HealthLeaders Media | Intelligence

FREE SUMMARY REPORT

JULY 2013

Advancing Clinical Quality From Data to Decisions

Powered by

HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the July 2013 HealthLeaders Media Intelligence Report, **Advancing Clinical Quality From Data to Decisions.** In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by William K. Cors, MD, MMM, FACPE, Vice President and Chief Medical Quality Officer, Pocono Health System, East Stroudsburg, Pa., and the Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Mayo Clinic in Rochester, Minn.; Sharp Grossmont Hospital in La Mesa, Calif.; and Pocono Health System in East Stroudsburg, Pa.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Table of Contents

Methodology

The *Clinical Quality and Patient Safety Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In April 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 339 completed surveys are included in the analysis. The margin of error for a sample size of 339 is +/-5.3% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, region, purchase involvement, dollar amount influenced, and types of products/services purchased. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

William K. Cors, MD, MMM, FACPE
Vice President and
Chief Medical Quality Officer
Pocono Health System
East Stroudsburg, Pa.

Timothy Morgenthaler, MD
Patient Safety Officer
Mayo Clinic
Rochester, Minn.

Michael Murphy, MD
Chief Medical Officer
Sharp Grossmont Hospital
La Mesa, Calif.

Paula Santrach, MD
Chair, Clinical Practice Quality
Mayo Clinic
Rochester, Minn.

Upcoming Intelligence Report Topics

AUGUST: ***Patient Experience***

SEPTEMBER: ***Physician-Hospital Alignment***

OCTOBER: ***Population Health***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

HealthLeaders Media
A Division of HCPro

Intelligence Report Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Publisher
MATTHEW CANN
mcann@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
CHERYL CLARK
cclark@healthleadersmedia.com

Intelligence Report Contributing Editor
MARGARET DICK TOCKNELL
mtocknell@healthleadersmedia.com

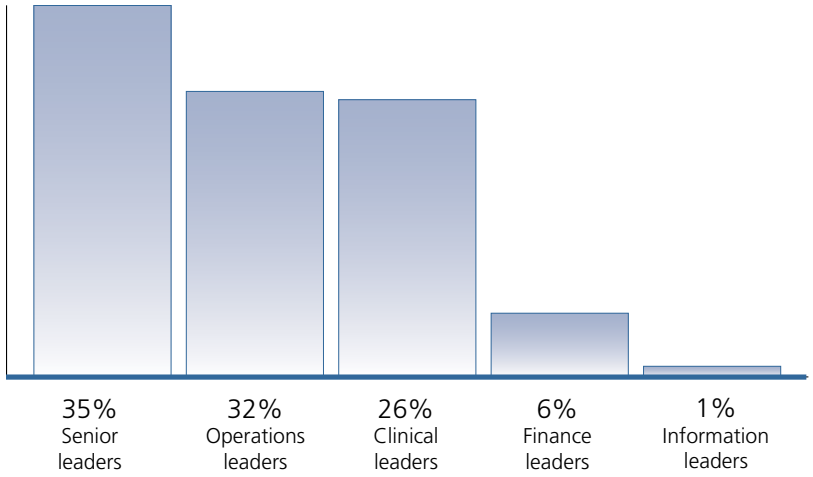
Intelligence Report Design and Layout
STEVE DINIS
sdinis@hcpro.com

Respondent Profile

Respondents represent titles from across the various functions at healthcare organizations.

Title

Base = 339



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Type of organization

Base = 339

Hospital	51%
Health system	22%
Physician org.	10%
Long-term care/SNF	8%
Ancillary, allied provider	4%
Health plan/insurer	3%
Government, education/academic	3%

Number of beds

Base = 173 (Hospitals)

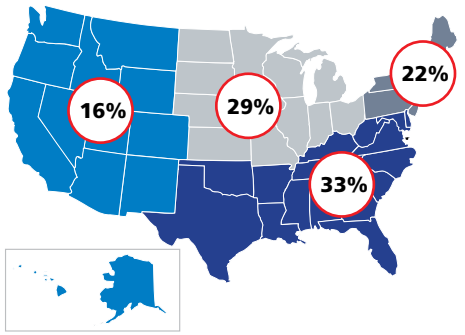
1–199	52%
200–499	32%
500+	16%

Number of sites

Base = 75 (Health systems)

1–5	24%
6–20	31%
21+	45%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Clinical Quality and Patient Safety: It's Not Just About Numbers

MICHAEL ZEIS

Healthcare leaders report increasing levels of experience with clinical quality and patient safety. They also have plenty of experience—perhaps too much—working with quality and safety metrics.

Nearly two-thirds (60%) of respondents to our annual *Clinical Quality and Patient Safety Survey* do have in place all of the selection of eight National Quality Foundation prevention or reduction protocols we presented in our questionnaire. Many of those who do not have particular protocols in place plan to add them within the next year. For instance, 31% expect to implement the NQF protocol to reduce falls and fall-related injuries within the next 12 months. If all follow through, within a year 91% will have in place NQF protocols for fall reduction.

"A transition is occurring," says William K. Cors, MD, MMM, FACPE, vice president and chief medical quality officer for the Pocono Health System, which treats patients in Monroe and surrounding counties in Pennsylvania and New Jersey through the 215-staffed-bed Pocono Medical Center and other facilities. "We see the increasing numbers of people who are looking at NQF measures, for example, getting their arms around quality and safety metrics, with the assumption that the reimbursement systems of the future are going to be geared more toward such metrics." This broad exposure to quality and safety metrics and the processes that track them seem

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders concerning their challenges in developing a culture of accountability regarding patient safety and quality outcomes.

"Changing a culture that took years to petrify will take many years regardless of the vehicle. With a blameless culture also comes a complete failure of accountability."

—CEO for a small hospital

"A big challenge is overcoming fear of making mistakes by demonstrating that learning can occur from mistakes if critically analyzed to determine root causes. Without learning from mistakes, we are apt to repeat them."

—CEO for a small ancillary provider

"We need to understand that accountability is not blame. We need to understand that errors occur and that being accountable for an area or issue means that you do those things necessary to reduce the chance of error and always be thinking of ways to improve a system."

—Director of emergency services for a large hospital

"Silos of information and lack of clear direction from top leadership represent a challenge. We lack a champion who communicates often and broadly on this issue."

—Chief compliance officer for a large hospital

Analysis (continued)

to be building a foundation in the art and science of quality and safety that, for many, goes beyond measuring and reporting, in such a way that quality and safety become ingrained in the organization's culture.

A glut of measurements strains resources

Virtually all respondents (95%) claim either a great deal of experience or some experience with clinical quality metrics and patient safety metrics. Although 39% cite the quality of data among their top three challenges in reaching the next level of clinical quality, and 24% say that a lack of data is among the top three stumbling blocks on the path toward adopting an effective patient safety program, there seems to be no shortage of measurement and reporting tasks.

"We have countless people systemwide who look at our metrics," says Michael Murphy, MD, chief medical officer of the 536-licensed bed Sharp Grossmont Hospital, which serves east San Diego County out of La Mesa, Calif. "We have a complete data warehouse, with a significant staff that handles all the data that goes into the warehouse and generates reports."

"The measurement requirement has generated an infrastructure need," Pocono's Cors adds. "Every year I have another three, four, five metrics that are added to the things I have to follow. I'm not necessarily getting any more money for it, but I still have to provide staff to collect, input, and report the data."

Cors, lead advisor for this Intelligence Report, notes, "On the one hand, I'm very happy to see 95% of respondents saying they are experienced with quality and safety metrics. But what do they all mean and how do they all tie together?" A principal concern, especially from physicians, is that so few metrics measure outcomes. "The only national metrics we have," Cors continues, "are the value-based purchasing measures from CMS. Most are process measures, and no one has been able to say definitively that a hospital that does really well on process measures actually has good outcomes. But with readmissions, mortalities, and morbidities, we are finally getting into something that is substantive. At least they are starting to get into the arena of outcome-based measures."

> "With readmissions, mortalities, and morbidities, we are finally getting into something that is substantive. At least they are starting to get into the arena of outcome-based measures."
>
> —William Cors, MD, MMM, FACPE, Vice President and Chief Medical Quality Officer, Pocono Health System, East Stroudsburg, Pa.

Timothy Morgenthaler, MD, patient safety officer at Mayo Clinic, a nonprofit health system that operates Saint Mary's Hospital and Rochester

Analysis (continued)

Methodist Hospital in addition to the Mayo Clinic in Rochester, Minn., and has facilities in Florida and Arizona as well, recognizes that some metrics have an administrative heritage and their appropriateness in a clinical environment can be questioned.

"There is often a gap between what administrative data shows and what is actually happening to patients," Morgenthaler says. "If we go to our clinicians, who are at the heart of driving our quality and safety efforts, and we say the administrative data shows we aren't doing very well, to be quite honest, that's not very motivating to them. Clinicians are motivated to improve when presented with clinically accurate data." He sees two business reasons to bridge the gap between what administrative data shows and what is actually happening to patients. First, it can be very costly to collect clinical data, especially when data collection is done via chart review. "We can't do it in large numbers and we can't do it in a sustainable fashion over time," he says. The second reason is related to the public nature of measuring and reporting. Public reporting allows those who perform well to let the public know about it.

EHR as a step toward clinical decision support

Nearly half of respondents (47%) expect to increase spending on clinical decision support as part of their investment in quality and safety. Paula Santrach, MD, Mayo Clinic's chair of clinical practice quality, says that establishing standard processes and augmenting with decision support where appropriate can contribute to clinical quality and patient safety. "For all of the doctors who work here," she says, "there is a common way of ordering a chest x-ray. We build these processes so that they happen consistently, and then we try to augment them with clinical decision support or other means in order to make care consistent and help providers do the right thing."

> "There is often a gap between what administrative data shows and what is actually happening to patients."
>
> —Timothy Morgenthaler, MD, Patient Safety Officer, Mayo Clinic, Rochester, Minn.

With a majority of respondents seeing improvement in clinical quality due to their EHR (42% cite moderate improvement, 18% significant), there is reason for hope. Santrach observes that better integration of the EHR with provider workflows will yield still more improvements. "When you try to really work with an electronic health record, it can be significantly harder to achieve your objective in terms of improving quality if there is a mismatch between clinical workflow and interacting with the computer. I think the EHR has helped us as an industry to some degree, but we could do much better if we had a better match between how the computer works and how providers work." Such a mismatch can occur if the system offers too much help. "If you create too many rules," she says,

Analysis (continued)

"providers either ignore them, get around them, or they get paralyzed. You can't continuously interrupt what the provider is doing, so you have to be judicious in your use of clinical decision support."

Sharp Grossmont's Murphy says that obtaining physician buy-in to EHR documentation tasks is easier because most see clinical decision support as a function that is enabled by the EHR. "It is the logical extension," he says. Murphy cautions about alert fatigue though. "There's a difference between the system telling you that there's an issue here and really having good clinical decision support."

Keys to sustainability

A culture that fosters input is an important key to enhancing quality and safety in a sustainable fashion. In our survey, the stumbling blocks mentioned most frequently as standing in the way of effective patient safety programs were fear of punishment for self-reporting errors (35%) and fear of retaliation for reporting others' errors (also 35%).

"If you want to have an effective safety program," Santrach says, "you have to be a continuous learning organization. You have to be able to talk about your errors in a safe way and learn from each other, and you have to have leadership supporting you in doing that. You have to have good communication and everybody has to be involved."

Sustainability will become more important as organizations reach parity in quality and safety performance. Mayo's Morgenthaler asks, "How do we get our performance from 90% to 99%? We want to because that's translatable into lives saved. What we learned is that we needed some more things so the memory of how important this is doesn't fade into yesteryear." Speaking about a venous thromboembolism prophylaxis performance effort, Morgenthaler identifies four items that support sustainability: building into the workflow immediate feedback via the EHR about whether performance requirements have been met, periodic feedback to practitioners about compliance, a phased and continuing education program, and transparency (communication) about successes and failures. "It's really become part of our culture and part of our processes," he says, "so we have been able to maintain pretty high reliability on VTP. We apply that same type of approach to most of our endeavors."

> "I think the EHR has helped us as an industry to some degree, but we could do much better if we had a better match between how the computer works and how providers work."
>
> —Paula Santrach, MD, Chair, Clinical Practice Quality, Mayo Clinic, Rochester, Minn.

Analysis (continued)

Quality and safety outside the walls

There are signs that healthcare leadership is aware of the importance of quality and safety outside of the hospital. More than one-quarter (27%) include ambulatory care among their top three areas of concern regarding clinical quality. Pocono Health System includes quality metrics with some of its outpatient initiatives. One such effort addresses chronic respiratory disease via patient-centered medical homes. Advisor Cors says, "At Pocono we will be looking at one or two quality metrics related to chronic respiratory disease. Within our EMR, we will measure the degree of compliance practitioners have with those quality metrics for this population." Behind the effort is recognition that the location of care is shifting. Says Cors, "We're doing it with the feeling that the primary coordination needs to occur in the outpatient setting."

Morgenthaler shares Cors' concern: "Because of the complexity of the care that we're now giving in the outpatient and ambulatory areas, I think that we're going to learn that there are a lot of opportunities for improvement." He observes that the quality and safety processes in hospitals, especially processes related to the OR and surgery, have evolved and matured. "And I don't think our systems are as robust in some ambulatory and outpatient areas, many of which have emerged very rapidly," he says.

Two-thirds of healthcare leaders (68%) place readmissions among their three biggest challenges with Hospital Compare metrics. "There's only so much that you have control over to prevent readmission," Cors says. "And yet the entire financial onus for readmissions is going to be put on the hospital. I think a lot of people are saying to themselves, 'How are we ever going to be able to control all of these factors in a very complex process?' " Says Santrach: "You can do everything to the best of your ability to prepare that patient for discharge, but it's the support of the patient once they're discharged that often can make a difference in readmission."

> "There's a difference between the system telling you that there's an issue here and really having good clinical decision support."
>
> —Michael Murphy, MD, Chief Medical Officer, Sharp Grossmont Hospital, La Mesa, Calif.

How much does it cost?

Healthcare leaders are split about tracking cost or calculating a return on the quality and safety investment—44% do and 40% don't. Santrach explains the difficulty of tracking costs on something like quality or safety: "You can calculate return on investment for specific projects, like process improvement projects. But calculating return on investment for doing

Analysis (continued)

daily operations, that's kind of hard. With a lot of this, you really don't have any choice—it's part of healthcare today."

The challenge of incurring expense without a clear idea of return is the second reason why executive-level support is vital to quality and safety efforts: Not only can executives lend verbal support that is important for culture building, but they can also help ensure that programs are funded. According to Santrach, "If it's important enough from a leadership perspective to pursue, there's money that has to come along with it."

Even if full program costs and ROI may be difficult to track, the components that go into quality and safety programs represent significant outlays. And, increasingly, those components have to do with IT. The top two areas for increased quality and safety spending are EMRs (55% say they'll increase spending) and, as mentioned above, clinical decision support (47%). Quality and safety staff and leadership also are part of planned spending increases, as are consultants.

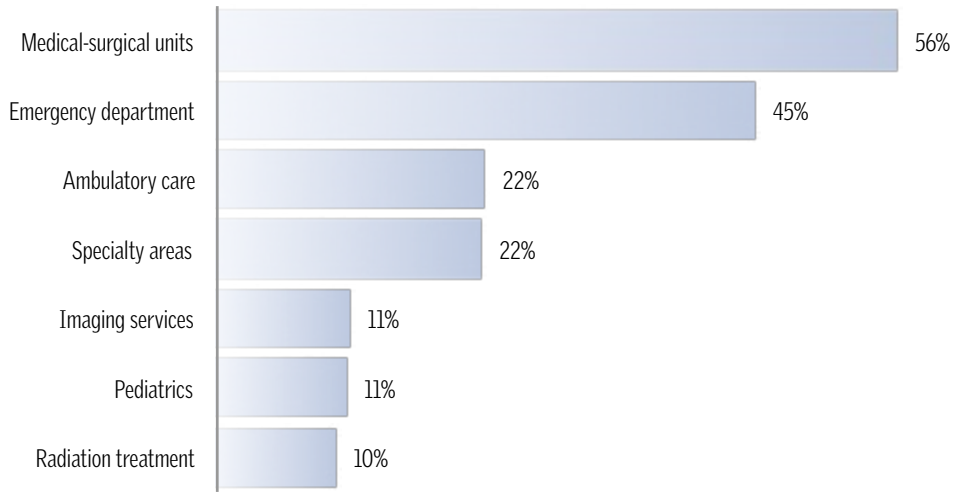
While nearly all healthcare organizations are burdened by reporting requirements, some seem to be above the fray, at least expressing the perspective that if they do what is right for the patients, the numbers may take care of themselves. When one sorts out what to do and when and how to do it, one can master the functions of measuring and reporting. When one controls the metrics in such a way, one can insist that the metrics (and the supporting IT systems) become part of an ingrained system of delivering care instead of a set of uncompensated reporting requirements. Organizations that integrate quality and safety into their culture with robust systems will maximize their own performance and will be in a good position to influence the performance of both close and arm's-length partners along the care continuum.

Michael Zeis is research analyst for HealthLeaders Media. He may be contacted at *mzeis@healthleadersmedia.com*.

FIGURE 4 | Areas of Patient Safety Concern

Q | Which of the following three areas in your organization concern you the most regarding patient safety?

Total responses



Base = 339, Multi-Response

TAKEAWAYS

- Patient safety in med-surg is of concern to 66% of hospitals and 64% of health systems.
- Within the hospital setting, fewer large hospitals (57%) indicate that med-surg causes patient safety concerns than small (69%) or medium (65%) hospitals.
- Among physician organizations, ambulatory care is a safety concern to nearly half (48%), while 36% say that med-surg causes safety concerns.

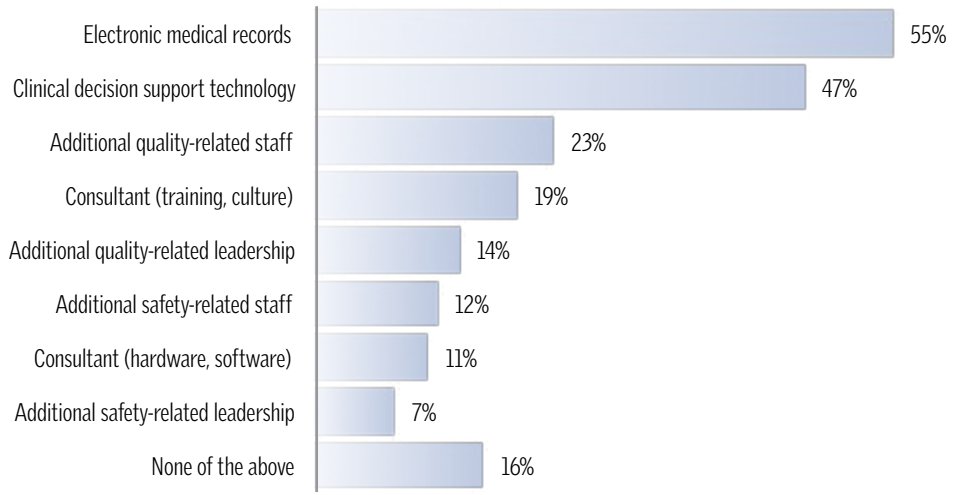
WHAT DOES IT MEAN?

Reflecting the nature of the care they provide, physician organizations mention ambulatory care more than any other area, for both patient safety (48%) and clinical quality (61%).

FIGURE 19 | Areas of Clinical Quality or Patient Safety Expecting Spending Increases

Q | In what areas does your organization expect to increase spending related to clinical quality or patient safety initiatives?

Total responses



Base = 339, Multi-Response

TAKEAWAYS

- The EMR is the most mentioned area for spending increases for clinical quality and patient safety, with 55% expecting an increase in spending.
- One-fifth of hospitals (20%) do not expect to increase patient safety or clinical quality spending in any category, a much greater figure than health systems (7%) or physician organizations (9%) that plan no spending in the categories listed.
- More than two-thirds of health systems (69%) expect to increase safety and quality spending for clinical decision support technology. This includes 76% of large health systems and 65% of medium health systems.

WHAT DOES IT MEAN?

Today, the big puzzles to solve involve implementing an EHR, extending the capability to clinical partners across the care continuum, integrating clinical and financial data, and developing clinical decision support capabilities. Our research demonstrates that the top clinical quality and patient safety spending categories are IT related. After that, ensuring that the staff has the proper quality- and safety-related skills is a priority, with skills coming via new hires or by hiring consultants to help boost the skills of the present staff.

FIGURE 19 *(continued)* | Areas of Clinical Quality or Patient Safety Expecting Spending Increases

Q | In what areas does your organization expect to increase spending related to clinical quality or patient safety initiatives?

Click on these icons to dig deeper

VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

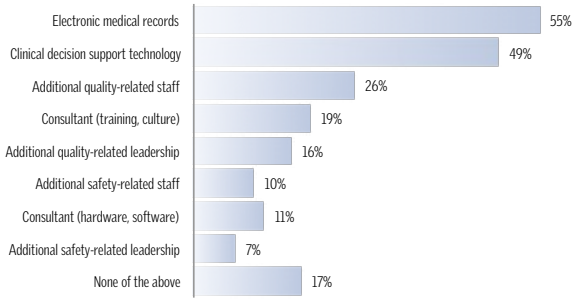
VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

Information technology

Base = 175, Multi-Response

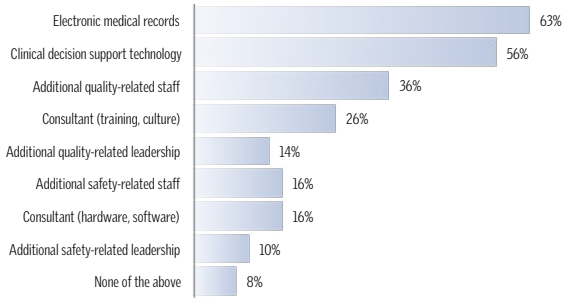
PRODUCTS/SERVICES

Clinical products



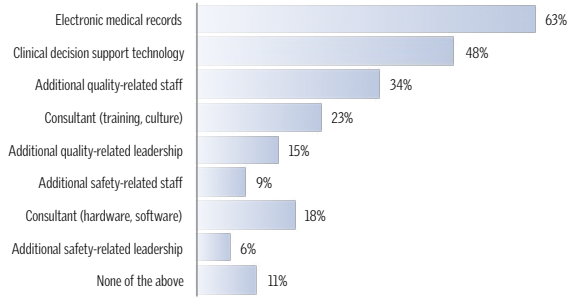
Base = 199, Multi-Response

Financial services



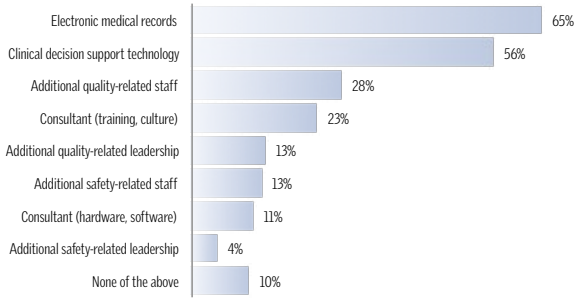
Base = 80, Multi-Response

Executive search



Base = 100, Multi-Response

Consulting services

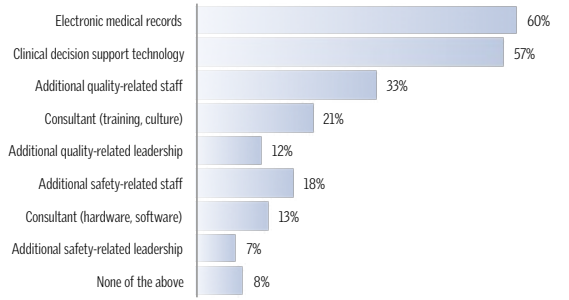


Base = 134, Multi-Response

Outsourcing services

Base = 96, Multi-Response

Legal services



Base = 84, Multi-Response

Access.
Insight.
Analysis.

Council

The nation's most exclusive
healthcare intelligence community

Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at *www.healthleadersmediacouncil.com*