands of dollars by doing the right thing."

In most cases, she continues, that is all that families want you to do. "When they see you've done all you can to mitigate the harm, a lot of them are magnanimous," she shares.

"Paying for what you asked for makes common sense; paying for what you didn't ask for doesn't make common sense," adds Weissburg.

Such a policy "also goes a long way with insurance carriers," Hilliard adds. "They are

always surprised; it's not uncommon for us to write off a bill before it even comes to them, as we are pretty transparent. When we operate that way and build trust, it has all sorts of implications down the road for you to be able to work together."

Greater adoption needed

What is stopping the other 48% of hospitals from adopting the policy? "Each piece of the policy has implementation challenges," notes Weissburg. "A lot has to do with the legal climate in each state — I've had many discussions with hospitals that want to implement the policy but say they do not have a place to report, or they are not accredited, or they are not in a state that has a reporting program in place, so they are in a 'no-man's land.'" For hospitals with such problems, she adds, there is an "FAQ" section on the organization's web site (www.leapfroggroup.org) that addresses many of them.

Quality managers, she adds, are the logical individuals to take a leadership role in the hospital adopting this policy. "The hospital quality manager should be the first to see the value of adopting this policy," she asserts. "It's a tool for hospitals to use to handle rare but ubiquitous events."

Finally, warns Hilliard, while this policy makes sense, hospital professionals should remain wary about others using it as an excuse to perhaps place unwarranted financial penalties on their facility. "We are worried about a spin-off effect; some insurance companies may use [the policy] as an excuse not to pay for other others things," she concedes.

For example, she observes, the recent announcement by the Centers for Medicare & Medicaid Services that it would no longer reimburse hospitals for certain preventable HAIs, or hospital-acquired infections, "could become a trend — a slippery slope, if you will. Denials [of reimbursement] do have the potential to get into areas that are gray."

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Facility, insurer seek to create a 'healthy city'

Move toward preventive health

Improving the health of patients in your hospital is a large enough challenge, but imagine taking on the well-being of an entire city. Well, that's exactly what The Cleveland Clinic and Medical Mutual of Ohio are doing in Solon. Their collaborative initiative, called "Healthy Solon," seeks to improve the health of the entire town through prevention.

As part of the initiative, the Cleveland Clinic is providing free medical screenings and health care advice to anyone who lives or works in Solon, a city of about 25,000 people just southeast of Cleveland. The goal of the program is to educate participants and encourage them to take an active role in their own health through walking, smoking cessation, and stress prevention programs, as well as improved nutrition.

A shift in focus

Getting involved in this initiative was important for the Cleveland Clinic because it was in line with a shift in focus that the organization

has been taking, says **Daniel Sullivan**, MD, a staff physician who specializes in internal medicine.

"It's important predominantly because of our big shift as an organization, to where we are now focusing on wellness," he says. "This is a dramatic shift from how many of us were trained; we've been trained to wait for illness to come to us and treat it — rather than focusing on prevention."

The rationale behind this shift, he continues, "is that we've identified that there are a variety of illnesses that are preventable, and if we can make a difference in prevention that will have a big impact on outcomes." **(The Emory Clinic in Atlanta is also focusing on prevention. See "Predictive health: A new paradigm for quality," *HBQI*, December 2007, p. 133.)**

In addition, says Sullivan, such a program fits comfortably within the facility's mission. "Our focus is all about patient outcomes and experiences — whether they are inside or outside our walls," he emphasizes. "Health care is becoming prohibitively expensive, and if we can make an impact outside our walls to make it less costly inside them, it will make it easier for employers and people who are self-insured."

What's more, he points out, hospitals in the United States are now scored by many national organizations, such as The Joint Commission, on outcomes. "If someone has diabetes, whether they are treated within or outside our walls, if they are under our care and if they have a good outcome that will affect our scores positively," he observes. "Companies look at these outcomes in deciding whether to use the Cleveland Clinic."

Not only is it important to have good outcomes in terms of national measures, he notes, "but every insurance company is measuring us as well."

Targeting a city

The "Health Solon" initiative got its start in December 2006, when the initial groundwork was laid. "Medical Mutual was looking at trying to improve their outcomes within their insured customers, and in reviewing the demographics, they saw they had a large number of insured in Solon," says Sullivan. "They figured it would make a lot of sense if they started a pilot program there." Medical Mutual wanted to partner with a city, and Solon has a "phenomenal" community center with exercise rooms, pools, and so forth, Sullivan says.

Key Points

- Citizens receive free exercise, smoking cessation, and stress prevention programs.
- Hospital shifting its focus from treating disease to preventing it.
- Patient outcomes — whether within or without hospital walls — should be part of your mission.

"When they started the process, they contacted us and asked if we wanted to be partners and we said absolutely yes," he says, adding that it is unique to see the three different types of organizations — which are sometimes on opposite sides of the fence — working together.

A key part of the program involves monthly gatherings at the community recreational center, each with a different focus. "For example, this past Saturday it was men's health," notes Sullivan. "I was one of the speakers. I gave a brief talk, and then invited the other speakers — a wellness expert and a former Cleveland Cavaliers [basketball] player — to address the group." In addition, free screenings were provided for blood sugar, cholesterol, and so forth, and free first-aid kits also were handed out.

Impact on the hospital

If the program is successful, might it not actually hurt the Cleveland Clinic down the road if admissions are reduced? "Potentially, yes, but health care is not just local anymore," notes Sullivan, pointing out that because of its reputation the Cleveland Clinic draws patients from all over the world. "Our perspective is to put the patient first, and do the right thing. If we do that, then as a business, we will succeed — rather than focusing on the economic model, which does not necessarily put patients first."

The participants are not yet able to determine if the program is succeeding, says Sullivan. "Right now, in terms of measuring outcomes, we and Medical Mutual are working together to find out the best way to capture data," he says. "It's a little tricky, because you have to identify people from Solon who participate in the program. Our IT people are looking at it; we have an [electronic medical record], but we still need to create a match between people from Solon

who are also with Medical Mutual and who also participate. We hope to have that available by early 2008."

Clearly, both the Cleveland Clinic and Medical Mutual have great interest in these data, Sullivan continues. "Medical Mutual wants to see if they should expand this program to other areas, because healthier clients help keep costs down," he explains. "And of course, we have an interest in showing that we care about fostering good outcomes, because it makes it more likely that insurers and employers will choose us for their health care services."

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AHRQ Data: 5% of those who contract MRSA die

One out of every 20 patients treated in United States hospitals for methicillin-resistant *Staphylococcus aureus*, or MRSA, in 2005 died from the infection, according to a recent "News & Numbers" summary from the Agency for Healthcare Research and Quality (AHRQ). Most of the patients who died were elderly or low income. AHRQ notes that the death rate for hospitalized MRSA patients was higher than the 4% death rate for patients hospitalized with another potentially deadly illness — tuberculosis.

AHRQ also found that:

• Approximately 332 Medicare patients per 100,000 were hospitalized for MRSA, compared to 184 Medicaid patients and 29 patients with private insurance. The rate for uninsured patients was 43 admissions per 100,000 people.

• Men were more likely to be hospitalized for MRSA (107 admissions per 100,000) than women (92 admissions).

• People in the south were 27% more likely (113 admissions per 100,000) to be hospitalized for MRSA than those in the northeast and midwest (89 admissions per 100,000 population). People in the west fell in between (96 admissions per 100,000). ▼

ED visits up by 5.1 million according to CDC report

Visits to hospital emergency departments increased by 5.1 million in 2005 to 115.3 million, according to a recent report by the Centers for Disease Control and Prevention.

That is an average of about 30,000 visits per ED, nearly one-third more than in 1995. The ED visit rate for patients without health insurance was about twice that of those with private insurance, according to the report. Infants under age 1 had the highest visit rate by age. The leading diagnosis for children under 13 was acute upper respiratory infection.

Other top diagnoses by age were bruises, adolescents; abdominal pain, adults under 50; chest pain, adults 50-64; and heart disease, seniors. About 12% of ED visits resulted in hospital admission. The leading diagnosis at discharge was heart disease.

The 2008 edition of AHA Hospital Statistics, which came out in late October , includes figures regarding ED usage in 2006. It reports that hospital EDs served 3.6 million more people that year than in 2005, while the number of inpatient admissions held steady.

ED visits totaled 118.4 million, up from 88.5 million in 1991, according to the AHA survey.

COMING IN FUTURE MONTHS

■ The Joint Commission gives hospital quality and safety progress report

■ Technology used to improve nursing practice

■ AHRQ, Joint Commission identify major risks to patient safety

■ Wristbands with embedded chips help avoid wrong-site surgeries

Contributing to the rise in visits, it reported, is the increased use of hospital services from baby boomers who recently turned 60, an age when use of health care services begins to go up dramatically. ▼

AHA survey report outlines uncompensated care costs

The cost of uncompensated hospital care in the United States was $31.2 billion in 2006, up from $28.8 billion in 2005 and $21.6 billion in 2000, according to the latest figures from the American Hospital Association's Annual Survey of Hospitals.

Underpayment by Medicare and Medicaid reached nearly $30 billion in 2006, up from 25.3 billion in 2005 and $4 billion in 2000. Medicare reimbursed 91 cents and Medicaid reimbursed 86 cents for every dollar hospitals spent caring for these patients.

In 2005, 65% of hospitals received Medicare payments less than cost and 77% of hospitals received Medicaid payments less than cost.

AHA President and CEO Rich Umbdenstock says survey data show that "hospitals are seeing more and more patients while future financing is uncertain, emergency departments continue to be overcrowded, and fewer workers are available to provide care."

The information is summarized in two AHA fact sheets, available on-line at www.aha.org. ▼

OSHA reports high injury/illness rates

More than 14,000 employers have been notified that their worksite injury and illness rates are higher than average — and that the Occupational Safety and Health Administration (OSHA) is watching.

In a letter sent to the employers in March, OSHA offered its help to any that wanted to proactively take steps to reduce their injury and illness rates. Workplaces with high injury and illness rates were identified by OSHA through employer-reported data from a 2006 survey that gathered 2005 data from 80,000 sites. The workplaces identified had 5.3 or more injuries or illnesses resulting in days away from work, restricted work activity, or job transfer (DART) for every 100 full-time workers. The national average during 2005 was 2.4 DART instances for every 100 workers.

OSHA says the list does not designate any employers earmarked for future inspections; the agency will announce targeted inspections later in 2007. The 14,201 sites are listed alphabetically by state on OSHA's web site at www.osha.gov/as/opa/foia/hot_13.html. ■