

The Future of Quality in Hospitals

South Texas Chapter
HFMA
May 2011



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The Texas Center for Quality & Patient Safety



- Initiated in Spring 2010 to advance Texas hospitals' performance in providing quality care to patients
 - Provide educational resources and support services implementing practices aimed at improving safety and patient outcomes

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Team Members

- Terri Conner, MS PhD, *Vice President*
 - 20 years of experience in healthcare economics, clinical research, and quality improvement
 - Work experience in hospital and outpatient settings, clinical research, and payer environments
- Maria Rascati, MA, *Research Specialist*
 - 4 years experience in public education, acute care and outpatient rehabilitation settings
 - Prior experience in developing, conducting, and presenting research projects related to stroke.
- Rachel Cicerchi, MPH, *Research Specialist*
 - Experience in acute care and rehabilitation settings, academic research and project management roles
 - Focuses on grant development and administration

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Policy Support

- Cameron Krier, JD, MPH *Senior Director, Policy*
 - Legislative Counsel for Senator Kay Bailey Hutchison (Washington DC)
 - Government Affairs (University of Texas Health Science Center Houston)
 - Certified Emergency Medical Technician

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Focus on health care quality has increased

- Just in the last 10 years, we have seen an explosion in
 - Hospital performance measurement
 - Data collection and analysis
 - Reporting requirements
 - Health care quality vendors
 - Quality/improvement organizations
 - NQF, NCQA, IHI, AHQA, NAHQ, Leapfrog, QIO

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Why?

Multiple factors

- Internet/technology
 - More savvy patients and family members
- Legislation
 - State and federal reform & mandates
- Economy/costs
 - 'The abyss between what physicians know should be done for patients and what is actually done accounts for more than \$9 billion per year in lost productivity and nearly \$2 billion per year in hospital costs'

– NCQA. *The State of Health Care Quality:2004.*

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What is quality in health care?

- Striving for and reaching excellent standards of care
- Doing the right thing, at the right time, in the right way, to achieve the best possible results
 - *Agency for Healthcare Research and Quality (AHRQ)*
- Striking the right balance of services by avoiding underuse and overuse, and by eliminating misuse
 - *AHRQ*
- The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
 - *Institutes of Medicine*

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What is quality in health care?

- Doing the same thing over and over again and expecting different results
 - *Albert Einstein, definition of insanity*

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Has quality of care improved in hospitals?

- Overall, quality and safety have been steadily improving across the country, but we continue to be suboptimal
 - Significant variation exists between facilities
 - Too many performance indicators with varying definitions
 - Little correlation between the amount spent and the outcomes achieved
 - Not enough understanding of what works and why
- However there is an assumption that mandatory measurement and reporting are powerful mechanisms to drive quality improvement

Lindenauer, Transparency as a strategy to improve the value of hospital care. Roundtable on Evidence-Based Medicine, IOM, 2009
 Sheldon, The healthcare quality measurement industry: time to slow the juggernaut? 2005
 Quality Forum. National Quality Forum Mission, 2004

Reporting Initiatives

- Which are more likely to increase value?

Not likely to change outcome or costs	May improve outcomes but increase costs	May improve outcomes with no change in costs	May improve outcomes and decrease costs
Hospital procedure rates	Mortality rates	Patient satisfaction	Readmission rates
Hospital charges	Process measure performance		Complication rates
			Hospital associated infection rates

Lindenauer, Transparency as a strategy to improve the value of hospital care. Roundtable on Evidence-Based Medicine, IOM, 2009 10

Significance of Hospital-Acquired Infections

- What is a hospital acquired infection?
 - An infection acquired in hospital by a patient who was admitted for a reason other than that infection (Ducel).
 - An infection occurring in a patient in a hospital or other health care facility in whom the infection was not present or incubating at the time of admission. This includes infections acquired in the hospital but appearing after discharge, and also occupational infections among staff of the facility (Benenson).

Ducel G et al. *Guide pratique pour la lutte contre l'infection hospitalière*. WHO/BAC/79.1.

Benenson AS. *Control of communicable diseases manual*, 16th edition. Washington, American Public Health Association, 1995.

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Who gets HAIs?

- The most frequent nosocomial infections are infections of surgical wounds, urinary tract infections and lower respiratory tract infections. The WHO and others have shown that the highest prevalence of nosocomial infections occurs in intensive care units and in acute surgical and orthopedic wards.
- Infection rates are higher among patients with increased susceptibility because of old age, underlying disease, or chemotherapy.

Schwegman D Prevention of Cross Transmission of Microorganisms is Essential to Preventing Outbreaks of Hospital-Acquired Infections. 2009.

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- Millions of HAIs occur in hospitals across the U.S. every year
 - 99,000 deaths result from HAIs every year (roughly 5%)
- 20%-70% of HAIs are preventable, depending on the setting and type of infection

Harbath S, Sax H, Gastmeier P. The preventable proportion of nosocomial infections: an overview of published reports 2003.

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Costs are significant

- Increased ICU stay by 8 days
- Increased hospital stay between 7.4 and 9.4 days
- Total dollar costs \$4.5-\$5.7 billion annually
- Average cost per infection \$13,973
- Cost to patients who survive \$40,000
 - MRSA 2.7 million extra hospital days and \$35,367 per infection

Zhan C, Miller MR. Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. 2003

Pttet D, Tarara D, Wenzel RP. Nosocomial bloodstream infection in critically ill patients. Excess length of stay, extra costs, and attributable mortality. 1994

Stone PW, Larson, E, Kavar LN. A systematic audit of economic evidence linking nosocomial infections and infection control interventions 1990-2000. 2002.

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Who pays?

- Only 5-18% of nosocomial infections would have caused the admission to be reclassified to a higher diagnosis related group (DRG)
 - Of those able to reclassify, the extra payment is 5% of the total cost to treat the infection.
 - 95% of the financial burden goes to hospitals and patients

Haley RW, White JW, Culver DH, Hughes JM. The financial incentive for hospitals to prevent nosocomial infections under the prospective payment system.

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Prevention

- Foundation for prevention: Hand Hygiene
 - Healthcare workers are about 50% adherent to hand hygiene guidelines
 - Must eliminate perceived barriers
- CDC published clear guidelines to reduce HAIs
 - Isolation precautions
 - Infection reduction

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Cost not an issue?

- How about public reporting and reimbursement?

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Quality Based Payment Reforms

- CLABSI and SSI Reporting
 - **Federal:** To receive the annual payment update from CMS, hospitals are required to report
 - January 2011: CLABSI. First quarter data must be submitted by August 15, 2011.
 - January 2012: SSI. First quarter data must be submitted by August 15, 2012.
 - **State:** Reporting of CLABSI and SSI *expected* September 2011
- Reporting will be to the CDC's National Healthcare Safety Network

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Quality Based Payment Reforms

▪ Readmissions

- **Federal:** PPACA imposes financial penalties on hospitals with high readmission rates.
 - Beginning October 2012, acute care hospitals with higher than expected 30 day risk adjusted readmission rates will receive reduced payments for every discharge. The reduced payment is the lesser of 1% or a hospital specific readmission adjusted factor. [2% in Oct 2013; 3% in Oct 2014]. CAHs exempt.
 - In the first two years, the payment policy will apply to heart attack, heart failure and pneumonia. Additional conditions will be added in future years.
 - Projected savings: \$7.1 billion/10 years
 - DataGen report

Other readmission provisions

- Requires publication of hospital readmission rates through *Hospital Compare* website

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Quality Based Payment Reforms

▪ Readmission (cont.)

- **State:** As per HB1218 (81st Session), Medicaid potentially preventable readmissions (PPR) data will be shared confidentially with hospitals.

A PPR means a **return hospitalization** of a person within a **period specified** by the commission that results from **deficiencies in the care or treatment provided** to the person during a previous hospital stay or from **deficiencies in post-hospital discharge follow up**. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge.

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Quality Based Payment Reforms

▪ Hospital Acquired Conditions (HACs)

– **Federal: PPACA imposes financial penalties on hospitals with high HAC rate.**

- Beginning October 2014, hospitals with HAC rate in bottom quartile of national average (i.e. high rate) will suffer a 1% payment reduction for all Medicare inpatient DRGs.
- Projected savings: \$1.5 billion/10 years
- DataGen report

Other HAC provision

- Requires reporting of hospital specific information on HACs to the public via *Hospital Compare*
 - Public reporting was scheduled for September 23 2010 but has been indefinitely delayed due to a discrepancy in the calculation of HAC rates by CMS.

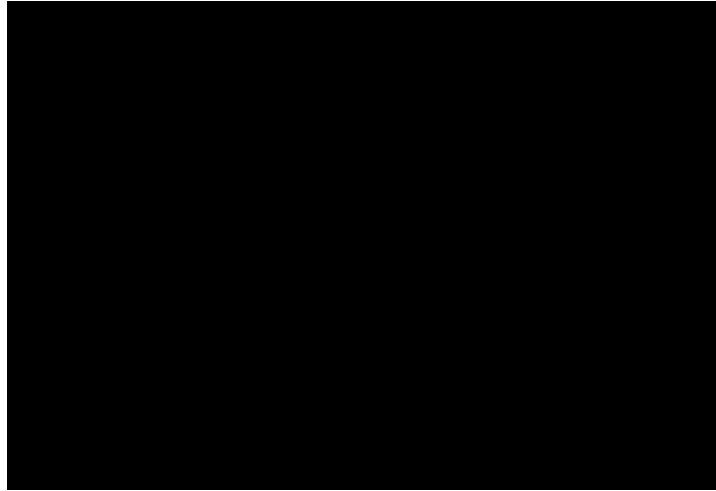
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Quality Based Payment Reforms

Inpatient Prospective Payment System (IPPS) Policy	Fiscal Year									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Market Basket (MB) Cuts for Productivity Adjustment (P) ¹ and Medicare Savings	MB - 0.25	MB - 0.25	MB - (P + 0.1)	MB - (P + 0.1)	MB - (P + 0.3)	MB - (P + 0.2)	MB - (P + 0.2)	MB - (P + 0.75)	MB - (P + 0.75)	MB - (P + 0.75)
Reporting Hospital Quality Data for the Annual Payment Update ² (Pay for reporting)	MB - 2.0 If Failure to Report	MB - 2.0 If Failure to Report	MB - 2.0 If Failure to Report	MB - 2.0 If Failure to Report	MB - 2.0 If Failure to Report	MB - ¼ of MB If Failure to Report	MB - ¼ of MB If Failure to Report	MB - ¼ of MB If Failure to Report	MB - ¼ of MB If Failure to Report	MB - ¼ of MB If Failure to Report
Hospital Value-Based Purchasing ³				MB - 1.0 Potential for Earn Back	MB - 1.25 Potential for Earn Back	MB - 1.5 Potential for Earn Back	MB - 1.75 Potential for Earn Back	MB - 2.0 Potential for Earn Back	MB - 2.0 Potential for Earn Back	MB - 2.0 Potential for Earn Back
Readmissions ⁴				MB - Hosp-specific amount capped at 1.0	MB - Hosp-specific amount capped at 2.0	MB - Hosp-specific amount capped at 3.0	MB - Hosp-specific amount capped at 3.0	MB - Hosp-specific amount capped at 3.0	MB - Hosp-specific amount capped at 3.0	MB - Hosp-specific amount capped at 3.0
Hospital Acquired Conditions						MB - 1.0 For Bottom Quartile Hospitals	MB - 1.0 For Bottom Quartile Hospitals	MB - 1.0 For Bottom Quartile Hospitals	MB - 1.0 For Bottom Quartile Hospitals	MB - 1.0 For Bottom Quartile Hospitals
Health Information Technology Meaningful Use ⁵ (MU)						MB - ¼ of MB If Failure to Meet MU	MB - ¼ of MB If Failure to Meet MU	MB - ¼ of MB If Failure to Meet MU	MB - ¼ of MB If Failure to Meet MU	MB - ¼ of MB If Failure to Meet MU

Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.

Getting started on improving quality of care



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What are the components of a quality improvement initiative?

- Must have a clearly-defined, feasible goal
- Form a team that includes the 'right people'
- Must use an acceptable method of measurement
 - A systematic approach demonstrates whether efforts are
 - 1) Leading to change in the desired direction
 - 2) Contributing to unintended results in other parts of the system
 - 3) Requiring additional efforts

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- **Measurement**
 - Control charts
 - Structure-process-outcome assessment
- **Tools**
 - Continuous quality improvement model
 - Plan-Do-Study-Act
 - Six sigma/lean methodology

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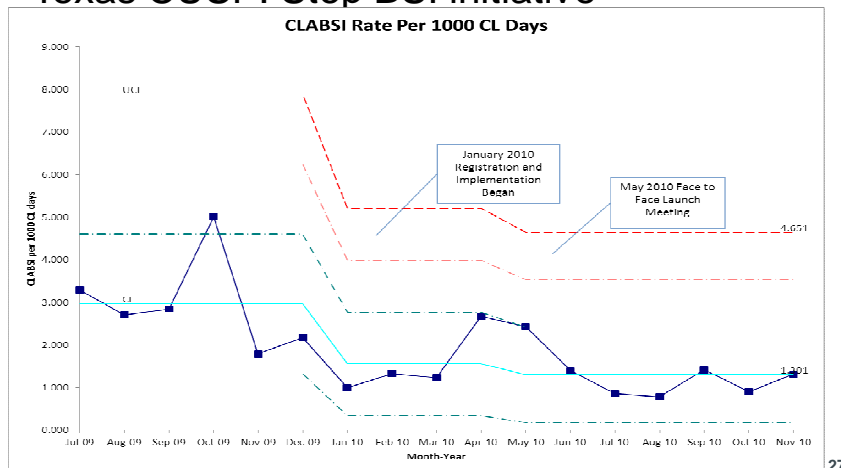
TCQPS Current Quality Initiatives

- **On the CUSP: Stop BSI**
 - A safety culture focus with bundle to achieve zero bloodstream infections associated with central lines
- **On the CUSP: Stop UTI**
 - A safety culture focus with bundle to achieve a minimum 25% reduction in urinary tract infections associated with catheters
- **Readmissions Reduction Initiative**
 - A collaborative among 20 hospitals to share resources and best practices
 - Password protected website to discussion forum
 - Project RED training

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Early results of first cohort

- Texas CUSP: Stop BSI initiative



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