Learning how much revenue they might be leaving on the table as a result of coming changes to Medicare payment, Baptist leaders refocused their goal-setting program on solving underlying challenges such as readmissions. Ultimately, they discovered that hospital-by-hospital change wasn’t enough; they would have to shift improvement efforts to a system-wide approach.

Vitals
Baptist Healthcare System is a seven-hospital system geographically dispersed across the state of Kentucky. It includes five owned and two managed hospitals with 1,908 licensed beds and 91,000 admissions. It’s the No. 1 or 2 provider in the state for most service lines.

Baptist uses incentives to achieve system goals. In 2002 it began linking a portion of executive compensation to measurable improvement on quality of care based on internal data. Beginning in 2004, it linked those incentives to publicly reported clinical quality measures. That same year, the board’s Quality and Mission Effectiveness Committee was established to oversee the development of a comprehensive set of standard dashboards to provide timely information to set goals, track performance and highlight best practices.

Challenge
Baptist leaders were stunned to learn the full impact of coming changes to Medicare hospital payment. They were used to being leaders in clinical scores in each of their regional markets. And yet, when the data were presented at an executive retreat in 2010, they learned they were not fully prepared for value-based purchasing (VBP), and likely to leave a significant amount of revenue on the table.

The news was delivered by Nikolas Matthes, MD, PhD, MPH, Press Ganey’s vice president of clinical products research, who provided an analysis that encompassed not just the 2% at risk based on the Hospital Inpatient Value-based Purchasing Program but also the impact of the federal initiatives on readmissions, hospital-acquired conditions, outcomes and meaningful use of information technology. Under VBP methodology, the thresholds and benchmarks are so high – especially for core measures – that even really strong performers run the risk of losing incentive dollars, Matthes said.
Solutions
In April 2011 Baptist adopted Press Ganey’s Value-Based Purchasing Calculator, a tool that uses an organization’s clinical quality measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance and outcomes results to estimate payment at risk and identify priorities for improvement with the greatest return on investment.

“The Press Ganey Value-Based Purchasing Calculator is an invaluable tool for us, allowing us to assess how we are doing compared with our competitors,” said Bernard Porter, corporate director of decision support for Baptist. “The fact that it is quickly updated to reflect regulatory changes is very important. However, the real game changer is this tool’s ability to report on virtually every hospital in the country, which allows us to go in and easily see where we stand versus our competitors.”

Performance and Outcomes
After the leadership retreat, the news spread quickly to the five owned Baptist hospitals. At Baptist Regional Medical Center in Corbin, Ky., a town hall meeting was held, where the VBP scores and financial impact were shared with staff. “We helped the staff understand that if we didn’t improve our scores, dollars that should be used to care for our patients and improve our outcomes may walk right out of the door and go to hospitals with higher scores, including our competitors,” said Helen Wilson, RN, MSN, the hospital’s director of quality. “I believe our staff has come to understand the connection between outcomes and resources that is at the heart of value-based purchasing.”

That understanding would have to take place across the system, something that would prove problematic. It would also be made more complex as the Centers for Medicare and Medicaid Services (CMS) kept changing the rules. As just one example, CMS originally proposed a set of 17 clinical measures for VBP, but the final rule for fiscal year 2013 effectively removed all the clinical measures everyone was doing well on, replacing them with indicators having more opportunity for improvement. The system understood the importance of being prepared for shifts and changes as payment reform progresses. Indeed, for fiscal year 2014, CMS has added new mortality measures for acute myocardial infarction, heart failure and pneumonia, each expressed as 30-day survival rates.

Each year, Baptist establishes three system-wide goals under a tiered system. These include level I goals, which are easily achievable; level II goals, which are achievable but require significant effort; and level III goals, which are “aggressive/stretch” targets. Levels I and II are usually focused on internal process improvements while level III is always based upon external measures and benchmarks with attainment defined by achieving specific scores.

Over the years, examples of the goals included focusing on achieving top 10% performance for quality indicators, having timely follow-up on outliers and identifying root causes of underperformance, with the goal of identifying and adopting best practices.

The results were generally quite strong, but maintaining Baptist’s competitive advantage became more difficult. It ultimately achieved being above the national 50th on nine of 10 indicators and at/near the national 90th percentile on five out of the 10 indicators. The most dramatic improvement came in pneumonia, which went from the 27th percentile to the 91st from 2004 to 2010.

Goal Setting
After the epiphany on VBP, in 2011 the system board adopted as its level I goal the area of readmissions. A system-wide readmissions team was established to develop timely internal calculations to match CMS readmission algorithms, come up with a readmissions dashboard, and identify and adopt best practices on key factors that influence readmissions.

The level II goal was the inpatient VBP program. The nursing vice president and quality director at each hospital selected one clinical and one patient satisfaction indicator for improvement, with the goal of raising performance to the national median for those indicators. (The system’s level III goal was not related to this effort.)

Quite surprisingly, the results of subsequent implementation efforts were disappointing. “We realized we would not meet all the improvement goals, something we had not experienced much in the past,” Porter said. One major issue was that no one indicator presented the same opportunity for all five hospitals owned by Baptist Healthcare, so each hospital chose its own set of indicators on which to focus. Hospitals that had selected an indicator as part of its goals were improving on the measure, while other hospitals were either improving much less, or were stagnant or even losing ground on the same indicator. So when the scores were added up at the system level, the improvement of some hospitals on the measures were washed out.

Most importantly, there was no effective mechanism in place to methodically replicate best practices – a situation that was exacerbated by the fact that everybody was working on different measures.

The system needed to align on two key fronts: content and process.

Dashboard Overload
One of the main roadblocks was data – in particular, how to share data with leaders on dashboards. By 2010, two sets of dashboards had evolved, to meet the needs of key constituencies. A summary dashboard was used by the board and senior executives to overview current results for key public reporting indicators. More detailed dashboards were also available for use by the board, hospital leaders and improvement teams.

“As by 2011, with the addition of VBP and readmissions data, we had dashboard overload,” Porter said, with no fewer than seven circulating throughout the system. The data and methodology were complex, especially for readmissions. The changes to the final VBP rule on the clinical indicators (topped-out indicators being dropped and replaced with additional SCIP indicators), new domains, the reweighting of domains and the HAC initiative, all spelled too much complexity of data.
BAPTIST’S SYSTEMWIDE PERFORMANCE

ON CORE MEASURES, SOME SUCCESS WITH GOALS...
FOR YEAR ENDED MARCH 31, 2011

Note: Shaded areas reflect measures targeted for improvement.

... CHALLENGES ON HCAHPS

Note: Shaded areas reflect measures targeted for improvement.
The whole picture made 2012 goal setting enormously challenging. So Baptist decided on a summit meeting to establish 2012 goals. Attendees would include both decision-makers and content experts from the system, individual hospitals and Matthes, and the agenda included a payment reform update, a goals discussion based on everyone’s input and a thorough review of the content/format of current dashboards and recommendations for changes to meet future needs.

One thing that emerged was the potential financial impact of all federal payment reforms over five years. It came to a whopping $66 million at risk for the system; a figure that did not take into account any impact from performance-based contracting with private payers. It also showed hospital-by-hospital impact.

When leaders looked at performance on all of the measures associated with goals, they found they were doing well with improvement on clinical indicators at the system level. On the patient satisfaction side, however, they were doing worse on the indicators that were part of the 2011 level II goals than on those that were not. “We decided to present the results on an indicator-by-indicator, hospital-by-hospital basis,” Porter said.

Other findings:

- Although best practices were shared, little synergy (adoption of best practice) between hospitals actually occurred. Many individual hospitals met their improvement targets, but system knowledge was not fully leveraged to improve overall VBP scores.

- Two new dashboards were added (one for VBP, another for readmissions). However, this brought the total number of dashboards to seven, a real challenge to manage.

- Baptist had met four of five clinical and four of five patient satisfaction indicators it had targeted, but relative performance was slipping on some of the other indicators.

- It had shared best practices, but that is not the same as adopting them across the system.

The system faced a special challenge of addressing all of the indicators associated with CMS payment reform. It targeted the indicators it needed to work on to gain from a financial perspective. Leaders realized it wasn’t one or two; doing that would only address anywhere from $216,000 to $403,000 of the $2.6 million withhold they were trying to regain.

Focused Effort

With help from Matthes, Baptist quickly realized that working on the surgical indicator set rather than the individual Surgical Care Improvement Project (SCIP) measures would allow it to address $700,000 of the withhold.

“It was possible with one large system-wide surgical initiative we could make serious progress on value-based purchasing,” Porter said. “Additionally, we didn’t want to just share information on best practices – we established specific milestones for adopting them on a system-wide basis. So for 2012, we adopted a level II goal of improving the projected system-wide VBP score and identifying and implementing a best practice across the system, and a level III goal of identifying best practices and demonstrating sustained improvement at all five of our owned hospitals for heart failure readmissions.”

In conjunction with its level II and III goals for 2012, to date Baptist has reviewed data from fiscal 2011 SCIP and HCAHPS scores and identified top performers. Individuals from top-performing hospitals have been asked to lead the system-wide improvement teams for SCIP, HCAHPS and heart failure. Team members have been chosen based on their knowledge of their hospital’s current improvement efforts, their ability to assess the potential effectiveness of best practices of the other facilities and their ability to lead the implementation of system-wide best practices at their facility.

Inventories of current initiatives, degree of success, status, barriers and opportunities are currently being collected. A meeting was scheduled with Press Ganey consultants to review external best practices.

“Though challenges remain, we are satisfied that our system is on the right path,” Porter said.