Pay-for-performance—it’s a term you’ll hear more about. Medicare officials think pay-for-performance (P4P) could encourage hospitals to improve quality while bringing costs down—a priority given that the hospital trust fund is projected to run out of money in 11 years. Congress has asked Medicare to come up with a plan that would pay hospitals a little more for improving on certain quality indicators, starting in 2009. The plan would build on Medicare’s current pay-for-reporting plan, which ties hospitals’ quality reporting to their payment updates.

The Centers for Medicare and Medicaid Services (CMS) proposed a P4P plan to Congress in November 2007. The CMS acting administrator, Kerry Weems, told hospital leaders in April that “the future of health care depends on pay for performance.”

Officials are taking a close look at a P4P demonstration that shows hospitals that receive a little extra reimbursement improved more and faster than other hospitals. Preliminary 3-year results were reported in January 2008.

The project, formally known as the Hospital Quality Incentive Demonstration (HQID), has been conducted jointly by CMS and Premier since 2003. About 250 hospitals are participating, collecting data on about 30 indicators for 5 conditions: coronary artery bypass graft (CABG), hip and knee replacement, pneumonia, heart failure, and acute myocardial infarction (AMI).

The financial incentive is modest. The top 20% of hospitals in each clinical area receive a bonus, with the top 10% receiving 2% and the second 10% receiving 1%.

But CMS and Premier say it is making a difference. Premier’s analysis of 1.1 million patient records found that if all hospitals improved as much as the HQID hospitals, they could:

- save about 70,000 lives a year, a 30% reduction in patient deaths
- reduce hospital costs by more than $4.5 billion annually.

For HQID hospitals, the median cost per patient admission declined by $1,000 over the 3 years.

Despite the enthusiasm, not much evidence on the project has been published. A study in the December 2007 *New England Journal of Medicine* compared hospitals that only do public reporting with the HQID hospitals over 2 years on 3 conditions, AMI, heart failure, and pneumonia. Findings showed the HQID hospitals had greater improvements, ranging from 2.6% to 4.1%.

But an editorial notes the HQID hospitals are a self-selected group whose leaders probably thought their performance would exceed the threshold. It says the findings still leave questions about what impact P4P would have.

Nevertheless, political momentum is behind P4P, and hospitals are likely to find themselves living with it before long.

**What is a culture of quality like?**

What is the culture of HQID’s better performers like in surgical services? How do they build their quality program, get physician buy-in, and keep up the momentum? *OR Manager* interviewed 3 better performers: Baystate Health, Springfield, Massachusetts; United Hospital Center, Clarksburg, West Virginia; and Aurora Health Care, Milwaukee.

A related article reports on Baptist Health of South Florida, a top 10% performer on total joint replacement and other measures.
Baystate Health

Performance improvement (PI) is woven into the surgical process at Baystate, says Deborah Fuller, RN, assistant director of surgery and anesthesia. Though Premier hadn’t released final Year 3 results, Baystate was on track to be in the top 50% of HQID hospitals in all clinical areas.

Surgical services, like every service line and nursing unit, has its own performance improvement (PI) team. The unit-based PI committee includes OR leaders, clinical managers, and educators who are involved in the care of surgical patients. The committee provides information to the Surgical PI Team, which includes, among others, the chief of surgery, vice presidents of nursing and anesthesia, the vice president of emergency services, and service leaders. The department of anesthesia has its own PI team. Baystate has an 18-room main OR and a 12-room outpatient surgery center.

The QI program is guided by a subcommittee of the board of trustees, which spends 100% of its time on quality. Under that is the Hospital Quality Council, chaired by the COO and chief medical officer. Supporting the quality program is the Division of Health Care Quality, headed by a physician and nurse. Two other leaders provide guidance and support specific to surgical services, Jan Fitzgerald, RN, MS, CPHQ, director of quality and medical management, and Gary Kanter, MD, associate director for health care quality.

The quality division is a “key driver in moving these initiatives forward,” Fuller comments. Regular data monitoring keeps everyone on track. “As soon as we see something that has changed from our expectation or is not going as planned, we address it.”

The surgical services PI team has broad representation from all departments

### Aurora Health Care “bingo” card

Progress toward 2007 goal of being in top 20% for all Medicare pay-for-performance measures by achieving above-median performance for each of the measures.

<table>
<thead>
<tr>
<th></th>
<th>Acute myocardial infarction</th>
<th>Coronary artery bypass graft</th>
<th>Pneumonia</th>
<th>Heart failure</th>
<th>Hip &amp; knee replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
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<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
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<tr>
<td>Hospital 2</td>
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<td>2</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
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<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2</td>
<td>N/A</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
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<td>N/A</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>2</td>
</tr>
<tr>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hospital 10</td>
<td>1</td>
<td>N/A</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 = Top performer; 10 = Bottom performer

*On track for top improvement award.

85% in upper median; 58% in top 20% based on Oct 2006-June 2007 data.

Source: Aurora Health Care. Reprinted with permission.
involved in surgery and all levels of personnel, from physicians to sterile reprocessing staff.

“There’s direct dialog among the team players,” Fuller says. “It makes a big difference when a person from sterile processing sits at the same table with the surgeons. Team members can talk about concerns and ask questions.”

**Steps toward reliable care**

Steps have been taken to drive reliable care. Standardized order sheets, for example, include the appropriate antibiotic for the procedure, hair removal (clipping or no hair removal), and deep-vein thrombosis prophylaxis.

Dr. Kanter says anesthesiologists are responsible for administering the preoperative antibiotic, a decision made after conducting several rapid-cycle QI projects. They prompt the surgeon for the order if necessary. For consistent charting, the anesthesia documentation includes spaces to record the antibiotic dose and time, patient temperature, and blood glucose level.

“This serves as a visual prompt and helps capture the information,” he says.

**Engaging physicians**

Because physicians respond to data, Dr. Kanter finds it helps to show individual physicians their numbers for key indicators and compare them with programs that are performing in the top 10% or 20%.

“That really gets their attention,” he says.

Quality data is presented to physicians and clinical PI groups quarterly.

If a physician misses a step, such as not giving the antibiotic on time or not stopping it within 24 hours, a letter is sent. A physician who misses the same step a certain number of times is contacted by a physician leader. In addition, the medical staff bylaws state that a certain number of misses on key indicators is considered an aberration in the standard of care and will be addressed by the medical staff.

**United Hospital Center**

Think through a process, offer a solution, and keep it real—that’s the straightforward approach of United Hospital Center’s director of quality initiatives and chairman of infection control, Mark D. Povroznik, PharmD. The hospital has 375 beds and 10 ORs.

For Year 3, UHC is on track to be in the top 10% of HQID hospitals on 3 conditions: acute myocardial infarction, heart failure, and total joint replacement and expected bonus pay of about $145,000. UHC’s culture of quality has also been recognized by the Institute for Healthcare Improvement.

UHC’s CEO says the key to moving the program forward is having the right person working with the physicians who understands both quality and the medical aspects of the conditions being addressed.

Because the physicians’ time is limited, Povroznik finds it helps to package solutions and make it easy for them to do the right thing, getting their feedback before any new process is finalized.

“They don’t have time to solve the problem for us,” he says. “We are not about herding people together for 4 or 5 meetings to come up with a solution or a new standard order. Instead, we think through the standing order, bring it to the physicians, and ask them to provide any final input. If we have to meet with someone in their office because that’s the most opportune time to get their feedback, that’s what we’ll do.”

**Discontinuing the antibiotic**

An example is stopping the antibiotic within 24 hours after a hip or knee replacement, an HQID indicator that can be tough to achieve.

“We devised a simple process to meet each others’ needs,” says Povroznik. Cefazolin (Ancef), for example, is given every 8 hours for 3 doses postoperatively, with the first dose given in the postanesthesia care unit and the other 2 on the patient unit. This prevents any patient from receiving beyond the 24-hour limit, but patients still receive the 3 doses the surgeons wanted.

“That step took us to 100% compliance, practically overnight,” he says, and it’s been sustained since. The process has since been expanded to other procedures.
Likewise, preoperative antibiotic selection was standardized for every type of procedure tracked in the quality demonstration.

“We gained anesthesia’s approval to be the leaders,” he said. For elective cases, the surgeons approved giving the selected antibiotic as a standing order, with alternatives identified for patients with allergies. An antibiotic reminder was added to the timeout in the OR for surgical site verification. If a surgeon doesn’t follow the standing order or interferes with the process, Povroznik calls or writes to let the surgeon know the antibiotic is not part of the protocol and works to address their concerns.

“We finished 2007 with a 99% compliance rate for antibiotic timing and 98% for antibiotic selection,” he says. The West Virginia average was 76% and 84%, respectively.

Before submitting data to Premier, as part of final verification, Povroznik personally reviews every chart that fails on any indicator and works with the physician involved or investigates the particular system failure.

“You always look for a way to help people see the evidence,” he says. “Sometimes you have to do it 2 or 3 different ways so they can hear what you’re saying.” The surgeons and OR staff are collaborative, he says, “but you are working with multiple specialties, their time is valuable, and they’re thinking about a lot of things.”

This was a challenge when working on the venous thromboembolism quality information, he says, but UHC has achieved 100% compliance.

“I keep it real—I think that’s the key,” he adds. “Everyone will slide because we all have lots to do. But every hospital has to find a way to keep it real, so everyone knows what the expectations are and that this is being looked at and attended to.”

**Aurora Health Care**

A simple reporting tool, nicknamed the “bingo card,” helps Aurora Health Care’s 12 acute care hospitals see how they’re doing. The color-coded chart shows their progress toward the goal of being in the top 20% of the HQID hospitals (illustration, p 8). With 11 participating hospitals in Year 3, Aurora was on track to be in the top 20% 23 times across the clinical areas, the most of any system.

With the bingo card, “anyone in any hospital is able to see, ‘Here is our performance. Where in the system are they doing better?’” says Candace Hennessy, RN, PhD, formerly a vice president for 2 Aurora hospitals and now president of the Aurora Visiting Nurse Association.

Hennessy says the card is a visible way to keep quality out front as Aurora’s number one priority.

Expanded reports allow the hospitals to see how they are doing on individual indicators. If they see another Aurora hospital is doing better, they can pick up the phone and ask that hospital what is working. Aurora also has an internal website with best practices.

**Feedback is given**

“The data is presented in a simple manner—we’ve been very strong at that,” Hennessy says. “Feedback is given, and input is solicited.” She found it was effective to have small groups of physicians, nurses, pharmacists, and others focus on the indicators that are relevant to their daily work. An example is the percentage of total hip and knee replacement patients who are discharged to their home.

“During a meeting we would review the latest quality data and say, ‘See how good our results are—we’re sending them home in a length of stay that meets or beats the best.’ But we also carefully monitor readmission rates to make sure we aren’t moving patients out of the hospital, only to have them come back.”

All of these strategies work to reduce variation and increase reliability.

“We know decreasing practice variation improves outcomes for patients. It becomes the way you deliver care,” Hennessy says.

It could well become the way all hospitals are expected to provide patient care.

—Pat Patterson
More about the Premier pay-for-performance HQID is at www.qualityHQID.com. The site has information only through Year 2.

References

HQID clinical indicators
Indicators for the 2 clinical conditions in the HQID project that pertain to surgery.

**Coronary artery bypass graft (CABG)**
- Aspirin prescribed at discharge
- CABG using internal mammary artery
- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients
- Prophylactic antibiotics discontinued within 24 hours after surgery end time
- Inpatient mortality rate
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangement.

**Hip and knee replacement**
- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients
- Prophylactic antibiotics discontinued within 24 hours after surgery end time
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangement.

Source: Premier, Inc. Reprinted with permission.

Leaders commit to quality
Premier has identified elements of leadership common to the HQID best performers:
- The hospital's board receives regular reports on quality data and spends at least 25% of its time on quality and safety issues.
- The board interacts closely with the medical staff on quality.
- Senior executive compensation is tied to quality improvement.
- The CEO is a key player in quality improvement and shows a personal commitment.