



Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides

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July 2010

Dear Colleague:

We are pleased to publish **Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides**. This compendium of guides, reports, and toolkits provides a wealth of actionable resources to help you design and implement strategies as you take your hospital to the next level of performance and address the challenges and opportunities of implementing health care reform.

Here are some of the ways in which **Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides** can help you:

- Support your organization's practice of competency-based governance in supporting health reform implementation and performance improvement -- *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness*.
- Assess the health needs of your community, a new requirement for tax-exempt hospitals -- *ACHI Community Health Assessment Toolkit*.
- Assess numerous strategies and tools that can help reliably drive performance improvement across your entire organization -- *A Guide to Achieving High Performance in Multi-Hospital Health Systems*. Many of the lessons learned are transferable to all types of hospitals.
- Implement effective and efficient practices to collect race and ethnicity data of your patients that can be used to reduce health disparities -- *HRET Disparities Toolkit*.
- Evaluate various practices for engaging your workforce to create a culture of safety and quality -- *Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals*.
- Design your hospital's strategy and action plans to reduce avoidable readmissions -- *Health Care Leader Action Guide to Reduce Avoidable Readmissions*.
- Understand the essential building blocks of an effective electronic health records implementation strategy -- *Health Care Leader Action Guide on Implementation of Electronic Health Records*.
- Gain a basic understanding of new payment and care delivery models -- *AHA Research Synthesis Reports on Bundled Payment and Accountable Care Organizations and the Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project*.
- Understand the key milestones of health reform provisions -- *AHA Health Care Reform Implementation Timeline*.

Through AHA's policy work and its *Hospitals In Pursuit of Excellence* strategy, we will publish a variety of implementation resources for you and your hospital colleagues across the country. In the coming months, you can expect resources and guidance on such issues as access to capital, electronic health record "meaningful use" provisions, diversity leadership, disparities reduction, and an updated version of the community health assessment toolkit, among others. We encourage you to visit www.aha.org on an ongoing basis to access this expanding resource collection that is being developed to assist you in assessing and selecting the right strategies to help your organization thrive in the coming years.

Thank you for all you do every day to pursue excellence in America's hospitals and health systems.

Sincerely,

A handwritten signature in black ink that reads 'Rich Umbdenstock'.

Rich Umbdenstock
President and CEO

**Hospitals in Pursuit of Excellence:
A Compendium of Implementation Guides**

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PREFACE

Hospitals in Pursuit of Excellence (HPOE) is the American Hospital Association's strategic platform to accelerate performance improvement and support health reform implementation in the nation's hospitals and health systems. HPOE provides education on best practices through multiple channels, develops evidence-based tools and guides, offers leadership development through fellowships and networks, and engages hospitals in national improvement projects. HPOE brings providers together to improve performance in several areas, including care coordination/readmissions, health care associated infections, patient safety, and the development of new payment and care delivery models that promote quality and efficiency.

Working in collaboration with allied hospital associations and national partners, HPOE synthesizes and disseminates knowledge, shares proven practices, and spreads improvement techniques to support health reform implementation at the local level.

- Education – Under HPOE, the AHA disseminates proven practices in performance improvement and health reform implementation through webinars, case studies and articles in AHA publications, and a dedicated web site – www.hpoe.org.
- Tools and Guides - To support improvement in clinical and operational efficiency and effectiveness, a variety of toolkits and guides that provide resources and strategies are being produced. These publications will be designed to be practical and action-oriented, help leaders readily identify the leading-edge practices and strategies that can help drive performance improvement in their organization. Representative topics include reducing avoidable readmissions, workforce practices, health information technology, capital planning, accountable care organizations, bundled payment, and diversity.
- Leadership Development - The nationally renowned AHA-NPSF Patient Safety Leadership Fellowship, now in its ninth year, prepares experienced health care professionals to assume leadership roles in advancing patient safety and quality in health care organizations. This successful model is being applied to the development of a new fellowship program on health reform implementation and transformation, which will launch in 2011.
- National Projects – The Health Research and Educational Trust (HRET) is engaging hospitals nationwide in a major expansion of its initiative to expand the implementation of the Comprehensive Unit-based Safety Program (CUSP) to help prevent health care associated infections, such as central line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs). It also is collaborating with the Agency for Healthcare Research and Quality (AHRQ) to promote hospital use of AHRQ's patient safety resources. The American Organization of Nurse Executives (AONE), another AHA affiliate, is leading Transforming Care at the Bedside, a nationwide initiative to help hospitals improve the quality and safety of patient care on medical and surgical units.

Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides is a compilation of health reform implementation tools and resources that have been developed to date. The AHA will continue to publish a variety of resources and make them available to all hospital and health system leaders. In the coming months, you can expect resources and guidance on such issues as access to capital, implementing electronic health record “meaningful use” provisions, and an updated version of the community health assessment toolkit. We encourage you to visit www.aha.org on an ongoing basis to access this expanding resource collection that is being developed to assist you in assessing and selecting the right strategies to help your organization thrive in the coming years. Together through *Hospitals in Pursuit of Excellence*, the AHA and the nation’s hospitals and health systems will actively support our nation’s objectives in achieving a health care delivery system that provides safe, timely, effective, efficient, equitable, and patient-centered care.

INTRODUCTION

In 2007, the American Hospital Association's Board of Trustees developed a roadmap for improving America's health care system. This framework - *Health for Life: Better Health. Better Health Care.* - contains a set of goals and policies for creating better, safer, more efficient and affordable health care, and a healthier America. It was developed with the support and advice of hospital leaders, leaders of allied hospital associations, and leaders of external organizations representing consumers, employers, insurers, physicians, and others. The *Health for Life* framework has been used as a guidepost for influencing national health care reform legislation.

As the nation moves forward with implementing health care reform, *Hospitals in Pursuit of Excellence* (HPOE) seeks to operationalize major facets of the *Health for Life* framework. HPOE's fundamental goals are to accelerate performance improvement and support health reform implementation.



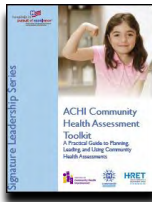
Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides includes guides and reports that provide critical competencies and practices for accelerating performance improvement and supporting health reform implementation. With health reform, numerous changes to care delivery and financing are forcing hospitals and health systems to rethink their fundamental business model. Moving toward a more integrated model of health care delivery that emphasizes value over volume calls for a greater emphasis than ever before on quality, cost, and efficiency. The development and execution of strategies around accountable care organizations, bundled payment, value-based purchasing, greater care coordination to avoid readmissions, clinical integration, and other reform-driven issues are now on the agenda of every hospital and health system in the country.

Sustaining success in the post-reform era will require a hospital to work on many strategies simultaneously, requiring a new level of leadership expertise to guide hospitals and health systems as they begin their journey toward success under health care reform. An environment that requires a laser-like focus on high performance and value creation with an expectation of fewer resources will require leaders to ensure that vulnerabilities in such areas as quality, cost,

and efficiency are fully addressed and new organizational competencies in such areas as clinical integration, care redesign, the development of accountable care organizations, and the management of financial risk are acquired. Solid and competent governance that has the skill sets and knowledge to guide the organization on this journey is more important than ever before.

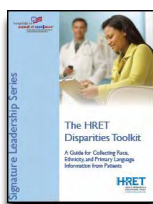


Competency-Based Governance: A Foundation for Board and Organizational Effectiveness makes the case for a competency-based approach to governance that can help drive performance and help boards simultaneously address the multiple challenges facing hospitals and health systems under health care reform.



New requirements for tax-exempt hospitals include assessing the health needs of your community. The **Association for Community Health Improvement (ACHI) Community Health Assessment Toolkit** provides a strategic and thoughtful approach to facilitating better health results for your communities.

Fortunately, there are a variety of management practices that can be employed across hospitals and health systems to improve care and overall organizational performance. However, as with the adoption of management practices in general, it is often the quality of execution that determines the overall result. **A Guide to Achieving High Performance in Multi-Hospital Health Systems** illustrates the importance of developing a culture of performance excellence, having a clear set of defined values and expectations that form the basis for accountability of results, and a disciplined and persistent focus by leadership on execution and implementation. It also provides numerous strategies and tools that leaders can use to help drive performance improvement regardless if they are part of a health system or not; the lessons are transferrable to all hospitals.



An important component of improving the quality of care is working to eliminate health disparities – from access to care to health outcomes – among racial and ethnic groups. In order to address health disparities, hospital and health system leaders must understand the unique characteristics of the communities they serve. The **HRET Disparities Toolkit** provides a comprehensive approach to the collection of race, ethnicity, and primary language data and offers guidance on how to use this data to improve quality of care and reduce health disparities for all populations.

The availability of a stable and capable workforce is a key ingredient in a health care organization's ability to deliver efficient and effective care, which will be critically important under health reform. As such, high-performing organizations are investing significant resources in creating a culture that focuses on quality and safety. **Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals** provides practical advice on workforce practices that hospitals and health systems can adopt to develop a high-performing workforce that can deliver safe, high quality, and efficient health care.



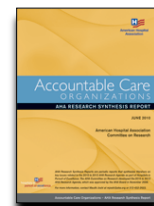


As health care reform moves hospitals to a more integrated delivery model that emphasizes value over volume and greater hospital accountability for care, more attention is being paid to reducing avoidable patient readmissions. Adding to the urgency is the health reform provision that reduces Medicare payments to hospitals with “excessive” readmissions beginning in FY 2013. Many hospitals across the country are currently engaged in efforts to reduce avoidable readmissions, working not only within the hospital, but also with other providers and care settings in their communities to improve coordination and transitions. The **Health Care Leader Action Guide to Reduce Avoidable Readmissions** helps hospital leaders assess, prioritize, implement and monitor strategies to reduce avoidable readmissions during hospitalization, as well as at discharge and post-discharge.

Another key ingredient for success under health care reform will be the ability to utilize health information technology (HIT) to manage the care of patients across the continuum of care and produce actionable data to help improve outcomes and reduce costs. The promise of HIT to help providers deliver efficient, high quality care is driving the federal government’s stimulus program to provide financial incentives for the “meaningful use” of electronic health records (EHRs) within hospitals and physician offices. But just like any major organizational improvement effort, the adoption and use of EHRs must be built on a solid foundation of leadership engagement and careful planning. The **Health Care Leader Action Guide on Implementation of Electronic Health Records** provides a roadmap to help senior executives develop a strategy to use EHRs that advances the organization’s ability to deliver care that is safer, more effective, and efficient.



The federal health reform legislation includes several demonstration projects that will be held in the coming years to test new models for care delivery and payment. For example, the law calls for the establishment of a Medicaid bundling demonstration program by 2012 and a national pilot program on payment bundling for the Medicare program by 2013. Furthermore, under the law, the Centers for Medicare & Medicaid Services (CMS) is required to create a program on accountable care organizations (ACOs) by January 1, 2012. Hospitals and health systems are encouraged to carefully study the provisions of these upcoming demonstration programs and clearly understand their requirements. The two **AHA research synthesis reports on bundled payment and accountable care organizations** included in this compendium provide an



overview of these concepts, summarize key conclusions learned from similar projects in the past, and offer key questions that should be considered by hospital and health system leaders when contemplating participation in the upcoming demonstration programs. **Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project** provides an overview and summary of lessons learned to date from the CMS Acute Care Episode (ACE) Demonstration, a current CMS pilot project to test the effect of bundling Part A and B payments for episodes of care on the coordination, quality, and efficiency of care. Each of these reports is designed to help hospital and health system leaders evaluate the opportunities that will be presented in upcoming demonstration projects.

It is essential that hospital and health system leaders become well-versed in the numerous provisions, programs, pilots, and deadlines associated with implementation during the next several years. The ***AHA Health Care Reform Implementation Timeline*** provides a chronological summary of many of the components of health care reform. More resources and tools to help leaders understand health care reform and inform their board, employees, and community about its implications can be found on the AHA web site (www.aha.org) under “Health Care Reform Moving Forward.”



It will require the full attention of hospital and health system leaders, working with their physicians, nurses, staff, governance, and the broader community to develop and execute strategies that will lead to success under health care reform. While the impact of reform may seem daunting and troubling, numerous opportunities within reform are available for hospitals and health systems to take charge of their future and lead the way toward the development of health care delivery systems that provide safer, more efficient, and effective care.

***To download the materials in this HPOE compendium,
please visit www.hpoe.org.***

Competency-Based Governance:
*A Foundation for Board
and Organizational Effectiveness*

P U B L I S H E D B Y

The American Hospital Association's



**CENTER FOR
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Monograph Series

About the Center for Healthcare Governance

The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.

About the Health Research & Educational Trust (HRET)

The Health Research and Educational Trust (HRET) is a private, not-for-profit organization that engages in timely research and education on topics of interest to hospitals and health systems and the communities they serve, including business leaders and policymakers. Founded in 1944 and affiliated with the American Hospital Association, HRET collaborates with health care, government, academic, business and community organizations across the United States to conduct this research and disseminate findings that will shape the future of health care. For more information visit www.hret.org.

About Hospira

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Competency-Based Governance: *A Foundation for Board and Organizational Effectiveness*

February 2009

Center for Healthcare Governance and
Health Research & Educational Trust

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*Denotes hospital or health services organization board member.

Acknowledgements

The panel wishes to thank Susan M. Huber, Vice President, Governance and Sponsor Relations, Ascension Health, for meeting with the panel and sharing Ascension's work in developing board competencies.

The panel also acknowledges Luanne R. Armstrong, Vice President, Governance, at Texas Health Resources, Arlington, TX; Mary Wicker, Governance Manager, Presbyterian Healthcare Services, Albuquerque, NM; Diane McDaniel, Governance Committee Chair and Former Board Chair, Sierra Vista Regional Health Center, Sierra Vista, AZ; and Sarah Buck, Board Chair, Mary Greeley Medical Center, Ames, IA for providing input on board competency development and use that helped inform the panel's work.

The panel is grateful to the National Center for Healthcare Leadership for sharing the competencies and associated behaviors included in its Health Leadership Competency Model, which the panel used as a resource in identifying the sets of knowledge and skills and personal trustee core competencies included in this report.

The panel also extends its thanks to Kevin Van Dyke, Research Manager, the Health Research & Educational Trust, who prepared the literature review and gathered input from hospitals and systems that contributed to the panel's work; and to Deborah Bohr, Senior Director, Special Projects and Cathy Wesley, Manager, Executive Administration, the Health Research & Educational Trust, for providing staff support to the panel.

Finally, the panel especially acknowledges its great appreciation to Mary Totten, governance consultant and Content Development Director for the Center for Healthcare Governance, who designed and facilitated the panel's work and wrote this report. The true scope and difficulty of these tasks became apparent in the initial phases of the work, and a much lesser product might have resulted without the skill and patience constantly demonstrated by Ms. Totten.

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Report At-A-Glance

The 2007 report of the Blue Ribbon Panel on Health Care Governance focused on building a foundation for exceptional governance and included several tools and practices to help boards move from good to great performance.

The Blue Ribbon Panel on Trustee Core Competencies was convened in 2008 to build on the earlier panel's work:

- to identify individual board member core competencies common to different types of boards that can be used to improve board and organizational performance; and
- to provide guidance and direction for the field in developing educational and other resources that can be used to apply these competencies to the work of hospital and health system governing boards.

Panel members drew on their own experiences and reviewed work done by others to develop board and leadership competencies for both for-profit and not-for-profit organizations. The panel then identified two sets of trustee core competencies for board members of hospitals and health systems.

Knowledge and Skills

- Health Care Delivery and Performance
- Business and Finance
- Human Resources

The panel recommended that all boards, regardless of the type of hospital or system they govern,

should include some members with these knowledge and skills competencies.

The panel further recommended that the competencies included in the list below should be sought in all board members.

Personal Capabilities

- Accountability
- Achievement Orientation
- Change Leadership
- Collaboration
- Community Orientation
- Information Seeking
- Innovative Thinking
- Complexity Management
- Organizational Awareness
- Professionalism
- Relationship Building
- Strategic Orientation
- Talent Development
- Team Leadership

In addition to developing individual board member competencies, the panel also considered what makes a board an effective team and identified tools and resources to help boards begin to apply competencies to health care organization governance.

Lastly, this report also includes recommendations for boards, educators and researchers to carry the panel's work forward to help the field better understand and practice competency-based governance.

Introduction

Competence is a concept we're all familiar with. Most of us have been in conversations where people say, "I really admire her. She's so competent," or "They've mishandled this situation badly. They're just plain incompetent."

If we were to ask others why they believe people are competent, they might focus on someone's knowledge or skills and say, "She knows so much about finance and investments," or "There's not a thing that's broken that he can't fix." But, we might be even more likely to hear, "She communicates so well. She makes everything easy to understand," or "He can solve any problem, big or small," or "She's a real team player." These observations focus more on people's behavioral abilities, rather than simply on what they know or tasks they can perform.

These answers tell us that true competence is more complex than we may have thought. It is more than just having specific knowledge, skills or other characteristics. It also has a lot to do with how we behave when we're in certain situations or when we perform various tasks or jobs, as well as how we work together with others in reaching decisions or meeting goals.

For almost 50 years, competencies—the combination of knowledge, skills, personal characteristics and behaviors needed to effectively perform a job—have been used to identify, develop and manage human resources in a variety of

organizations. However, recently competencies have received more attention because of their potential to increase both personal and organizational success.

A growing body of research is beginning to connect competencies to both individual and organizational performance in many sectors including health care. This link is motivating interest in competency-based selection and development of people in roles outside of the workforce, including service on both for-profit and not-for-profit governing boards.

In the wake of corporate failures calling for greater board effectiveness and accountability, competencies are beginning to be applied to board work because of their capacity to improve performance. For several years, competencies have been used in health care governance at the individual level, although most boards tend to focus only on certain aspects of competency, such as professional knowledge and skills. Few boards systematically look for or develop in their members aspects of competency that have to do with behavior, both individual and social. This behavioral aspect of competency is important because it not only helps people more clearly demonstrate their knowledge and skills, but can also support effective team work, which research indicates is linked to better board and organizational performance.

In the fall of 2005, the Health Research & Educational Trust (HRET) with funding and support from Russell Reynolds Associates and the

Center for Healthcare Governance, convened a blue ribbon panel to identify issues critical to board effectiveness. The panel's work also focused boards on their accountabilities to stakeholders for achieving the hospital's mission and goals; overseeing financial, quality, safety, CEO and leadership performance and for ensuring continuous improvement of governance performance as well. The 2007 report of the Blue Ribbon Panel on Health Care Governance focused on building a foundation for exceptional governance. It also included several tools and practices to help boards move from good to great performance.

The Blue Ribbon Panel on Trustee Core Competencies was convened in 2008 by the Center and HRET, with funding from Hospira, to build on the earlier panel's work by focusing on what makes individual trustees, and boards, successful.

The charge of the Blue Ribbon Panel on Trustee Core Competencies was:

- to identify individual board member core competencies common to different types of boards that can be used to improve board and organizational performance; and
- to provide guidance and direction for the field in developing educational and other resources that can be used to apply these competencies to the work of hospital and health system governing boards.

Over several months the panel gained a deeper understanding of competencies and their value and how they are being used at both executive and board levels in health care and other sectors. The panel reviewed a variety of leadership and governance competencies in the context of board

work in hospitals and systems and identified a set of board member core competencies applicable to all boards, regardless of the type of health care organizations they govern.

This report presents the panel's findings and explores new ways for boards to look at and begin to apply individual trustee core competencies. It also discusses the critical importance of boards as effective teams and suggests how they can better understand and begin to assess their performance as a group.

Recommendations for further exploration of the ideas presented here also are included for:

- boards and those who work with them;
- educators who want to develop competency-based programs and other resources for boards; and
- researchers interested in further studying and validating governance competencies and their impact on both board and organizational performance.

This report includes appendices that show how boards of systems, community hospitals, rural hospitals and other types of health care organizations are using competencies in their work. The appendices also include a sample tool that can help boards begin to apply the individual trustee competencies identified by the panel to board member recruitment and selection.

How to Use This Report

The panel believes that trustee core competencies should be integral to all board practices. This report suggests how boards can apply competencies to their work and calls for additional education,

research and development of tools and resources to further support their adoption and use.

Board Nominating Committees and other groups that appoint trustees will find this report useful in understanding how competencies can help them better identify the best candidates for board service. Governance Committees can use this report to identify competency strengths and weaknesses among board members and develop education programs, mentoring and other resources to build greater board member competency over time. Board and committee chairs can use competencies to help select committee members and to identify and develop future board leaders. Competencies can also be used to establish board policies designed to foster and develop them so that they

become a thread that strengthens the tapestry of effective governance.

Comparing their practices to the competency-based approaches suggested in this report will help boards gauge how far they have come on their journey to better governance. The panel encourages all boards to adopt the tools and approaches suggested in this report and to share their knowledge and experience in applying them with the Center for Healthcare Governance. The Center will then share these results more broadly with the field. In this way, boards nationwide will have access to knowledge, tools and resources to make board service more meaningful and rewarding and ultimately, to make a more valuable and lasting contribution to the stakeholders and communities they serve.

The Case for Competence

A growing interest in competency-based governance is not surprising. In fact, ample evidence strongly suggests a compelling need for it. Failures of organizations such as Enron, Tyco and the Alleghany Health, Education and Research Foundation have focused a spotlight on boards and the way they govern and prompted a variety of reforms and mandates aimed at improving board performance and accountability. The Sarbanes-Oxley Act at the federal level and more recent mandates requiring trustee education in states such as New Jersey and New York are but a few examples.

The ripple effect of these corporate and nonprofit failures has been profound. Major donors are now paying more attention to the governance of the organizations they fund. State attorneys general are looking at board practices related to hospital CEO compensation, use of charitable assets and billing and collection practices. And, bond rating agencies are reviewing the quality of governance in assessing hospital and health system creditworthiness. Voluntary trustee certification is on the rise as well, with programs now being developed and/or implemented by hospital associations in states such as Tennessee, Texas, Minnesota, and Georgia.

The corporate failures of the last decade also are reshaping traditional perspectives on what it means to govern well. It is now clear that the boards of many failed organizations were composed of very knowledgeable, capable individuals who were unable or unwilling to prevent these disasters. This

realization, and a growing body of research linking effective board and organizational performance, are motivating us to look beyond traditional notions of board composition or structure as the keys to good governance to also examine board culture and what makes boards work together as effective teams (Sonnenfeld, 2002) (McDonagh, 2006).

Understanding the characteristics of effective board culture and teamwork will become more and more important as the work of hospitals and systems grows more complex. This increasing complexity requires boards to simultaneously address multiple, challenges and to govern at levels of detail that used to be considered “micromanagement,” indicating the need for new or deeper governance competency, as well (Orlikoff and Totten, 2008).

Yet, despite greater clarity about factors that contribute to better board performance, health care trustees are often appointed without a clear understanding of the job they are supposed to perform and without receiving any written information about their roles, responsibilities, expectations and accountabilities. As Jim Small formerly of Ascension Health suggests, health care trustees are generally asked to serve for their influence or affluence rather than on the basis of predetermined competencies. “Because this is so,” he says, “many boards are made up of very bright, able people whose skills and experience do not match up with the board’s needs. In these cases, the board turns out to be a whole that is less than the sum of its parts....Boards should, in fact, be competency-based.” (Small, 2000).

Understanding Competency

Research and writing about competency tells us that true competence is a combination of several components required for effective job performance (see Figure 1).

For its purposes, the panel defined competency as the combination of knowledge, skills, personal characteristics and individual and social behaviors needed to effectively perform a job.

Competencies also can be categorized as threshold and differentiating. Threshold competency is the generic knowledge, skills, characteristics and

behaviors essential to job performance, but not causally related to superior performance. Threshold competencies are considered the minimum necessary for performance on the job and can apply to the same job industry-wide. For example, all airline pilots, regardless of the type of aircraft they fly or the airline they fly for, must have certain competencies to be successful in performing their jobs (Simpson, HRSG). Competencies are considered differentiating when they relate to superior job performance for a specific type of organization. Differentiating competencies are not generic.

Experts suggest that threshold competency is often assumed and checked by asking a few questions. However, they caution that to appropriately match needed competencies to a specific job, assuming competence or asking the wrong questions to verify it can produce unsatisfactory outcomes and may even result in under-performance or more serious negative consequences.

Experts also emphasize two aspects of competency critical to understanding and effectively applying it in the real world. The first is that competence is not related to the individual, but rather to performance of a task or job. In fact, it is meaningless to talk about competency outside of this context.

The second aspect of competency relates to behavior. The literature suggests that competencies

Figure 1: Definitions of Competence

1. A person's ability or capacity to undertake a particular task or job (Sapre, 2002)
2. The knowledge, skills and ability required to be successful in the job (Simpson, HRSG)
3. A cluster of related knowledge, attitudes and skills that affects a major part of one's job and correlates with performance on the job (Lee and Phan, 2000).
4. A complex combination of underlying characteristics. A window through which one can glimpse a person's capability. (Loughlan, Centerpoint for Leaders)
5. An underlying characteristic of an individual that is causally related to criterion referenced to effective and/or superior performance in a job or situation (McClelland in Sapre 2002)

are linked to deep, enduring aspects of an individual's personality that can predict or cause behavior and performance. They indicate ways people are able to think and generalize across situations. True competencies focus on intentional behavior, rather than simply on a person's knowledge, skills or other personal characteristics and abilities. After all, even the most brilliant or highly skilled people bring little value to a board unless they translate that knowledge and skill into action that supports both board and organizational effectiveness. Therefore, a person's behavior

provides a lens through which others can better understand how competent that person really is.

The bottom line: competency is both job- and behavioral-based. These two aspects of competence can help us better understand and apply competencies to improving both individual board member and full board performance. They also can help shed light on how this level of understanding differs from the way competencies are viewed and used in health care governance today.

Developing and Using Competencies

Developing competency models is a rigorous process that involves several steps: identifying job roles and responsibilities; collecting and analyzing data on both average and superior performers using behavioral-based tools and approaches; and then developing, testing and validating the model both in and outside of a given industry. Competency development also should consider those needed for both current and future success.

The good news is that several sets of behavioral competencies have already been developed for governing and leading for-profit and nonprofit organizations. Several sets of these competencies are discussed here and provide a basis for identifying core competencies and applying them to the work of health care organization board members and boards.

Individual Board Member Competencies

In their article “Competencies of Directors in Global Firms: Requirements for Recruitment and Evaluation”, Lee and Phan (2000) discuss 12 groups of “supra-competencies” for corporate directors: strategic perspective, business sense, planning and organizing, analysis and judgment, managing staff, persuasiveness, assertiveness and decisiveness, interpersonal sensitivity, communication, resilience and adaptability, energy and initiative, and achievement motivation. They also identify six additional specific competencies important for effective governance of global firms: managing

competitiveness, managing complexity, managing adaptability, managing teams, managing uncertainty, and managing learning.

The National Center for Healthcare Leadership (NCHL)’s Health Leadership Competency Model is based on research that identified 26 competencies for practicing health leaders in administrative and clinical positions. The model defines competencies as the technical and behavioral characteristics that leaders must possess to be successful in positions of leadership across the health professions. NCHL’s model includes both baseline (threshold) and distinguishing competencies. NCHL competencies are scaled into three to six levels, indicating the progression individuals can make from novice to expert.

NCHL’s model takes into account both current and future health care challenges, including:

- The emergence of a global health care system focused on wellness and preventive care;
- The transition of treatment from disease management to prevention or minimalization;
- The exacerbation of rising costs, resource allocation and priority-setting as baby boomers become senior citizens around 2020;
- The need for a customer-focused environment fueled by patients taking more control over their personal health decisions;
- Most Americans receiving care from specialized centers for chronic disease;

- Diagnostic processes enabled by electronic data collection and monitoring devices that patients can use at home.

The model incorporates benchmark data from other health sectors and insurance companies and composite leadership competencies from a group of global corporations. NCHL believes that competencies require continuous re-evaluation and updating as the environment changes.

While its competencies are not specific to health care boards, NCHL and other experts suggest that competencies for leaders and executives could be adapted for use by governing board members, although additional research would be needed to determine the relationship between board member competencies and trustee performance.

Collective Board-Level Competence

Research on nonprofits including colleges and universities and further studies involving health care organizations indicates that effective boards are distinguished from less effective ones in six areas of competence:

1. Contextual dimension—understanding and valuing the institutional history and context

2. Educational dimension—building the capacity for board learning
3. Interpersonal dimension—nurturing the development of the board as a cohesive group
4. Analytic dimension—recognizing the complexities and nuances of issues
5. Political dimension—respecting and guarding the integrity of the governance process
6. Strategic dimension—envisioning and shaping future institutional directions.

Ascension Health also has developed a set of Board Competencies and Benchmark Behaviors. They include: Mission, Vision and Values Integration; Strategic Leadership; being Results-Oriented; Relationship Building and Contributions to Board Performance. The behaviors associated with given competencies are critical to clearly understanding them. They also play a role in accurately assessing whether individuals have specific competencies and in creating tools and resources to develop them. Ascension's competencies also have been applied to board chairs and organizational leaders, with benchmark behaviors reinterpreted for organizational leadership roles.

Identifying and Using Trustee Core Competencies for Health Care Governance

The work described above has many implications for development of health care governance competencies. In considering these implications it is important to keep in mind that competencies are composed of several components, including knowledge, skills, personal characteristics and individual and social behaviors. They also relate to performance of a specific job, are behaviorally based, and can and should help improve performance.

While significant work has been done to identify individual board member competencies, less focus has been given to developing competencies for the board as a team. Therefore, the panel expanded its charge and not only identified competencies for individual board members but also characterized how the full board might function at different levels of proficiency within the six board competency dimensions discussed above on page 15. The panel believed that additional focus on effective board culture and teamwork in governance research and practice will improve the board's performance as a whole. This focus can also help identify and leverage individual competencies to further support better overall board performance, as well.

Core Competencies for Individual Board Members

For several years health care organization boards have considered components of competency in identifying and developing their trustees.

Appendix 1 shows the Board Leadership Continuity and Growth Plan for Texas Health Resources (THR). The plan includes matrices profiling the current and anticipated professional backgrounds, skills and demographic diversity of THR trustees to help determine future board membership needs. Many boards use similar profiling techniques to identify their current mix of trustee professional expertise, skills and demographic characteristics (gender, age, race and ethnicity, geographic location, etc.). They then compare the current profile against the organization's strategic priorities, identify gaps and recruit and develop new board members to fill them.

The panel affirmed that specific professional knowledge, experience and skills are needed to effectively govern different types of health care organizations. These competency components will vary among public and private hospitals, national and local systems, and urban academic medical centers and rural community hospitals, depending on an organization's individual needs and priorities. However, the panel suggested that all boards, regardless of the type of health care organization they govern, should include some members with the professional knowledge and skill competencies and associated behaviors described on page 17.

The panel also emphasized that competency-based governance goes beyond ensuring that a board is composed of individuals with diverse professional

Board Member Core Competencies: Knowledge and Skills

Health Care Delivery and Performance

Has the knowledge and skills to:

- Track measures of quality, safety customer satisfaction, financial and employee performance.
- Ensure patient and customer satisfaction scores, as well as demographic and epidemiological statistics, are used to set organizational priorities, plans and investments.
- Monitor and evaluate organizational success by tracking community wellness and clinical performance against benchmarks.
- Anticipate community needs.
- Ensure close adherence of performance to the Institute of Medicine Six Aims: to provide care that is safe, timely, effective, equitable, efficient and patient-centered.
- Advocate for care decisions that are evidenced-based.

Business and Finance

Has the knowledge and skill to:

- Guide development of long-term plans for funding growth and development.

- Oversee development of revenue sources and understand their financial implications.
- Consider the impact of reimbursement and payment systems when assessing management alternatives.
- Oversee development of long-term capital spending for renovation and expansion of facilities, equipment and services.

Human Resources (employees, physicians, volunteers, etc.)

Has the knowledge and skill to:

- Ensure human resource functions are aligned to achieve organizational strategic outcomes.
- Ensure that recruitment and selection, job design and work systems, learning and development, reward and recognition and succession planning are aligned to encourage behaviors and performance needed today and into the future.

Source: Adapted from NCHL Healthcare Leadership Competency Model, 2005

knowledge, skills and experience who have the time and interest to serve. While these criteria are useful, true competence requires that board members also possess personal capabilities and behaviors that demonstrate how they have or would apply their specific knowledge, skills and perspectives to board work to meet the organization's needs and further its goals. These

personal capabilities and the behaviors that express them transcend the differences among boards and also should be viewed as core competencies common to all boards.

Keeping in mind that competencies are job-based, the panel reviewed basic job descriptions for the board of a freestanding hospital, a system board

and the board of a hospital in a system that appear in Appendix 2. Mindful of its charge to develop core competencies that could be applied across different types of boards and seeking to build on and adapt existing competency work, the panel compared several sets of the existing board and leadership competencies described above with the board job descriptions in Appendix 2. The panel then identified the set of personal core competencies for health care board members and the behaviors associated with them that appear below. Appendix 4 beginning on page 47 of this report shows how these personal core competencies can be applied to one board practice: trustee recruitment and selection.

The panel believed that these basic competencies would be valuable for members of all hospital and health system boards. Unlike professional knowledge and skill competencies that would reside in some, but not all, board members, competencies focused on the personal capabilities described below would be sought in all board members or board candidates.

Experts suggest that not every board member needs to exhibit all necessary competencies upon joining the board. Rather, the goal is to ensure that the board, as a whole, encompasses all needed competencies and further develops them among all board members.

Board Member Core Competencies: Personal Capabilities

Accountability: guides creation of a culture of strong accountability throughout the organization; appropriately and effectively holds others accountable for demanding high performance and enforcing consequences of non-performance; accepts responsibility for results of own work and that delegated to others.

Achievement Orientation: ensures high standards are set and communicated; makes decisions, sets priorities or chooses goals based on quantitative inputs and outputs, such as consideration of potential profit, risks or return on investment; commits significant resources and/or time in the face of uncertain results when significantly increased or dramatic benefits could be the outcome.

Change Leadership: maintains an eye on strategic goals and values during the chaos of change; exhibits constancy of purpose, providing focused, unswerving leadership to advance change initiatives; demonstrates quiet confidence in the progress and benefits of change; provides direction for overcoming adversity and resistance to change; defines the vision for the next wave of change.

Collaboration: promotes good working relationships regardless of personal likes or dislikes; breaks down barriers; builds good morale or cooperation within the board and organization, including creating symbols of group identity or other actions to build cohesiveness; encourages or facilitates a beneficial resolution to conflict; creates conditions for high-performance teams.

Board Member Core Competencies: Personal Capabilities

Community Orientation: advocates for community health needs at community, state and federal levels; engages in meaningful actions at the national level to move recognized priorities forward; partners across health constituencies to create a coordinated and dynamic health system that meets long-term health and wellness needs; understands needs of health stakeholders and pushes their agenda forward.

Information Seeking: Asks questions designed to get at the root of a situation, a problem or a potential opportunity below the surface issues presented; seeks comprehensive information; seeks expert perspective and knowledge; establishes ongoing systems or habits to get information; enlists individuals to do regular ongoing information gathering; encourages adoption of best practices from other industries.

Innovative Thinking: makes complex ideas or situations clear, simple or understandable, as in reframing a problem or using an analogy; fosters creation of new concepts that may not be obvious to others to explain situations or resolve problems; looks at things in new ways that yield new or innovative approaches—breakthrough thinking; shifts the paradigm; starts a new line of thinking; encourages these behaviors in others.

Complexity Management: balances tradeoffs, competing interests and

contradictions and drives for the bigger, broader picture both to reach resolutions and expand one's knowledge; exhibits highly developed conceptual capacity to deal with complexities such as expanding markets; understands the vision, mission and strategy and their implications for the organization's structure, culture and stakeholders.

Organizational Awareness: becomes familiar with the expectations, priorities and values of health care's many stakeholders; recognizes internal factors that drive or block stakeholder satisfaction and organizational performance; addresses the deeper reasons for organization, industry and stakeholder actions, such as the underlying cultural, ethnic, economic and demographic history and traditions; uses these insights to ensure organizational leaders are building long-term support for creating local, regional and national integrated health systems that achieve a national agenda for health and wellness.

Professionalism: develops governance roles/values compatible with improving population and individual health; ensures that the organization values and exhibits professional, patient- and community-oriented behaviors; commits to addressing the health and wellness needs of the total population, including adopting new approaches that address diverse cultural attitudes about health; ensures organizational stewardship and

Board Member Core Competencies: Personal Capabilities

accountability for honesty and fair dealing with all constituents.

Relationship Building: Builds and maintains relationships with influential people in the health care field, the community and other constituencies that involve mutual assistance and support.

Strategic Orientation: understands the forces that are shaping health over the next 5 to 10 years; helps shape the organization's vision and future direction; aligns strategy and resource needs with the long-term environment and guides positioning the organization for long-term success; develops a perspective on long-term health and wellness trends and developments that is respected by colleagues and leading policymakers; helps shape competitive positioning for the organization and the industry through policymaking forums and industry-specific groups.

Talent Development: holds management accountable for developing people in the organization; ensures that succession plans for the CEO and senior leaders are robust and current; serves as a coach and mentor within the board and organization as needed and industry-wide to develop health care talent.

Team Leadership: establishes and models norms for board behavior; takes appropriate action when board members violate the norms; works with board members to gain their personal commitment and energy to support board goals; removes or reduces obstacles to board effectiveness; coaches and develops board members to top performance; encourages these team leadership behaviors organizationwide; is recognized throughout the health industry as an outstanding leader.

Source: Adapted from NCHL Healthcare Leadership Competency Model, 2005 and Lee, Soon-Hoon and Phillip H. Phan. "Competencies of Directors of Global Firms: Requirements for Recruitment and Evaluation." *Corporate Governance: An International Review*. Vol. No. 8, No. 3: 204-214 (2000), at 204, 207-210.

Using Individual Board Member Competencies in Health Care Governance

The panel acknowledged that boards will need new approaches and tools to identify and further develop these core competencies.

Interview and assessment tools to select new board members should dig deeply to learn how candidates have used various behavioral competencies in situations relevant to the board's work and the

organization's needs and priorities. Successful application of these competencies will help boards take trustee recruitment and selection to the next level, enabling selection of the most capable candidate from among several with similar backgrounds and experience.

Competencies can be used in developing evaluation tools that assess board member performance against them. Feedback from these evaluations should

then be used to identify educational opportunities to strengthen or develop new competencies in individual board members. Feedback from individual board member evaluations also will indicate strengths and weaknesses across the full board that can then be addressed through board retreats and other board education programs.

Appointing trustees to board committees should maximize use of existing board member competencies and help board members gain additional competence in areas where they have less capability. Board member core competencies should be integrated into board leadership development and succession planning, as well. They also could be used to improve capabilities that make the most difference to performance, promote standards of leadership excellence and support organizational transformation initiatives (NCHL, 2005). In this way, competencies can become the foundation for a system of governance designed to achieve better board member, board and organizational performance.

The panel suggested that trustee competencies should be regularly reviewed and revised as needed to remain relevant as health care organization priorities and needs change over time. Achieving superior governance performance also may require additional board member competencies.

The panel also acknowledged that a deeper exploration of competencies for health care organization board members and their relationship to board and organizational performance would be valuable. Further work would be necessary to validate the core competencies identified by the panel and to identify additional competencies that may be needed as well.

Appendix 3 shows how Presbyterian Healthcare Services based in Albuquerque, NM, uses board member core competencies in a variety of board practices systemwide. Appendix 4 provides a tool for interviewing prospective board members that assesses the extent to which candidates exhibit behaviors associated with the 14 personal core competencies identified by the panel.

Collective Board-Level Competence: The Next Frontier

While competent board members are the foundation for competent boards, it is clear that board effectiveness requires more than just a collection of competent individuals. If high-performing, effective boards required no more than competent members, then the corporate failures of the last decade might never have happened. The boards of these failed organizations were all composed of highly capable people who were nonetheless unable to prevent these catastrophes. Why did otherwise competent individuals fail to perform well as a group? Research into these governance failures concludes that their causes are rooted in board culture and how boards function as teams.

These conclusions are not surprising. Both board members and CEOs can recall situations where their boards voted on a proposal without much discussion, only to have the real issues debated vigorously in the parking lot after the meeting. Many trustees would be able to describe more than one meeting where discussion was dominated by one or two board members, quelling participation from others. These situations suggest that people behave differently in groups than they might as individuals and that group action tends to overwhelm individual behavior. In acknowledging these differences, the panel suggested that the board's behavior as a group is at least as important as individual board member behavior and explored elements of board culture and behaviors of effective teams to gain insight into board-level competence.

Board Culture and Teamwork

Culture can be defined as the norms, values and beliefs held by groups and the way they function within that context. David Nadler in his work on building better boards says that the key to improved governance lies in the working relationships between the board and the organization's executives, the social dynamics of board interaction and the competency, integrity and involvement of individual board members. In his analysis of why governance failed in companies such as Enron and Tyco, Jeffrey Sonnenfeld concludes that the social system of the board is what sets exemplary boards apart from the rest. He says great boards focus on achieving the organization's mission; building trust and candor; encouraging open, respectful dissent; avoiding inflexible roles and behavior; requiring individual accountability and evaluating performance.

Chait, Ryan and Taylor, in *Governance as Leadership*, say that boards that govern beyond the fiduciary or strategic modes and engage in generative governance operate differently as a group than more traditional boards. They focus on making sense of issues facing the organization, inviting questions and alternative explanations for these issues, shedding new light on perceived problems and opportunities and finding and framing new problems and opportunities that may change the organization's values, beliefs and behaviors.

Recent studies linking board and organizational performance also suggest that board effectiveness relates to boards as social systems. This view supports a governance culture of active, engaged oversight and board members who possess quality of mind, a tolerance for ambiguity, an appetite for organizational puzzles, fondness for robust discourse and commitment to team play (McDonagh, 2006).

Examinations of board culture have identified dimensions of high-functioning and low-functioning boards, as well. Boards that are high-functioning include members who are highly interested and engaged, have a sharp focus on well-defined governance priorities, exhibit high-attendance and enthusiasm, engage in extensive questioning, dialogue and deliberation, offer constructive dissent and welcome debate. A low-functioning board culture is characterized by members who are passive and reactive, have unclear priorities and spotty attendance with low energy, spend much of their time listening with little discourse and suppress challenges and disagreements. (Prybil, 1999) (BRP, 2007).

Work focused on understanding effective teams defines them as groups of people committed to balanced participation, equal contribution, and regular deliberation. Effective teams use the ideas and abilities of individual members for the overall good. A list of characteristics of effective teams appears in Figure 2.

High-performing teams are interactive, cooperative, creative and results-oriented. They achieve their level of performance intentionally, by focusing on three types of behaviors.

Figure 2: Characteristics of Effective Teams

Effective teams:

1. have clear unity of purpose.
2. are intentional and explicit about how they function.
3. set concrete, demanding performance goals.
4. establish a working environment that is informal, comfortable and relaxed.
5. engage in a lot of discussion where almost everyone participates.
6. allow members to freely express their ideas and feelings.
7. encourage constructive disagreement.
8. make decisions when there is general agreement.
9. have members that carry their own weight.
10. engage in frequent, frank, constructive criticism.
11. shift the leadership of the group from time to time.

Adapted from "Characteristics of Effective Teams", www.stanford.edu.

Task behaviors are those that move a team toward accomplishing its objectives. Examples of these behaviors include setting goals, identifying tasks, gathering facts, providing information, clarifying and summarizing ideas and building consensus.

Interaction behaviors are those that define how the team will function and are sometimes referred to as rules of engagement. Examples include encouraging participation, expressing feelings, deciding how to handle conflict, determining how work will be distributed, determining how the group will make decisions, keeping communication open, setting and applying standards for group performance and building on each other's ideas.

**Figure 3:
Board Competencies Implemented at Various Proficiency Levels**

	Education	Contextual
Novice	Conducts board orientation, provides background information with board agenda materials	Input received primarily at board meetings; understands organization’s mission; understands role of the medical staff; lacks input and participation from stakeholders
Competent	Conducts board orientation and provides orientation manual; provides background information tailored to the board with board agenda materials; conducts education sessions at board meetings; conducts annual board retreat; has a budgeted line item for board education	Understands mission and role of the medical staff; involved with staff at committee meetings; involved in discussions with the community; conducts stakeholder analyses; integrates mission into board activities; implements policies to deal with medical staff issues and conflicts
Expert	Conducts all competent board practices and: assigns mentor to new trustees; develops and follows a policy stating board education requirements; has a budgeted line item for board education to support board member and full board educational activities; has an annual board education plan tied to the organization’s strategic objectives and to educational needs identified by annual board and individual board member evaluation results; takes advantage of cross-industry learning and collaborative learning opportunities with other organizational leaders; provides individualized board member education to leverage skills and clarify roles; supports off-site educational opportunities for board members	Conducts all competent board practices and: participates with CEO in advocacy efforts; uses results of stakeholder analyses in matching competencies of individual board members with organizational needs; evaluates all board decisions and organization’s business plans to ensure mission fulfillment; integrates physician board members into all board committees and work; engages proactively with the community to determine community benefit and needs

Self-oriented behaviors are those that place individual needs ahead of group needs and can undermine teamwork. Effective team members avoid dominating discussion, interrupting, wasting time, pursuing tangents, not listening, withdrawing from discussion and having side conversations.

High-performing teams pay attention to all of these behaviors. And, their members are willing to challenge the team when it behaves in ways that

compromise group effectiveness. High-performing teams attend to both the task and the way the team interacts to accomplish it; members of these teams also manage themselves to comply with desired team behaviors.

A good team, therefore, doesn’t just happen. It takes work and vigilance on the part of all team members to support effective team function. Given what it takes to be a high-performing team and

Figure 3 (continued)		
Board Competencies Implemented at Various Proficiency Levels		
	Strategic	Political
Novice	Reviews and approves strategic plan proposed by management; ensures strategic plan is consistent with mission; operates with a short-term perspective	Pursues individual agendas versus a collective approach; changes direction when pressured by key stakeholders; episodically involved in advocacy activities; CEO sets board agenda and directs board work
Competent	Involved in strategy development and setting strategic priorities; uses environmental issues and trends in planning process; approves strategic plan and ensures it is consistent with the mission; annually reviews progress toward achieving the strategic plan; operates with a mid-range (1 to 3-year) perspective	Understands that mission-focus supersedes individual agendas; works as a whole with those impacted by hospital decisions; understands that stakeholder needs and priorities differ; collaborates with CEO to set meeting agendas and determine board work; sets expectations and performance goals for CEO; incorporates advocacy issues into board meetings and work
Expert	Conducts all competent board practices and: involves stakeholders in developing strategies and priorities; conducts ongoing environmental scanning to support dynamic strategy development; evaluates progress on key strategies at each board meeting; flexibly responds to environmental change; incorporates lessons from other industries; operates with a long-term perspective	Conducts all competent board practices and: proactively advocates for hospital and community needs in both legislative and policy arenas; balances stakeholder needs to optimally fulfill organization's mission; leads in partnership with the CEO in a mutually trusting, supportive relationship and incents and rewards CEO for achieving goals

recognizing that group behavior typically trumps individual behavior, it's not difficult to understand why boards often don't do the hard work required to perform well as a team. It's also easy to see why many highly capable individuals serve on poorly performing boards.

Assessing Board-Level Competence

To help boards better assess their own level of competence as a team, the panel developed the

matrix shown in Figure 3 which identifies, within the six dimensions of board competence discussed on page 15 of this report, a range of typical board practices and ways boards behave in executing them at different levels of proficiency: novice, competent and expert. Boards can compare how they execute various governance practices with those included in this matrix to identify both strengths and opportunities for improvement in their overall performance.

Figure 3 (continued)
Board Competencies Implemented at Various Proficiency Levels

	Interpersonal	Analytical
Novice	Board members interact primarily at meetings; sets minimal guidelines about decision-making, handling conflicts and other norms for board behavior; discussion dominated by a few individuals; rehashes past and present versus being future-focused; little or no evaluation of governance processes; only vague sense of board culture and need for cohesion and teamwork	Reacts to issues and crises; asks minimal questions and rubber stamps management proposals; operates primarily in fiduciary governance mode; relies on anecdotal, informal information-sharing rather than engaging in evidence-based decision-making; uses little to no formal performance reporting, such as scorecards or dashboards and is often overwhelmed with “too much data”; uncomfortable with ambiguity and seeks black and white solutions
Competent	Establishes guidelines for board practices and behaviors consistent with board norms and culture; has a Governance Committee that uses results of board evaluations to develop board initiatives and goals; participates in organizational and board events and social functions	Brainstorms ideas and considers multiple scenarios and alternatives in planning and decision-making; operates primarily in the strategic governance mode; relies on data provided by management to inform decision-making; uses standardized performance reports and benchmarks; understands complexity and nuances of issues and strategies
Expert	Conducts competent board practices and: has a robust Governance Committee focused on board and individual member development and performance improvement; conducts board, individual and peer performance assessment; engages in candid, constructive dialog and debate; is willing to call the board to task when it deviates from established culture and norms; mentors board members; develops positive working relationships among board members and with CEO and other organizational leaders in support of the board’s and organization’s culture	Proactively assesses risks and ensures alternative courses of action are in place to address them; conducts ongoing succession planning including identification of internal and external candidates to ensure leadership and operational continuity and momentum; pursues robust dialog to discern impact of strategies and future plans; operates across all governance modes including generative mode to frame issues and problems in new ways that may change strategies, mission and values; seeks diverse sources of information beyond those provided by management and employs “devil’s advocate” role to ensure thorough analysis of issues and to inform board decisions; uses results of performance reporting and benchmark comparisons to set goals and drive performance improvement organization-wide; leverages complexity and competing priorities to develop robust strategies in a dynamic environment

Panel Conclusions and Recommendations

The charge of the Blue Ribbon Panel on Trustee Core Competencies was:

- to identify individual board member core competencies common to different types of boards that can be used to improve board and organizational performance; and
- to provide guidance and direction for the field in developing educational and other resources that can be used to apply these competencies to the work of hospital and health system governing boards.

In pursuing its work the panel sought to:

- foster a better understanding of competencies and their potential to increase individual and group performance;
- present the case for why competencies are needed to improve the work of health care organization trustees and boards;
- review work that has been done in health care and other sectors to develop and use leadership and governance competencies;
- suggest opportunities for health care organization boards to deepen and expand their use of competencies beyond current practice;
- build on existing work to identify trustee core competencies for boards of hospitals and health systems and suggest how they can be applied to board work;

- indicate how competency concepts and practices could be used beyond their application to individual trustees to improve the performance of boards as teams.
- provide tools and resources that can be used to carry the panel's work forward.

In sharing its deliberations and findings, the panel concluded that competencies, when understood and appropriately applied, are more than the sum of their parts. They can help boards move beyond personality-driven governance to leadership based on the knowledge, skills and behaviors best suited to helping organizations achieve their mission and goals. Even if a competent board may threaten some organizational leaders today, as the scope and pace of change deepens in health care, the overriding value of a competent board will become clear. Competencies also have the potential to eliminate destructive board behaviors, such as micromanagement and rubber-stamping decisions, replacing these behaviors with others that support active, effective oversight and leadership.

The panel acknowledged that a competent board alone cannot propel itself or the organization it governs to improving performance or outcomes. It can, however, reach these goals by engaging in shared governance with executives and clinicians and can lead the way by adopting competencies as the basis for elevating board practice and performance. The panel envisioned that boards

that practice competency-based governance will become part of a community dedicated to high standards of leadership and committed to continuous performance improvement and excellence.

Recognizing that more work is needed to validate and broadly apply board competencies, the panel offered the following recommendations to help the field better understand and adopt competency-based governance. The panel's recommendations focus on:

- practical steps boards can take to begin applying competencies to board work;
- suggestions for educators interested in developing curricula and other resources to improve board competency; and
- additional research that should be undertaken to validate the utility of governance competencies and more firmly establish the link between competencies and better board and organizational performance.

Recommendations

1. The panel encourages boards to use this report and the trustee core competencies, resources and tools included here to begin applying competencies to their work, especially in selecting, orienting, educating and developing board members; assessing their performance; and preparing future board leaders (see Appendices 1, 3 and 4).
2. The panel urges boards to share their experiences in using governance competencies with the Center for Healthcare Governance and in other forums to help more boards better understand competencies and adopt competency-based governance practices (see Appendices 1 and 3).
3. The broad dissemination of this report to hospital and health system board members and chief executives nationwide will facilitate board discussions about governance improvement. Other organizations can help by championing this work. The panel encourages hospital associations, payers, regulators, insurers, rating agencies, accreditation organizations and others who support board effectiveness to endorse competency-based governance and consider providing incentives for boards to adopt it.
4. The panel encourages governance educators to assist boards in assessing current member competencies and to develop new or adapt existing tools to help boards apply governance competencies across the range of board practices outlined in this report.
5. The panel also urges governance educators to develop curricula designed to educate boards and those who support their work to better identify and further develop member competencies.
6. The panel calls for identification of “early adopters” who can help move competency-based board work into the governance mainstream (see discussion of Ascension Health’s board competency development on page 15 of this report as well as Appendices 1 and 3).
7. Health care organization CEOs will play a critical role in successful adoption of competency-based governance practices. The panel suggests convening CEO/board chair focus groups to determine how to best implement use of governance competencies.
8. Additional research is needed to explore linkages between governance competencies and board and organization performance.

The panel encourages researchers to study whether competencies can predict improved performance and help achieve improved performance over time.

9. The panel calls for research focused on high-performing organizations and their boards to help validate currently identified board competencies and to identify specific or differentiating competencies associated with superior performance.
10. The panel also encourages comparison of the outcomes of health care governance competency research with results of similar research conducted in other sectors.

More information about competencies and their applications in health care is available in the appendices and bibliography that can be found at www.americangovernance.com/american-governance/BRP/files/brp-2009.pdf.



ACHI Community Health Assessment Toolkit

A Practical Guide to Planning,
Leading, and Using Community
Health Assessments



Executive Summary

Community health assessment is a vital function of hospitals and health systems in promoting health both inside and outside the hospital's walls. At its core, community health assessment is about collecting information on the health status of a population, and using that information to set priorities and allocate resources to have the greatest impact on community health.

An effective assessment is one that:

- creates a clear, evidence-based picture a community's health and well-being;
- provides a strategic focus for deploying limited community benefit resources; and
- engages community partners in shared responsibility for the community's health.

Hospital vice presidents, directors, and managers of community health, community outreach, and community benefit are among those frequently responsible for conducting assessments.

Community health assessment and tax exempt hospitals

With the passage of the *Patient Protection and Affordable Care Act*, tax exempt hospitals will be required to conduct a community health needs assessment at least once every three years (the first to be completed by end of their tax year that begins after March 23, 2012), and to adopt an implementation strategy to meet the needs identified through the assessment. According to the legislation, these assessments must "take in to account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health."

ACHI Community Health Assessment Toolkit

The American Hospital Association has a guide to community health assessment, created by its Association for Community Health Improvement (ACHI) personal membership group.

The ACHI Community Health Assessment Toolkit is a web site to help plan, lead, and use community health assessments to better understand – and ultimately improve – the health of communities. The Toolkit:



- illustrates six steps of a typical health assessment process (see graphic above);
- offers case examples, task checklists, budget and timeline guides, and links to data sources; and
- provides a forum for hospital staff to learn from one another about conducting effective assessments.

Using the Toolkit at www.assesstoolkit.org

The Toolkit is available with a valid log-in to members of AHA, ACHI, and the Society for Healthcare Strategy and Market Development. Write to assesstoolkit@aha.org or call (312) 422-2193 for log-in assistance or information.

ACHI Community Health Assessment Toolkit

Step 1 Summary: Establishing the Assessment Infrastructure

A thoughtful and strategic approach to community health assessment will facilitate a process that:

- Achieves desired outcomes and results
- Engages community participants and builds commitment for ongoing involvement
- Uses resources effectively

To ensure that you have the internal resources and support in place for this process, establish an assessment infrastructure that includes:

- Buy-in from key organizational leaders
- Project management support
- Financial, organizational, and community resources
- A committed advisory committee
- A general framework for the assessment with some preliminary agreement about purpose, scope, and time frame

Skills Needed

- Leadership
- Project management
- Collaboration development and team-building
- Budget development and resource analysis
- Group facilitation skills

Time Drivers

Aspects of the process that might unexpectedly lengthen your time line include:

- Getting on the calendars of senior managers/leaders to discuss the community health assessment and obtain their buy-in
- Securing financial and in-kind resources to support the assessment process
- Forming and orienting an assessment advisory committee

Budget Drivers

We recommend that you review the budget drivers for all the core process steps when developing your budget and determining the resource needs for the community health assessment process. Aspects of the process that may have an impact on your budget include:

- Project staff to oversee, implement, and provide administrative support to the process
- Operational needs such as meeting space rental, and reference materials
- Possible travel dollars for any site visits to other communities with model community health assessment processes
- Consultation and technical assistance related to forming the advisory committee, team-building, and defining committee and staff roles

Task Checklist

The following tasks should be in progress or completed before moving to Step 2:

- Obtain support from and educate senior leaders.
- Determine the staff team and assign project management roles and responsibilities.
- Create a work plan and time line.
- Develop a budget and determine other resources needed.
- Form an assessment advisory committee.
- Establish agreement on advisory and decision-making roles for staff and advisors.



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Step 2 Summary: Defining the Purpose and Scope

The purpose and scope of an assessment is driven by the target populations you study, what you want to know about those populations, and the types and amount of data that are collected.

Determining what your organization or community partnership wants to learn is a key part of planning your community health assessment. It is useful to study previous assessments that may have been conducted in your community - or even in other communities - and to consider how well they served their stated goals.

Among the questions to ask are:

- What is the overall goal of the assessment?
- What are the target populations and geographic areas?
- What is the range of health and social issues to be addressed?
- What specific types of data are needed?

Skills Needed

- Leadership
- Project management
- Collaboration development and team-building
- Group facilitation
- Consensus-building

Time Drivers

Aspects of the process that might unexpectedly lengthen your time line include:

- Reviewing and summarizing lessons from past assessments
- Obtaining consensus on what is the most important information to learn
- Obtaining consensus on the purpose and target populations for the assessment

Budget Driver

Aspects of the process that may have an impact on your budget include:

- Meeting facilitation assistance to help the assessment planning committee complete this step

Task Checklist

The following tasks should be in progress or completed before moving to Step 3:

- Determine and document what you want to learn about the community.
- Define the primary users of and target audience for the assessment results.
- Clarify the purpose(s) and expected uses of the assessment results.
- Determine the geographic area and any target populations.



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Step 3 Summary: Collecting and Analyzing Data

Once you define the audience, purpose, target population, and key subjects for your assessment, develop a data collection plan to answer the following questions:

- What specific information do you need?
- Does the desired information already exist in the form that you need it?
- Will new data be needed to answer some questions or to address gaps in information?
- Who will be responsible for collecting and analyzing the data?

Surveys, interviews, and focus groups are among the frequently used methods for collecting new, or primary, data. Consider examining comparative data as a part of your assessment, both to understand trends over time and to place your local data in the context of state or national figures.

Finally, consider collecting information on community assets, in addition to documenting health needs and deficits.

Skills Needed

- Ability to evaluate data quality and usefulness
- Knowledge of social science research methods
- Survey design and implementation
- Focus group and interview design and implementation
- Quantitative and qualitative data analysis
- Database management

Time Drivers

Aspects of the process that may unexpectedly lengthen your time line include:

- Deciding which data to collect
- Locating secondary data sources
- Waiting for data sources to provide requested data
- Extracting local data from larger data sets
- Collecting primary data, including designing and piloting data collection methods
- Analyzing collected data
- Conducting inventories of community assets

Budget Drivers

Data collection and analysis is the most resource-intensive part of the community health assessment process. Costs will vary according to the extent and nature of data collection. Aspects of this step that may have an impact on your budget include:

- Secondary data collection, including extracting local information from larger databases
- Primary data collection, including:
 - Designing survey and interview questions
 - Designing data collection methodology
 - Collecting data
 - Analyzing and summarizing data
- Collection of community asset information

Task Checklist

The following tasks should be in progress or completed before moving to Step 4:

- Identify data needed to meet the goals of the assessment.
- Create a data collection plan for primary and secondary data.
- Collect primary and secondary data, including comparative data and information on community assets.
- Create a system for managing data.
- Evaluate data quality and validity.
- Analyze data.



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Step 4 Summary: Selecting Priorities

Choices must be made about which issues to designate as priorities for action in the short to intermediate term (e.g., one to three years). In general, aiming for three to six priorities is a reasonable number to move your community to action.

Priorities should reflect the values and criteria agreed upon by your organization or community stakeholder group. A neutral, skilled facilitator can assure an unbiased priority-setting process, and can keep the process moving forward.

You can decide to select priorities before publishing and disseminating the assessment findings and can include them with the important data in the formal report.

Alternatively, you can publish a summary of assessment data without taking a position on priorities, and then invite community stakeholders into a priority-setting process.

Skills Needed

- Group facilitation and consensus-building
- Knowledge of priority-setting techniques

Time Drivers

Aspects of the process that may unexpectedly lengthen your time line include:

- Convening stakeholders for sufficient review of the assessment results and for setting priorities (this may take two or more meetings)
- Preparing assessment data for a preliminary report and/or verbal presentation so that participants understand and can evaluate them
- Developing criteria for evaluating assessment data on health issues
- Determining and engaging in a consensus-based priority-setting process
- Identifying and contracting with an experienced facilitator

Budget Driver

Aspects of the process that may have an impact on your budget include:

- Obtaining assistance for meeting facilitation to establish criteria and set priorities

Task Checklist

The following tasks should be in progress or completed before moving to Step 5:

- Determine who will review assessment data and help set priorities, beginning with the advisory committee.
- Prepare a written summary of the assessment findings for the priority-setting group.
- Review and discuss the assessment findings with this group.
- Consider selecting a facilitator to assist with the priority-setting process.
- Establish criteria for evaluating assessment data and for setting priorities.
- Identify the top three to six priorities.



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Step 5 Summary: Documenting and Communicating Results

Documenting your findings is important so that the results can be shared and used to improve your community. A written record of the community health assessment process and its outcomes should be created and made available to key stakeholders and the general public. We recommend that your report be reviewed by a communications or public relations specialist.

The report may be used for multiple purposes, including:

- Developing and implementing program plans to address key issues
- Writing grants
- Supporting community advocacy or policy development
- Establishing baselines as a reference point for measuring progress over time

In addition, create a plan to publicize the assessment findings and to promote community dialogue on key issues.

Skills Needed

- Public relations and marketing
- Communications and writing
- Graphic design

Time Drivers

Aspects of the process that might unexpectedly lengthen your time line include:

- Preparing the written community health assessment report, including comparative data and graphics
- Obtaining review and approval of the report's contents and key messages, as needed
- Designing and printing the report (and/or Web page design)
- Developing and implementing the communications plan

Budget Drivers

Aspects of the process that may have an impact on your budget include:

- Consultant assistance to help prepare written copy and graphic elements of the assessment findings, and to ensure readability and consistency
- Production of the report in print and online
- Costs associated with the communications and community engagement plan, including public meetings and media costs

Task Checklist

The following tasks should be in progress or completed before moving to Step 6:

- Review data and priorities to highlight key messages.
- Prepare a written assessment report that includes graphs and tables.
- Obtain approval for the report's contents, as needed.
- Publish the report on paper and electronically.
- Develop and implement a community dialogue and communications plan.



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Step 6 Summary: Planning for Action and Monitoring Progress

Once you have collected the data and established priorities, develop, implement, and monitor an action plan to address the priorities and improve community health. According to the Planned Approach to Community Health, a comprehensive intervention plan:

- Includes multiple strategies (e.g., educational, policy, environmental)
- Uses various settings for the implementation (e.g., schools, worksites)
- Targets the community at large as well as subgroups
- Addresses factors that contribute to the health issue

Identifying specific goals for the action plan will help focus the suggested interventions and provide a method of valuing each option.

Examine the experiences of other communities and evaluate formal research to help determine what is already known about how effective programs or policies can have an impact on your priorities

In addition, action plans developed with community input and involvement are most likely to garner active support and therefore are more likely to succeed.

Skills Needed

- Planned-process facilitation
- Evaluation plan development

Task Checklist

The following tasks should be completed before concluding your community health assessment process:

- Incorporate additional partners into the planning and action process, if warranted.
- Collect information on existing community efforts and on effective programs for identified priorities.
- Develop goals, objectives, and strategies as well as an action plan for top priorities.
- Begin implementation of the action plan.
- Develop an evaluation plan to monitor implementation and measure results.
- Meet periodically to monitor implementation and results.

Time Drivers

Aspects of the process that might unexpectedly lengthen your time line include:

- Inviting and incorporating additional partners into the planning and action process, if warranted
- Determining goals, objectives, and strategies to act on identified health priorities
- Researching effective interventions for possible use in the action plan

Budget Driver

Aspects of the process that may have an impact on your budget include:

- Facilitation assistance to help develop an evaluation plan with appropriate metrics



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A Guide to Achieving High Performance in Multi-Hospital Health Systems

March 2010



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Executive Summary

Multi-hospital health system leaders have a significant impact on the quality of health care in the United States. The 200 largest hospital systems (a hospital system being defined as having 2 or more general acute care hospitals) account for over half of all hospital admissions in the United States.

Through generous support from The Commonwealth Fund, the Health Research & Educational Trust (HRET) embarked on a project to identify and disseminate best practices associated with high performing health systems. Through the use of publicly available quality data, interviews with leaders of 45 multi-hospital health systems, and analysis, identified below are three major themes, four major best practice categories and seventeen specific best practices that are associated with high performance.

Major Themes

1. No one system type was most associated with high performance

We examined the relationships of many system characteristics to an overall composite measure of quality as well as to more specific measures, such as the HQA core measures, overall patient satisfaction, and a combined, risk-adjusted readmission rate and mortality rate. From the analysis, it was evident that high quality scores were achieved by a variety of different system types—large or small systems, geographically regional or multi-regional systems, systems from all regions of the country, and systems with differing levels of teaching components.

2. No one factor was clearly associated with high performance

Over 50 system factors that might distinguish between top performing systems and those with lower quality scores were analyzed, and no one factor clearly separated the top systems from the others. In every single case, factors that were observable in high performing systems also existed in at least some of the lower performing systems. Moreover, there was no unanimity among top performing systems with respect to factors associated with high performance. As discussed in this guide, success depends on a range of actions.

3. Creating a culture of performance excellence, accountability for results, and leadership execution are the keys to success

From the study, a culture of performance excellence and accountability for results was strongly exhibited during the interviews with the high performing health systems. This was best defined through cultural markers such as: focusing on continuous improvement, driving towards dramatic improvement or perfection versus incremental change, emphasizing patient-centeredness, adopting a philosophy that embraces internal and external transparency with regard to performance, and a having a clear set of defined values and expectations that form the basis for accountability of results. The other finding connected with the culture of performance excellence was a disciplined and persistent focus by leadership on execution and implementation to achieve the lofty goals. The culture of performance and excellence was strongly connected to leadership's execution doctrine.

Best Practices Associated with High Performing, Multi-Hospital Health Systems

1. Establish a System-wide Strategic Plan with Measurable Goals

- A. Set both measurable short and long-term goals.
- B. Set goals for quality and safety based on the pursuit of perfection rather than improvement.
- C. Link the system's quality goals with its operational and financial goals.

A system-wide strategic plan for quality and safety with measurable goals across multiple dimensions is a best practice for improving system performance. Many systems also establish threshold, stretch, and (in some cases) high stretch goals. They then track the progress of achieving these through frequently using system performance dashboards.

2. Create Alignment Across the Health System with Goals and Incentives

- A. Establish system-level quality steering/oversight committees to provide direction to system leaders in setting system-wide goals and aligning them with all hospitals.
- B. Embed health system goals into individual hospital leaders' goals.
- C. Link annual bonuses for system and hospital leaders to performance targets in the system's key strategic areas.
- D. Align incentive pay and/or accountability for achieving system-level quality and patient safety targets into contracts with physicians.
- E. Align emphasis on culture with efforts to understand and improve it.

Aligning the system's quality and safety goals with the goals of the individual hospitals as well as the hospital leaders' is a practice used by top performing systems to improve system performance. Having highly aligned goals facilitates performance tracking and reporting across multiple hospitals and promotes standardization in performance measurement. Additionally, aligning performance incentives (financial or other) for system and hospital executives with the system's strategic goals (e.g., quality, patient satisfaction, financial) is a strategy top performing systems use to improve overall performance.

3. Leverage Data and Measurement Across the Organization

- A. Use an "all or none" or "perfect care" approach to set targets for all performance measures.
- B. Consider setting targets based upon event counts (numerator) as well as rates.
- C. Share dashboards with hospital leaders and staff frequently to identify areas in need of improvement and then take immediate actions to get back on track.
- D. Post dashboard information on the system's intranet.
- E. Engage in national benchmarking initiatives to achieve greater transparency as well as foster healthy competition between hospitals.
- F. Utilize corporate support through data mining of existing information systems, frequent analyses, and reporting of measures for hospital-level performance improvement.

High performing systems use dashboards (e.g., a balanced scorecard) to measure and manage system performance. Setting system-level targets within each strategic priority area is also a strategy used by top performing systems to improve performance across hospitals. Additionally, sharing system dashboards regularly with hospital leaders, clinicians, and other staff helps promote quality improvement and accountability.

4. Standardize and Spread Best Practices Across the Health System
A. Establish a process to identify and select practices for standardization.
B. Use ongoing education and skills development to spread best practices.
C. Effectively disseminate best practices across the system.

In order to successfully adopt best practices, the standardization of care processes and the use of education and skills development programs are vital in the spread of best practices as well as the acceleration of their use among the entire health system.

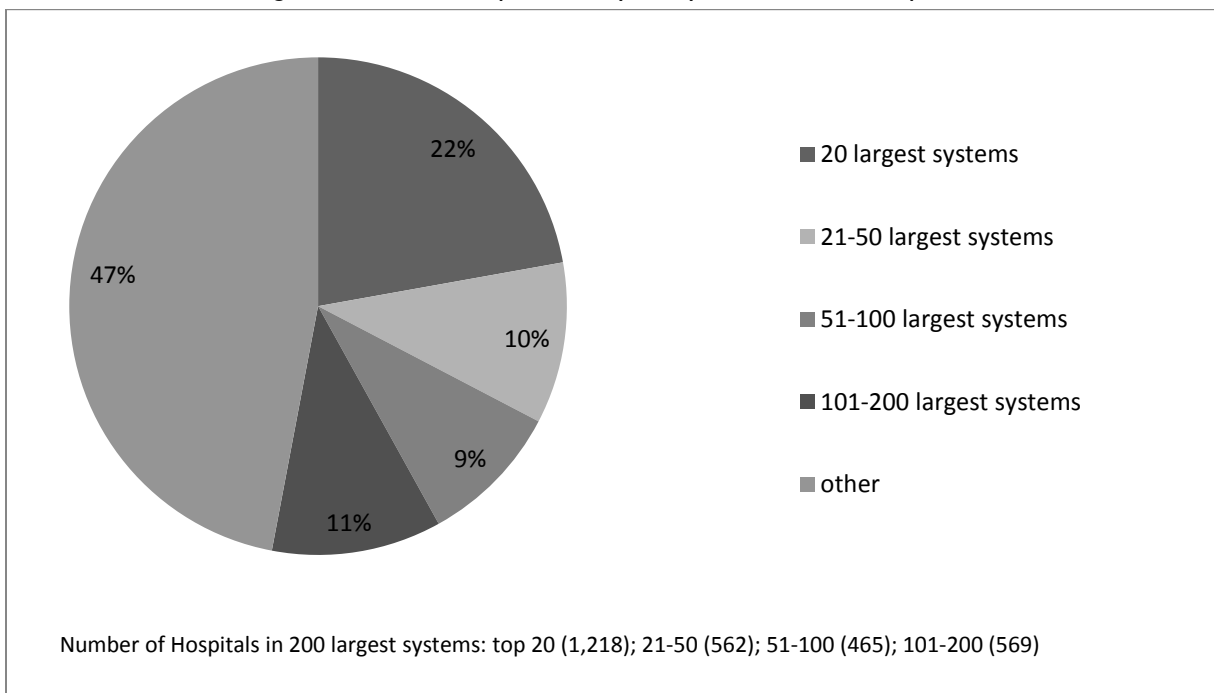
Multi-hospital health system leaders can employ a variety of practices to improve care across their multi-facility organizations that focus upon overall system improvement. However, the keys to success are not the specific practices themselves, but the execution of those practices and the creation of a culture that supports performance improvement.

Introduction

Leaders of hospitals and health systems play a vital role in driving quality and patient safety care.¹⁻³ Organizational leaders, along with their boards, establish the strategic plan, set goals, and drive the execution of reliable processes to improve, spread, and sustain performance improvement.

Leaders of multi-hospital health systems play a critical role in patient care in the United States. Multi-hospital health systems are the most common organizational structure in the hospital industry. Two hundred hospital systems (a hospital system being defined as having 2 or more general acute care hospitals) account for half of all hospitals and hospital admissions in the United States. Figure 1 depicts the large volume of care provided by the largest health systems in the country.

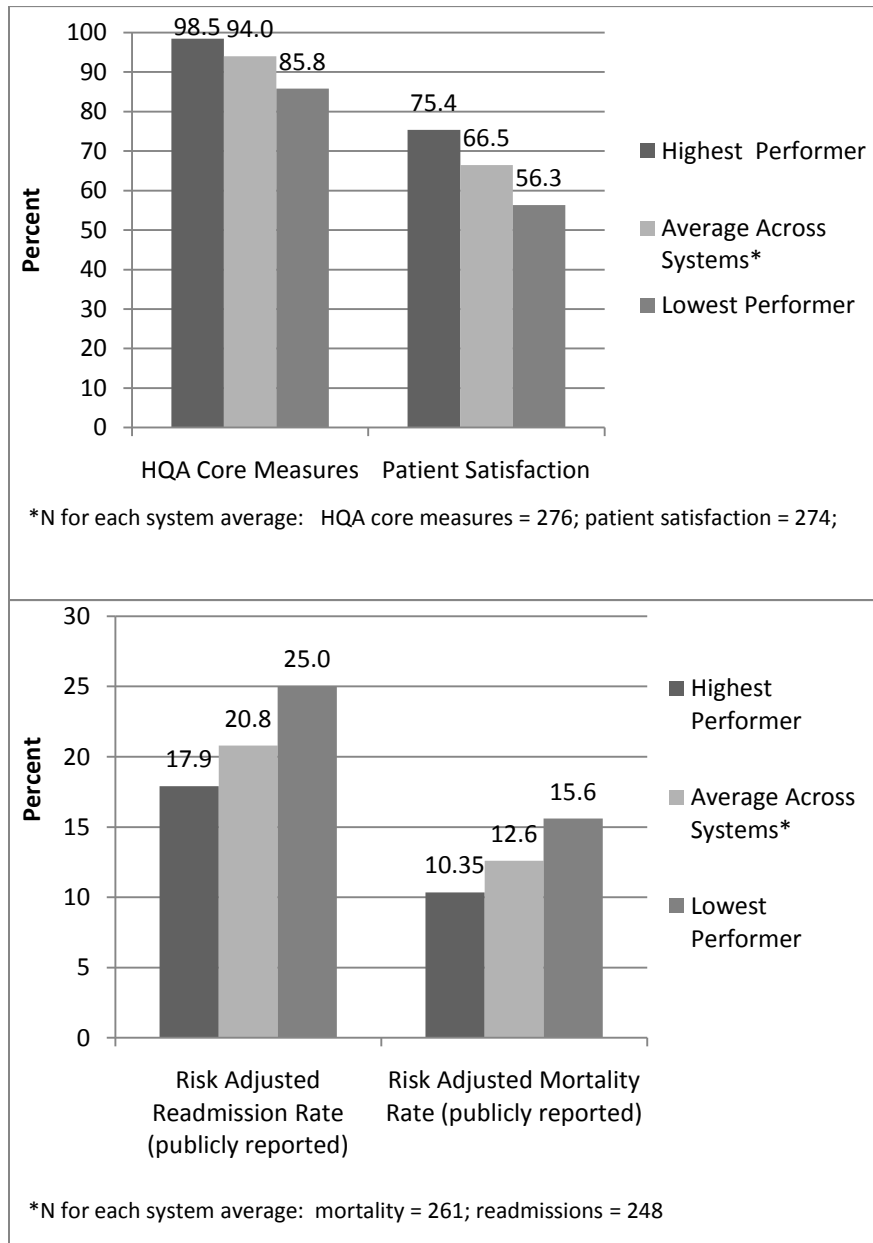
Figure 1: Percent of Inpatient Stays in System-Affiliated Hospitals



However, even though many hospitals are parts of larger health care systems, the role of health system leaders in strengthening quality and safety is less well understood. While system leadership makes key decisions related to purchasing, negotiations with insurers, and capital investments, whether, and how, they can influence the quality of care that their hospitals' patients receive has been unclear. This guide asserts that system leaders can dramatically impact care quality across their systems and explains how system leaders can achieve this goal.

Current data demonstrate a national opportunity for improvement. Figure 2 below illustrates the difference in performance on publicly reported core measures, risk adjusted readmission rates and risk adjusted mortality rates for three common conditions, and patient satisfaction. While all of this information is currently publicly reported at the hospital level, only recently has this data been aggregated to the health system level.

Figure 2: Differences in System Performance



A concerted effort by the leaders of the 200 health systems to assure that their patients obtain the highest quality, safest care has the potential to dramatically impact overall care quality throughout the United States.

Purpose and Approach

The purpose of this guide is to inform system leaders about what they can do to insure that patients across all of their hospitals receive the highest quality care available. It is based on three sources of information:

- Publicly available quality information: For each system we created aggregate measures of quality using the HQA core measures, risk-adjusted readmissions, risk-adjusted mortality (based on rates for acute myocardial infarction, congestive heart failure, and stroke), and patient experience. While all of these measures are reported for hospitals at the CMS *Hospital Compare* website⁴, for this project we aggregated them to reflect the experience of all patients within the system.
- System level information contained in the American Hospital Association database: We examined the relationships of many system characteristics to our overall quality measure. These included location, size, ownership type, extent of centralization, and other factors that may be related to the quality of care a system provides.
- System quality activities elicited in a survey: We interviewed leaders from over 45 health care systems that represented a broad range of quality scores. We asked them to rank their system on key dimensions, describe their quality monitoring and improvement efforts at the system level, and reflect on what they believed was working and why. Their insights provided much of the information shared in this guide. The survey (see Appendix A) focused on multiple dimensions of health system management, including those found in Table I below.

Table I: Major Survey Topics

Corporate health system structure	Accountability and use of incentives for quality goals	Use of health information technology
Alignment of goals between corporate and individual hospitals	Standardization and spread of best practices	Communication systems
Use of performance measurement across the health system	Centralization of services and decision-making	Implementation of a culture of quality and patient safety

We recognize that there are many limitations to this study. The publicly available data is mostly based on Medicare data and limited dimensions of overall health system performance. We did not interview every health system, but a sample of health systems. Additionally, only one leader per system was interviewed. Finally, not all relevant information can be captured in an hour-long interview. This guide is not intended to be a comprehensive resource of all factors related to health system performance as there may be best practices not discussed herein. The goal of this guide is to communicate examples of practices that are most associated with high performance in order to share what we learned as well as opportunities for improvement.

Analysis

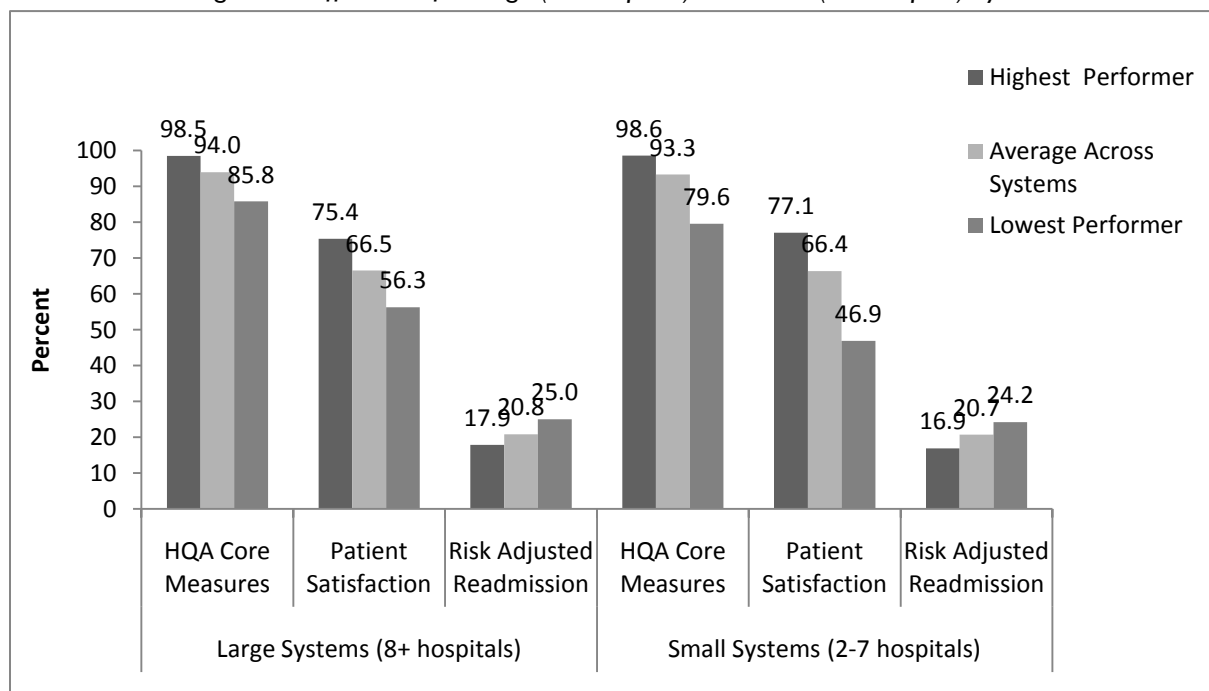
Our analysis leads to a number of specific recommendations for consideration by system leaders seeking to drive quality and safety improvements across their organizations. But there are three general observations about our findings that lay an important foundation for the recommendations that follow. These observations are:

1. High quality care is found in every type of health system.
2. No single factor produces high quality care in a health system.
3. Creating a culture of performance excellence, accountability for results, and leadership execution are the keys to success.

Observation 1: High Quality Care Is Found in Every Type of Health System

We examined the relationships of many system characteristics to an overall composite measure of quality as well as to more specific measures, such as the HCA core measures, overall patient satisfaction, and a combined, risk-adjusted readmission rate and mortality rate. Regardless of the quality measure, the most important conclusion we reached from our analyses is that high quality is delivered across different types of systems. High quality scores are achieved by: systems with a large or small number of hospitals, systems from all regions of the country, systems that are regionally based or multi-regional, and systems that have different levels of teaching components. As an example, Figure 3 illustrates the differences in quality measures between large and small systems.

Figure 3: Differences for Large (8+ hospitals) and Small (2-7 hospital) Systems



We observed the same variability within geographic regions, with systems in all four regions differing by at least 10% on the core measures, by 15% in patient satisfaction, and by 5% in risk-adjusted readmissions.

Even though some system characteristics were statistically related to the quality measures, none of these relationships was so strong a predictor of quality that success or failure was inevitable. So whatever the type of system—regardless of its size, geographic location, or financial situation—it can achieve high quality care.

Observation 2: No Single Factor Produces High Quality Care in a Health System

Although we examined over 50 system factors that might distinguish between top performing systems and those with lower quality scores, no one factor clearly separated top systems from others. In every single case, factors that were observable in high performing systems also existed in at least some of the lower performing systems. Moreover, there was no unanimity among top performing systems with respect to factors associated with high performance.

Although simplistic solutions are appealing, these solutions are often wrong. The goal of providing consistently high quality care is achievable, but not through any one single change. Instead, success depends on a range of actions that are discussed later in this guide.

Observation 3: Creating a Culture of Performance Excellence, Accountability for Results, and Leadership Execution are the Keys to Success

We found that many of the lower performing systems had many of the same processes, policies, and structures as those with very high quality scores. But in our conversations with system leaders, distinctions became apparent. In some cases, lower performing systems had made changes recently that were likely to enhance quality, but hadn't yet. In other cases, a myriad of positives were offset by a single significant weakness. And in some cases, while the processes and policies appeared to be in place on paper, the passion and commitment to them seemed lacking.

Every single leader of a high performing system who we interviewed was passionate about making their system one where each patient received safe, high quality care in each encounter. Many had been pursuing this goal for years, and were part of a system where this goal was shared by all. All acknowledged quality and safety failures, but could clearly see the progress their organization was making towards achieving their quality and safety goals. So while the specific recommendations in the remainder of this guide are very useful, they cannot substitute for a culture where safe, high quality care is paramount and where the pursuit of this goal is a continuous high priority rather than a short term emphasis. High performing hospital systems exhibited a culture of performance excellence, continuous improvement, and accountability for results. Systems with a strong culture of quality and safety demonstrated the following elements:

- A shared, system-wide commitment/focus on achieving the system's quality and patient safety goals (e.g., "system management is as important in achieving quality goals as is physician compliance with evidence-based guidelines. So complying with evidence-based guidelines becomes not just a physician responsibility but a system responsibility as well").

- A system board that is very engaged in quality and safety, e.g., board is directly involved in setting the system's strategic goals for quality and safety and in frequent monitoring (at least monthly) of hospitals' progress toward achieving these goals.
- Extensive opportunities and vehicles for hospitals to collaborate and share best practices for improving quality and safety.
- Transparency around reporting performance both internally and externally.
- An emphasis on the importance of teamwork to improve quality and safety and shared accountability for good outcomes.
- Having a mindset of perfect care and dramatic increases or stretch goals as compared to incremental improvement.

As a corollary, lacking a uniform culture across hospitals, within-hospital resistance to culture change, and the absence of leadership commitment to culture were cited as barriers to performance improvement.

Best Practices of High Performing, Multi-Hospital Health Systems

Although there are a number of examples of best practices associated with high performing health systems, the following are examples of some of those found from our study along with specific examples from various health systems. The table, in its entirety, is in Appendix B.

Category I: Strategic Planning

I. Establish a System-wide Strategic Plan with Measurable Goals
A. Set both measurable short and long-term goals.
B. Set goals for quality and safety based on the pursuit of perfection rather than improvement.
C. Link the system's quality goals with its operational and financial goals.

Health systems continue to evolve, as evidenced by the myriad of different infrastructures that exist within well-established and newly-formed systems. Strategic planning for system-wide quality and safety improvement has also become increasingly prevalent over time. Having a system-wide strategic plan for quality and safety with measurable goals across multiple dimensions is a best practice for improving system performance. Many systems establish threshold, stretch, (and for some) high stretch goals and then track the progress frequently using system performance dashboards.

A. Set both measurable short and long term goals

Many organizations set annual goals (short term), as well as three to five year goals (long term) in key quality and patient safety areas.

B. Set goals for quality and safety based on the pursuit of perfection rather than incremental improvement.

Organizations use a variety of approaches to goal setting, including considering statistically significant improvement from the previous year, top decile nationally, or an “all or none” method, such as striving for zero harm events or 100% of perfect care. The common theme is that the goals are stretch goals and represent for the organization a dramatic improvement versus incremental improvement.

At Covenant Health System, Inc., when all facilities are meeting a system goal (e.g., the top decile for a national benchmark) they set a more aggressive stretch goal based upon their internal performance.

IASIS sets system goals using the highest benchmark available (e.g., a state benchmark instead of national).

This is similar at Memorial Hermann Health System where threshold targets are set at the 85th percentile and stretch targets are set at the 90th percentile of national benchmarks. When national benchmarks are not available or they have exceeded the top decile of performance, they look at internal data and set a new (higher) target percentage improvement. Setting very high stretch goals and achieving these goals was cited as having had the greatest impact on their system's performance within the past two years.

C. Link the system’s quality goals with operational and financial goals

For many organizations, the link between quality and finance are critical to their strategic plan.

Aurora Health System established a new area called Care Management Growth to examine the impact of quality improvement on revenue and expenses. They analyzed the number of lives touched and number of dollars saved due to quality improvement initiatives. Each year they plan to focus on four key evidence-based initiatives that are expected to enhance operational performance.

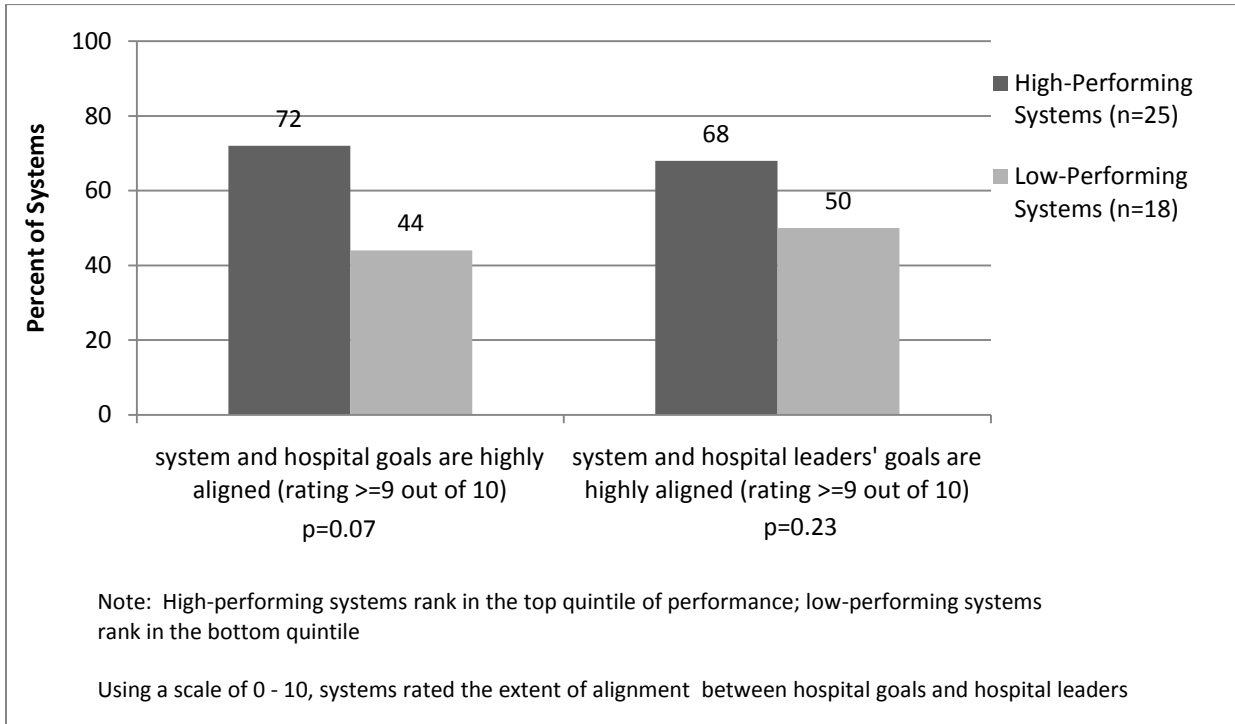
As another example, Bon Secours ties finance, quality, and operations together to meet the system’s strategic objectives. Goal setting is done collaboratively using a “clinical transformation collaborative” which includes the following staff from each local facility: (1) vice president of medical affairs; (2) chief nursing officer; and (3) chief financial officer. Choosing the “right” quality of care issues will result in financial savings for the system and increase capacity to care for more patients without needing to add more staff.

Category 2: Alignment

2. Create Alignment Across the Health System with Goals and Incentives
A. Establish system-level quality steering/oversight committees to provide direction to system leaders in setting system-wide goals and aligning them with all hospitals.
B. Embed health system goals into individual hospital leaders’ goals.
C. Link annual bonuses for system and hospital leaders to performance targets in the system’s key strategic areas.
D. Align incentive pay and/or accountability for achieving system-level quality and patient safety targets into contracts with physicians.
F. Align emphasis on culture with efforts to understand and improve it.

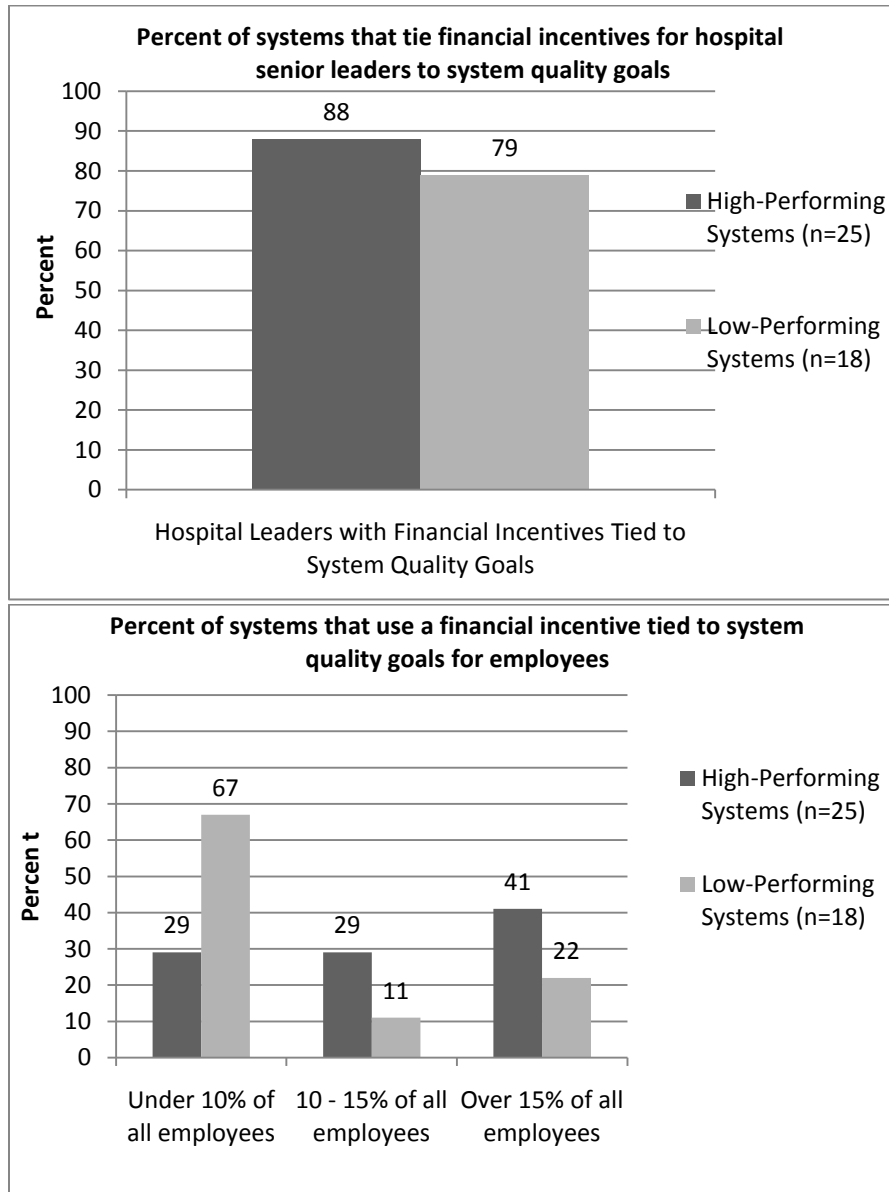
Aligning the system’s quality and safety goals with the goals of the individual hospitals and hospital leaders’ is a practice used by top performing systems to improve system performance. Having highly aligned goals facilitates performance tracking and reporting across multiple hospitals and promotes standardization in performance measurement. Aligning performance incentives (financial or other) for system and hospital executives with the system’s strategic goals (e.g., quality, patient satisfaction, financial) is a strategy top performing systems use to improve overall performance. We found that compared to other systems, high performing systems believed there was higher alignment between the system’s quality goals and those of the system hospitals and hospital leaders (Figure 4).

Figure 4: Goal Alignment between the System, Hospitals and Hospital Leaders



High performing systems linked financial incentives to quality goals for a higher percentage of their staff and had more hospital leaders with financial goals aligned with system performance (Figure 5).

Figure 5: Linkages between System Goals and Financial Incentives



Note: High performing systems rank in the top quintile of performance; low performing systems rank in the bottom quintile.

From our discussions with multiple health systems it is clear that alignment is operationalized in different ways. For example, a highly centralized approach is to set goals, measures, and programs at the system level and then standardize these across hospitals. A more coordinated, decentralized approach is one in which the system sets the goals but allows individual hospitals to decide how they will achieve them.

Furthermore, since individual hospitals within a system may be at different starting points with respect to performance, systems may choose to set hospital-specific targets instead of a standard system-wide target. This practice reinforces the point that each system's approach to alignment will differ based upon their hospitals' performance levels, targets, and opportunities for improvement.

Additionally, although striving for "perfection" as a goal may be the strategic target; financial incentives are often based on other targets that are representative of progress toward perfection. This practice is common among high performers and demonstrates their flexibility in executing system strategies effectively.

To align goals and incentives, systems can:

A. Establish system-level quality steering/oversight committees to provide direction to system leaders in setting system-wide goals and aligning them with hospitals.

Most organizations have system-level committees that include multiple clinical and operational leaders across the organization for the collaborative purposes of:

- Setting goals
- Identifying major initiatives for participation
- Overseeing major project implementation
- Reviewing performance measurement standardization
- Overall support of the execution of the quality strategic plan

As was specifically noted in many of the interviews, nursing professionals play an integral role in the system-level oversight and support and linkage to the front-line care and improvement.

B. Embed health system goals into individual hospital leaders' goals.

For some organizations there are system-wide goals for which all hospital leaders are held accountable.

At Mayo Clinic, there are seven system-wide goals that leaders must focus on.

C. Link annual bonuses for system and hospital leaders to performance targets in the system's key strategic areas.

Organizations connect financial incentives to system goals through a variety of mechanisms.

At Baylor Healthcare System, 50% of performance-based compensation (compensation at risk related to performance ranges from 15% of base salary for hospital unit directors to approximately 50% of base salary for senior system leaders) is based on achieving system goals which are derived from one of four pillars: (1) people (nursing retention), (2) service (patient satisfaction), (3) quality (includes hospital standardized mortality reduction and the CMS/Joint Commission 16-item core measure composite), and (4) finance.⁵

At Bon Secours Health System, 25% of incentive pay for system and hospital leaders is tied to goals within each strategic pillar: (1) liberating the potential of people (patient and employee satisfaction); (2) extraordinary care (quality); (3) partisan to the community (community service); and (4) financial operations. By holding everyone in senior management accountable for reducing mortality from sepsis,

they have reduced the mortality rate for patients presenting to the ED with sepsis by more than 50% in just 2.5 years.

At Providence Health and Services, 60% of leaders' incentive pay is linked to overall system performance and 40% linked to regional, local or personal goals. System targets are based upon (1) mission; (2) people; (3) service; (4) quality (clinical reliability index which is a composite of all core measures); (5) financial; (6) expanding service.

D. Align incentive pay and/or accountability for achieving system-level quality and patient safety targets into contracts with physicians.

John Muir Health began incentivizing their physicians two years ago. They are held accountable for specialty-specific quality metrics that can be impacted by their performance. For example, surgeons are held accountable for surgical quality and safety indicators. Transparency rather than pay is the incentive, as physicians' performance is reported across the system each year by medical leadership.

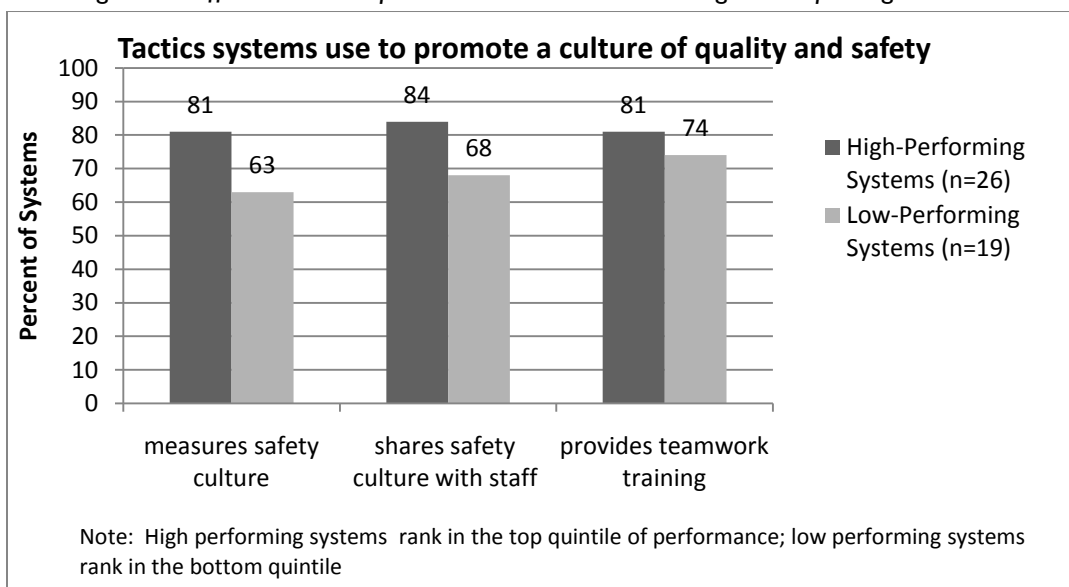
At Nebraska Methodist Health System, over 10% of hospitalists' pay is linked to system quality goals.

At Memorial Hermann Health System, quality performance targets are included in contracts with physicians. Including patient safety indicators in all employees' incentives plans, including physicians, has been a very effective approach to reducing the rate of safety events across the system.

E. Align emphasis on culture with efforts to understand and improve it

While virtually all system leaders attest to the importance of a culture of safety, high performing systems tend to go further in measuring their culture, communicating its importance to staff, and providing training designed to improve it. Figure 6 (on page 14) illustrates these differences.

Figure 6: Differences in Emphasis Placed on Understanding and Improving Culture



Systems that fail to align their metrics with their core values are less likely to achieve outstanding results.

Category 3: Leverage Data

3. Leverage Data and Measurement Across the Organization
A. Use an “all or none” or “perfect care” approach to set targets for all performance measures.
B. Consider setting targets based upon event counts (numerator) as well as rates.
C. Share dashboards with hospital leaders and staff frequently to identify areas in need of improvement and then take immediate actions to get back on track.
D. Post dashboard information on the system’s intranet.
E. Engage in national benchmarking initiatives to achieve greater transparency as well as foster healthy competition between hospitals.
F. Utilize corporate support through data mining of existing information systems, frequent analyses, and reporting of measures for hospital-level performance improvement.

High performing systems use dashboards (e.g., a balanced scorecard) to measure and manage system performance. Dashboards enable systems to translate priorities for quality and safety improvement, fiscal performance, and customer satisfaction into measurable targets. Setting system-level targets within each strategic priority area is a strategy used by top performing systems to improve performance across hospitals. Sharing system dashboards regularly with hospital leaders, clinicians, and other staff helps promote quality improvement and accountability.

Below are several approaches that systems can use to set performance targets:

A. Use an “all or none” or “perfect care” approach to set targets for all performance measures.

High performing health systems are more likely to use composite measures or bundled measures for driving performance improvement. This may include an “all or none” approach where you only receive credit for meeting all the measurement or care standards for a specific condition set. Alternatively, organizations can or bundle different measures into a composite metric.

At John Muir Health the goal for CMS core measures is that 95% of all patients will receive all of measures. For harm measures the goal is set at zero.

At Novant, the top decile of performance is the goal for every indicator on their scorecard. As a system they score themselves based upon the percentage of indicators that are $\geq 90^{\text{th}}$ percentile. The system’s target is to have at least 75% of all indicators on scorecard at or above top decile.

At Alegent Health, when they reached 98% compliance on core measures, they took system performance to the next level and created an “evidence-based care composite score.” This score combines all clinical processes of core measures and clinical outcomes targets.

Covenant Health (Tennessee) created a new "safety bundle" performance target which encompasses medication errors, falls, and hospital-acquired infections.

Aurora Health System uses a “care management impact score” to assess system-wide performance, a composite score that combines performance on 33 quality and safety indicators.

B. Consider setting targets based upon event counts (numerator) as well as rates.

In addition to tracking rates, which are often useful for benchmarking and performing risk adjustment, systems may use actual event counts (e.g., the number of patient deaths) to assess performance. Using event counts to report performance may reveal additional areas for improvement and help systems drive toward achieving perfect care scores.

At Mayo Clinic, once they surpassed the top decile of performance they changed the way they set targets. For example the target for reducing hospital-acquired infections is now set based upon the patient count rather than the rate.

Similarly Covenant Health (Tennessee) uses the number of patient events (numerator) rather than the rate for their harm reduction target.

C. Sharing dashboards with hospital leaders and staff frequently.

At Covenant Health (Tennessee), quality scores for each facility are reported monthly. If they see that one is going off course, they have a chance to devise an action plan and get back on course much more quickly than would otherwise be possible.

At Partners Health Care, internal reporting of performance has proven to be an effective incentive for improvement – such transparency promotes healthy competition among its hospitals to strive to do better as compared to their colleagues.

At North Mississippi Health Services and IASIS, sharing results with staff on core measure performance is a major contributor to the system’s performance improvement within the past two years.

D. Post dashboard information on the system’s intranet.

This is a commonly used approach for systems to provide all employees access to up-to-date information on system and hospital-specific performance.

E. Engage in national benchmarking initiatives to achieve transparency and foster competition.

Compared to other systems, high performing systems participated in national improvement initiatives 7% more frequently. The transparency and public commitment required by these activities has played a significant role in performance improvement for all healthcare organizations. By publicly reporting their information and participating in national or regional benchmarking or quality collaborative activities has shined the light on opportunities for improvement and spurred pressure to improve. Examples include participation with VHA, Premier, IHI, and state hospital association activities, among other collaboratives.

For example, at Baystate Health in Massachusetts, participation in a variety of collaboratives, such as Premier QUEST and CMS Hospital Quality Improvement Demonstration Project, has improved transparency and served as a strong incentive for improvement.

Through its engagement in Thomson-Reuters programs and databases, Health Quest has promoted greater standardization of performance measurement across the system and transparency—“wanting to look better, not worse than the next person” has been a major motivator to improve.

F. Utilize corporate support through data mining of existing information systems, frequent analyses, and reporting of measures for hospital level performance improvement.

Health system corporate quality and patient safety departments may provide the enterprise significant support through data mining, analysis, and reporting to support individual hospital level improvement.

For example, Catholic Health Initiatives uses its corporate business intelligence teams to support the quality functions.

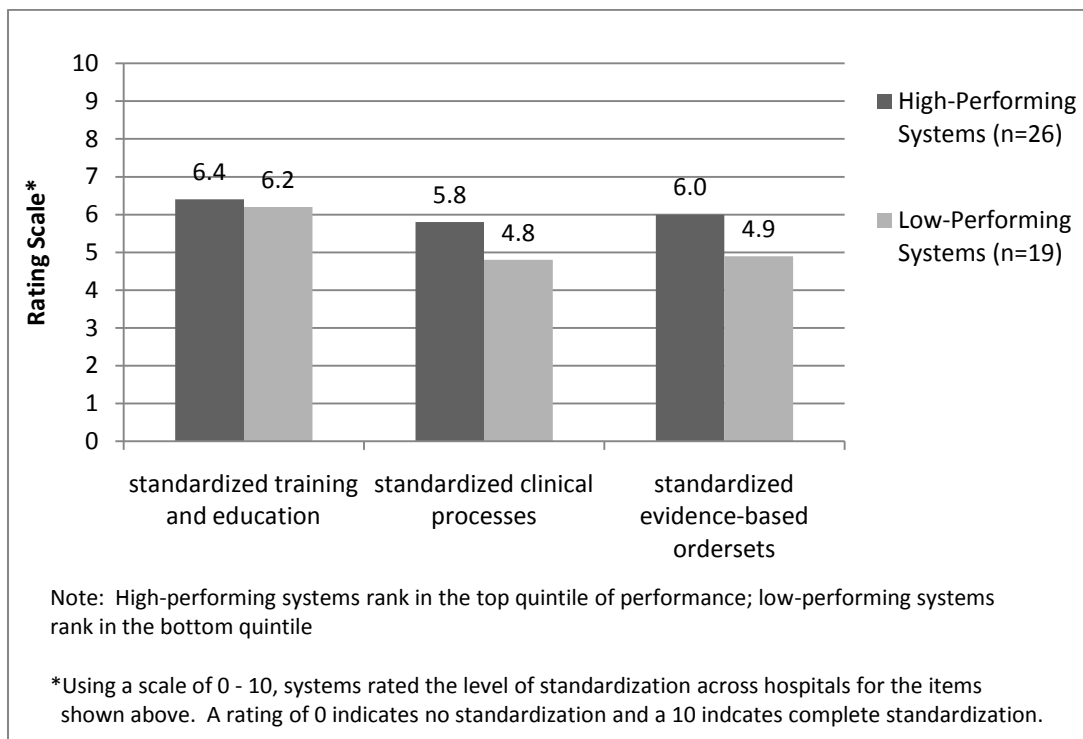
At Catholic Healthcare Partners, the corporate department provides support for standardization and reporting of quality measures across the system, as well as ad hoc information as needed.

Category 4: Standardize and Spread Best Practices Across the System

4. Standardize and Spread Best Practices Across the Health System
A. Establish a process to identify and select practices for standardization.
B. Use ongoing education and skills development to spread best practices.
C. Effectively disseminate best practices across the system.

One of the fundamental opportunities for a health system is to standardize care processes and to accelerate learning among the health system organization for adoption of best practices.

Figure 7: Levels of Standardization for High and Low Performing Systems



Higher performing systems tended to report more standardization for both their training and care processes. These differences may not directly produce differences in care quality, since it's quite possible to standardize on paper processes that are very different in practice. However, systems that have made the effort to work through these issues and build consensus relate to standardization may achieve better results.

A. Establish a process for identifying and standardizing best practices.

High performing health systems employed multiple and various ways for identifying and standardizing best practices across the health system. Although local autonomy is important, for the high performing systems, there is an expectation that evidenced based practices are consistently implemented throughout the health system in every facility.

At Avera Health, there is a best practice committee comprised of quality directors and clinical leaders from each region. Best practices are identified using outcomes data. Strategies from hospitals with the best outcomes are selected for system-wide implementation.

Alegent Health standardizes best practices by creating system-wide evidence-based order sets.

At Providence Health and Services, when evidence-based best practices are identified, system leaders decide which ones to standardize and determine the process for how standardization will occur. For example, in the past 10 months they have adopted 2 standardized processes: the WHO surgical safety checklist and protocol for screening and prevention of excessive bilirubin in newborns. Individuals responsible for implementing these in a common fashion are then identified.

At Catholic Health Initiatives, the selection process occurs collaboratively between the staff from the national office and the local hospital markets. On an annual basis, the collaborative identifies evidence-based practices being used either in one of the local markets or from the medical literature. They then roll out policies and procedures linked to these best practices. This year they are rolling out 15 bundled best practices.

Ardent Health Services uses their clinical quality council to identify and spread evidence-based best practices across the system.

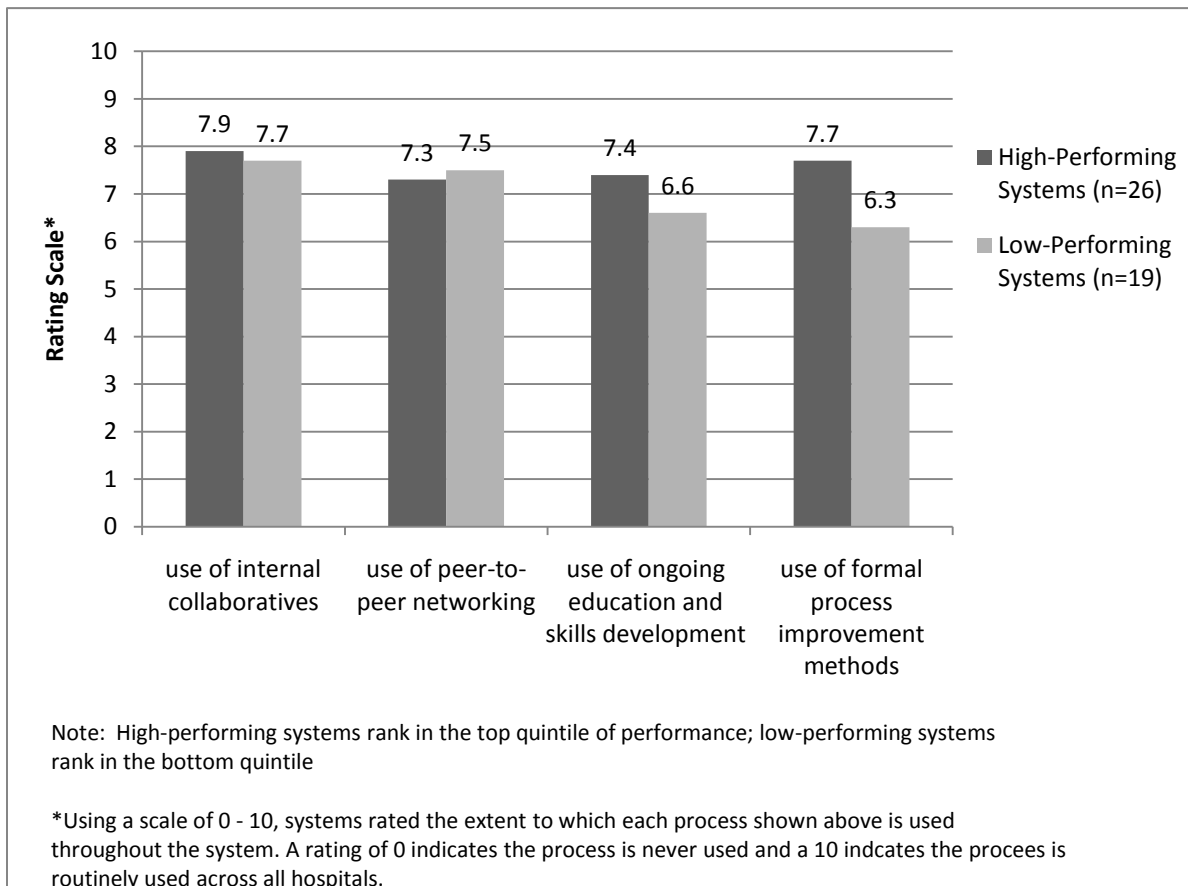
At IASIS, system-level best practices are determined in partnership with its hospitals. For example, system-wide adoption of multi-disciplinary ICU rounding came out of hospital participation in IHI.

Virtua Health uses a six-sigma mechanism for deployment. Each time a facility-specific quality improvement (QI) project is completed, black belts are required to describe (and document) to others throughout the system on how they will spread and implement the practice throughout the system.

B. Use of ongoing education and skills development to spread best practices throughout the system.

From the interviews with the health systems, high performance health systems noted they were more likely to use ongoing education and skills development to spread best practices. For example, expanding the role of nurses to include participation in system-wide quality improvement initiatives was cited as a key driver of performance improvement by high performing health systems. Specifically, nurses being accountable for entering heart failure discharge instructions and for following up with physicians regarding ACE inhibitor use led to measurable improvement. Figure 8 contrasts top and other systems on the extent to which the system employs a variety of strategies to educate their personnel and improve their processes. With one exception, higher performing systems make greater use of these strategies.

Figure 8: Use of Strategies to Strengthen People and Processes



As an example, at Catholic Healthcare Partners, the system CEO personally participates in Leadership WalkRounds at the individual facilities for improving patient safety. The CEO's experience has been profound, and the feedback from all the participating facilities and their staff has had a positive effect as a mechanism for improving safety system-wide.

C. Effectively disseminate best practices across the health system

Although best practices may be identified, the effective and efficient dissemination and adoption of better practices by other parts of the health system requires strong processes.

Baystate Health, for example, hardwires the practices by incorporating best practices and clinical guidelines into their electronic medical record system.

Aurora Health System has created a searchable "lessons learned database" to capture best practices for staff.

Iowa Health System stores best practices electronically, and they are made accessible via the intranet.

Conclusion

The findings of this study, as evident in the major themes and the best practices, demonstrate the significant potential and opportunity for delivering high quality care in the United States by health systems. Effective system-wide strategic planning, alignment across the enterprise, leveraging data and measurement for performance management, and implementing standardization and spread of best practices throughout the system are important elements to high performance. However, these practices rest upon a foundation that includes a culture that enables performance improvement and effective and efficient execution as the keys to success.

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Appendix A: High Performing Health System Survey

The following represent the major interview questions asked of health system leaders.

A. People

1. Please indicate whether the following positions exist at the system level and how long they have existed: a. CQO (chief quality officer); b. CPSO (chief patient safety officer); c. CMO (chief medical officer); d. CNO (chief nursing officer)
2. Is there a health system or corporate quality department?
3. Is there a health system-wide quality steering committee?
4. Does your health system have a corporate or system board quality committee?

B. Goal Alignment

5. Does the health system have quality and safety improvement goals?
6. To what extent are the quality and safety improvement goals of each hospital aligned with those of the whole system?
7. To what extent do hospital leaders' (e.g., hospital CEO's) goals align with the system goals?

C. Quality Measurement/Reporting

8. Do you have a health system dashboard for reporting system-level quality performance?
9. To what extent is performance measurement standardized across the system?
10. How are performance targets for the system set?
11. Does each hospital in the health system use the same targets or does it vary?

D. Incentives/Accountability

12. Do the corporate health system leaders have financial incentives linked to the overall performance of the health system? On what measures and what percentage?
13. Do the individual hospitals' senior leaders have financial incentives linked to the overall performance of the health system? If yes, who (e.g., CEO, COO, CMO, CNO)? On what measures and at what percentage?
14. Do you incorporate performance measures and accountability for targets into contracts with medical staff? Affiliated physicians?
15. What percentage of your employees have an annual financial incentive specifically tied to quality goals?
16. Other than financial, what, if any, other types of incentives are used?

E. Standardization and Spread of Best Practices

17. What is your policy and process for standardizing best practices across the system?
18. To what extent are the following standardized across all hospitals in the system: a. quality and safety policies and procedures; b. training and education programs; c. clinical processes; d. evidence-based order sets (for both medicine and nursing).
19. Overall, how well does your health system efficiently and effectively deploy best practices across the health system?

F. Centralization

20. How centralized is overall decision-making in the health system?
21. How centralized is quality and patient safety (measurement, resource allocation, best practice standardization, etc.) in the health system?
22. How integrated is the health system across clinical services and service line management?

G. Health Information Technology (HIT)

23. How far along is your health system with respect to having a fully deployed CPOE?
24. Do you have an electronic health record in your health system?
25. Do you have a strategic goal that specifies when (which year) you will achieve full deployment and use?

H. Communication

26. How frequently are strategic priorities and initiatives to improve quality and safety communicated and by what means?
27. Do you have a common information system for reporting errors, complications, and health-care associated infection rates across the health system?
28. How are adverse events or patient safety/quality triggers alerted throughout the health system and addressed? For example, if an adverse event occurs in one site, how are all hospitals alerted and how are practices put in place to prevent those events?
29. How well do you think this process of alerting other hospitals and implementing changes quickly and effectively across all hospitals occurs?
30. Does your system use de-identified reporting of serious adverse events as a strategy to generate impetus for change internally?
31. Is there a system-wide policy for disclosing errors to patients and families?

I. QI Initiatives

32. To engage staff across multiple hospitals to participate in QI initiatives, do you: a. offer incentives (financial or other) to physicians; b. offer incentives (financial or other) to clinicians other than physicians; c. include participation in QI work as part of performance evaluation criteria; d. link opportunity for promotion to participation in QI work

J. QI Training/Development

33. Is formal quality improvement training provided by corporate/health system?
34. How long does this training last (e.g., < 1 day, several days, a week)?
35. How frequently is the training offered (one-time training, annually, etc)?

K. Culture

36. As a health system leader, how do you promote a culture that perceives quality as a core value? Do you: a. conduct annual culture surveys; b. share survey results with staff; c. provide teamwork training on improving quality and safety; d. have HR policies that promote a culture of safety and quality; e. produce a health system annual report on quality and patient safety
37. How would you rate your system's emphasis on establishing a culture of quality and patient safety?

Appendix B: Major Themes and Best Practices Associated with High Performing, Multi-Hospital Health Systems

Major Themes

- | |
|--|
| 1. No one system type was most associated with high performance. |
| 2. No one factor was clearly associated with high performance. |
| 3. Creating a culture of performance excellence, accountability for results, and leadership execution are the keys to success. |

Best Practices Associated with High Performing, Multi-Hospital Health Systems

1. Establish a System-wide Strategic Plan with Measurable Goals
A. Set both measurable short and long-term goals.
B. Set goals for quality and safety based on the pursuit of perfection rather than improvement.
C. Link the system’s quality goals with its operational and financial goals.
2. Create Alignment Across the Health System with Goals and Incentives
A. Establish system-level quality steering/oversight committees to provide direction to system leaders in setting system-wide goals and aligning them with all hospitals.
B. Embed health system goals into individual hospital leaders’ goals.
C. Link annual bonuses for system and hospital leaders to performance targets in the system’s key strategic areas.
D. Align incentive pay and/or accountability for achieving system-level quality and patient safety targets into contracts with physicians.
G. Align emphasis on culture with efforts to understand and improve it.
3. Leverage Data and Measurement Across the Organization
A. Use an “all or none” or “perfect care” approach to set targets for all performance measures.
B. Consider setting targets based upon event counts (numerator) as well as rates.
C. Share dashboards with hospital leaders and staff frequently to identify areas in need of improvement and then take immediate actions to get back on track.
D. Post dashboard information on the system’s intranet.
E. Engage in national benchmarking initiatives to achieve greater transparency as well as foster healthy competition between hospitals.
F. Utilize corporate support through data mining of existing information systems, frequent analyses, and reporting of measures for hospital-level performance improvement.
4. Standardize and Spread Best Practices Across the Health System
A. Establish a process to identify and select practices for standardization.
B. Use ongoing education and skills development to spread best practices.
C. Effectively disseminate best practices across the system.

Appendix C: Acknowledgements

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Chief Medical Officer, Atlantic Health

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James Conway
Senior Vice President, Institute for Healthcare Improvement

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The HRET Disparities Toolkit

A Guide for Collecting Race,
Ethnicity, and Primary Language
Information from Patients

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Project Team

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HRET Disparities Toolkit

A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients

Endorsed by the National Quality Forum

The Health Research & Educational Trust Disparities Toolkit provides hospitals, health systems, clinics, and health plans information and resources for systematically collecting race, ethnicity, and primary language data from patients. We trust you will find this Toolkit useful for educating and informing your staff about the importance of data collection, how to implement a framework to collect race, ethnicity, and primary language data at your organization, and ultimately how to use these data to improve quality of care for all populations.

**An online version of the HRET Disparities Toolkit is available at
<http://www.hretdisparities.org/>.
The online version contains many additional resources and web links.**

How to Use the Toolkit

The Toolkit is designed to help hospitals, health systems, community health centers, medical group practices, health plans, and other users understand the importance of collecting accurate data on race, ethnicity, and primary language of persons with limited English proficiency and/or who are deaf or hard of hearing. By using this Toolkit, health care organizations can assess their organizational capacity to collect this information and implement a systematic framework designed specifically for obtaining race, ethnicity, and primary language data directly from patients/enrollees or their caregivers in an efficient, effective, and respectful manner. This section provides information about the Toolkit's design and contents.

Toolkit Design

The Toolkit's contents are outlined below. Each section has a main heading followed by subheadings. In some instances, these subheadings are broken down further. We designed the Toolkit so you can quickly look at information targeted specifically to your role or needs within your organization. There is considerable overlap in the content for different audiences. We hope you will target the items in the list of contents that are most useful for you and find the Toolkit easy to navigate.

Toolkit Contents

The Toolkit content is designed to help you navigate the most frequently encountered questions about collecting race, ethnicity, and primary language data. The topics include information about:

- Who should use the Toolkit
- Why collect race, ethnicity, and primary language data
- Why collect data using a uniform framework

- The nuts and bolts of data collection
- How to ask questions about race, ethnicity, and primary language
- How to use race, ethnicity, and primary language data to improve quality of care
- How to train staff to collect this information
- How to inform and engage the community
- How to address the communication access needs of deaf and hard of hearing populations
- Available tools and resources
- Answers to frequently asked questions

Resources (Check the online version at <http://www.hretdisparities.org>.)

- Overview presentation on collecting race, ethnicity, and primary language data
- Staff training presentation on collecting race, ethnicity, and primary language data
- Presentation on addressing concerns from patients with applicable questions and answers
- Survey on collection of race and ethnicity data by hospitals
- Office of Management and Budget's race and ethnicity definitions
- Office of Management and Budget's granular code set on race and ethnicity
- Centers for Disease Control and Prevention's granular code set on race and ethnicity
- Reference booklet for staff on data collection categories

Who Should Use the Toolkit

We designed the Toolkit so you can look at information targeted specifically to your role or needs within your organization quickly. This section provides targeted information for the following specific audience or stakeholder:

- Chief Executive Officer
- Legal Affairs Department
- Quality Improvement
- Clinicians
- Patients/Consumers
- Registration/Admission
- Information Technology Department
- Interpreter Services

Chief Executive Officer

Health care leaders are charged with advancing and managing individual organizational priorities. As hospitals and health care organizations work toward serving diverse populations, leaders must recognize the importance of understanding the unique characteristics of the communities they serve. Efforts to improve health care delivery require working with key staff. Leaders can be most effective by helping others develop the abilities and tools to create the best responses to problems and opportunities.

Improving the quality of care for all patients and eliminating health care disparities are central challenges facing our health care system. As emphasized by two Institute of Medicine reports (*Crossing the Quality Chasm* and *Unequal Treatment*), the need for better data about patients' race, ethnicity, and primary

language is critical. Each section of the Toolkit provides information to hospital and health system leaders about collecting race, ethnicity, and primary language information from patients.

Legal Affairs Department

The law permits health care organizations to collect race, ethnicity, and primary language data from patients for quality improvement purposes. For example, the collection of race, ethnicity, and primary language data is permitted under Title VI of the Civil Rights Act of 1964. Additionally, the collection and assessment of information about the communication access needs of individuals who are deaf or hard of hearing promotes compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

Quality Improvement

The ultimate goal for collecting information about patient's race, ethnicity, and primary language is to improve the quality of care for all patients. Evidence indicates that quality improvement efforts, when linked to data on race and ethnicity, can improve quality of care and reduce health care disparities. These data can be linked to assess technical quality (clinical measures) and service quality (wait times) within your health care organization. The Toolkit's online version provides background information and tools (questionnaires) to help hospitals assess their current practices collecting race, ethnicity, and language data as well as surveys to determine whether complete and accurate information is being collected from patients once a systematic framework is implemented.

Clinicians

Doctors, nurses, and other health care practitioners are central to the functioning of health care systems and to societies as a whole. However, few societies have been as racially, ethnically, and culturally diverse as the United States, presenting challenges and opportunities. Each new wave of immigration provides a reminder of these challenges and opportunities.

In their individual encounters with patients, other clinical professionals who care for diverse populations need to incorporate knowledge about their patients' perceptions of illness and disease, belief systems, individual preferences, communication styles, and preferred language. In doing so, clinicians can provide the best possible care to their patients and equip them with appropriate resources.

The need for accurate data is critical so hospitals can target the resources clinicians need (interpreter services, patient educational materials, food, etc.) to provide quality health care to their patients. The Toolkit's online version provides more background information about the importance of collecting information about patients' race, ethnicity, and language and about how to collect the data.

Patients/Consumers

Patients should understand why they are being asked to provide information about their racial and ethnic background and primary language. Providers do not want to alienate patients by asking these questions, so it is important to explain why the information is being collected and how it will be used ("to ensure that everyone receives the highest quality of care"). The Why Collect Race, Ethnicity, and Primary Language section provides information about why collecting this data is important for providing patient-centered care, protecting privacy, and involving members of the community in the process.

Resources for Information About Privacy and Confidentiality

The Institute for Ethics at the American Medical Association has built a toolkit for health care organizations to assess whether their policies, practices, and organizational culture are consistent with protecting patient privacy, including the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

1. The toolkit provides four self-evaluation instruments for health care organizations to use to assess their policies and practices for safeguarding patient privacy and confidentiality including a *Practitioner Survey*, *Patient Survey*, *Policy Checklist*, and *Facility Evaluation Form*. To obtain more information about the privacy toolkit, go to <http://www.ama-assn.org/ama/no-index/physician-resources/3592.shtml>.
2. To access the report entitled "The Domain of Health Care Information Privacy: Protecting Identifiable Health Care Informational Privacy: A Consensus Report on Eight Content Areas for Performance Measure Development," go to <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/privacy-confidentiality/consensus-report.shtml>.
3. The Joint Commission and the National Committee for Quality Assurance (NCQA) released a joint publication, *Protecting Personal Health Information: A Framework for Meeting the Challenges in a Managed Care Environment* (1998). The document makes several recommendations and addresses accountability; consent; educating patients and providers about privacy policies, procedures, rights, and responsibilities; technology; providing legislative support; and guiding research.
4. Georgetown University's Institute of Health Policy and Research is sponsoring the Health Privacy Working Group (HPWG). The HPWG has developed a set of principles for health privacy and issued a report entitled *Best Principles for Health Privacy*. The Health Privacy Project has prepared a practical, comprehensive guide to state health privacy laws. For more information, go to <http://www.cdt.org/issue/health-privacy>.

For more information about the HIPAA Privacy Rule, including summaries, tools, and frequently asked questions, go to www.hhs.gov/ocr/privacy.

Registration/Admission

Patient registration/admission staff are often the first point of contact for many patients, and they are responsible for collecting information directly from patients or caregivers. Registration staff have expressed concern that asking patients to provide information about their race and ethnicity may alienate them. Our research and field work have shown that when registration staff are partners in the process and receive the training—which focuses on the reasons for collecting this information, how to ask patients and address their concerns—they feel comfortable asking and patients respond positively as well. The Toolkit's online version includes information for registration/admission staff about asking patients to provide information about their race, ethnicity, and primary language and about how to ask for this information and respond to patients' concerns and questions.

Information Technology Department

The IT department and staff are key in implementing the framework for collecting patient race, ethnicity, and primary language data within a hospital or health system. IT staff can identify infrastructure capacity and needs and are best able to integrate the necessary elements of the framework (codes, fields, etc.)

into existing systems or to modify the systems, if necessary. The most often asked questions or points of clarification for IT staff to consider include:

- Is it possible to incorporate the actual script (for asking the questions) on the registration screen so front-line staff can explain or provide the rationale for why they are asking patients to provide information about their race and ethnicity?
- Can a "declined" response category be added for those patients who do not want to answer this question and decline to do so (this is different than "unavailable")? Is it possible to flag these responses in different colors to make it easier for staff (e.g., "declined" indicates do not ask again and "unavailable" indicates ask again)?
- Do the order of the questions matter (i.e., race before ethnicity question or vice versa)? Some hospitals could not change the order on the registration screens.
- Will the old race/ethnicity data be purged or stored?
- Can modifications be made to the fields to match the OMB categories?
- Can a separate field for ethnicity be added (for those hospitals which only have a race field)?
- Will all registration staff (in the hospital and those off-site) see the same registration screens once modifications are made?

The Toolkit's online version has information on different coding schemes for race and ethnicity data and provides one example of a registration system that has incorporated the framework for data collection.

Interpreter Services

More than 55 million people---over 20% of the U.S. population---speak a language other than English at home. Health care providers from across the country have reported language difficulties and inadequate funding of language services to be major barriers to limited English proficient (LEP) individuals' access to health care and a serious threat to the quality of care they receive. Whether large or small, urban or rural, hospitals and health systems are encountering more and more patients with LEP.

A recent survey conducted by the Health Research & Educational Trust found that 63% of hospitals reported treating LEP patients either daily or weekly and an additional 17% reported seeing LEP patients at least monthly. Seventy-nine percent (79%) of hospitals in the survey indicated that training on how to respond to patients and family members who do not speak English would facilitate providing language services. Though 66% of hospitals indicated that they maintain information about a patient's primary language in medical records, only 38% said that they maintain a database of patients' primary language that they could use to track changes over time or make decisions about allocating resources for language services in the hospital.

The Toolkit provides information about collecting primary language information from patients and family members. It also addresses collecting data and providing services for deaf and hard of hearing populations.

Why Collect Race, Ethnicity, and Primary Language

Numerous studies document that racial and ethnic minorities often receive lower quality care than non-minorities. Although much information on health care comes from health care organizations, data on race, ethnicity, and primary language are often unavailable or incomplete.

In addition, deaf and hard of hearing populations face challenges in accessing high-quality health care. According to the National Institute on Deafness and Other Communication Disorders report, "Statistics about Hearing Disorders, Ear Infections, and Deafness" (2007), approximately 28 million Americans have hearing loss.

Valid and reliable data are fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific populations. The capacity to measure and monitor quality of care for various racial, ethnic, and linguistic populations rests on the ability both to measure quality of care in general and to conduct similar measurements across different racial, ethnic, and linguistic groups. This section provides information about why your health care organization should collect these data.

Making the Case

Measurement and outcomes have become increasingly important for demonstrating the effectiveness of health care. Evidence from the last 20 years shows that racial, ethnic, and language-based disparities remain present in health care. The Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, issued in 2002, is one of several recent studies documenting such evidence. There is a clear need to document and improve the quality of care provided to vulnerable populations. The need for data to track these disparities and develop effective programs to reduce and eliminate them is clear.

Disparities in health care can be addressed through a quality of care framework if data on race, ethnicity, and primary language are available. According to the report "The Right to Equal Treatment" issued by Physicians for Human Rights, data collection has long been central to the quality assurance process. The data may also help evaluate population trends and help ensure nondiscrimination on the basis of race and national origin, such as providing meaningful access for persons with limited English proficiency.

Most hospitals (82 percent) currently collect data on their patients' race and ethnicity, and 67 percent collect information on patients' primary language. However, the data are not collected in a systematic or standard manner and are often not shared, even between different departments within the same hospital. Organizations that collect accurate data can use this information to ensure they have sufficient language assistance services, to develop appropriate patient education materials, and to track quality indicators and health outcomes for specific groups to inform improvements in quality of care.

Race and Ethnicity Data

Health care organizations should collect information on patients' race and ethnicity in order to measure disparities in care---and see if they exist in the organization. Identifying and measuring disparities helps organizations initiate programs to improve quality of care. Experts assert that a growing consensus accepts a strategy integrating reduction in disparities in quality of care as a coherent and efficient approach to redesigning the U.S. health care system.

Communities want health care providers to be accountable and responsive to them. According to the American College of Physicians position paper on racial and ethnic disparities in health care, "An ongoing dialogue with surrounding communities can help a health care organization integrate cultural beliefs and perspectives into health care practices and health promotion activities." Tracking racial and ethnic composition with concurrently changing health care needs of communities is vital if health care providers are to fulfill their functions.

Primary Language Data

Patients with limited English proficiency or who are deaf or hard of hearing need to be able to communicate with their health care providers to ensure that the quality of care they receive is not compromised. According to the U.S. Census Bureau's 2007 American Community Survey, over 24 million people in the United States speak English less than "very well." Poor patient outcomes that have been attributed to language barriers include increased use of expensive diagnostic tests, increased use of emergency services and decreased use of primary care services, and poor or no patient follow-up when follow-up is indicated.

In a survey of hospital language services conducted by the Health Research & Educational Trust (2006), the most commonly cited barriers were the inability of staff to identify patients who need language services before they arrive at the hospital and the difficulty in obtaining community-level data about the languages spoken in the community versus collecting this information directly from patients. This Toolkit is designed to help hospitals and other health care organizations obtain this information directly from patients.

Language Needs of the Deaf or Hard of Hearing

The communication needs of deaf and hard of hearing patients should be integrated into programs and services provided in health care settings as the ability to effectively communicate in health care settings is critical to providing quality health care to this population. The Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, which prohibit discrimination on the basis of disability, require health care organizations to provide auxiliary aids and services as necessary to insure effective means of communication for patients, family members, and hospital visitors who are deaf or hard of hearing. To be compliant with the law, the health care organization must ensure that the individual who is deaf or hard of hearing actually understands what is being communicated through an alternative communication option.

The following are auxiliary aids and services:

- Qualified interpreters
- Note-takers
- Computer-aided transcription services
- Written materials
- Telephone handset amplifiers
- Assistive listening devices
- Assistive listening systems
- Telephones compatible with hearing aids
- Closed caption decoders
- Open and closed captioning
- Telecommunications devices for deaf persons (TDDs)
- Videotext displays
- Other effective methods of making aurally delivered materials available to individuals with hearing impairments

In most circumstances, the patient who is deaf or hard of hearing is in the best position to determine what means of communication is necessary to insure that effective communication occurs. Therefore, the individual's judgment regarding what means of communication is necessary to insure effective

communication should be documented in the medical record. This should be followed by an assessment of the types of aids and services that may be needed during the various types of interaction between the health care provider's staff and the deaf or hard of hearing patient throughout the patient's treatment.

In order to identify the needs of deaf or hard of hearing patients and their companions, health care providers should collect information from these patients, their companions, and communities about their language needs. Our research to date has not specifically focused on the best methods of collecting information about the language needs of deaf and hard of hearing populations, but we understand the importance of collecting this information to provide high-quality care to these populations. In our national survey of hospital language services conducted in 2006, 11 percent of hospitals reported frequently encountering patients with American Sign Language as their primary language. For more information, see the Deaf and Hard of Hearing Populations section.

National/State Reporting Requirements

An increasing number of federal policies emphasize the need for obtaining race, ethnicity, and language information. According to the Commonwealth Fund report, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (2001) by Perot and Youdelman, these major federal policies govern racial, ethnic, and primary language data collection and reporting:

- Office of Management and Budget (OMB) revised standards (1997)
- Health Insurance Portability and Accountability Act of 1996
- Initiative to Eliminate Racial and Ethnic Disparities in Health (1998)
- Consumer Bill of Rights and Responsibilities (1997)
- Benefits Improvement and Protection Act (2000)
- Report of U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity* (1999)
- Executive Orders 13166 "Improving Access to Services for Persons with Limited English Proficiency" and 13125 "Improving the Quality of Life of Asian Americans and Pacific Islanders" (2000)
- Minority and Health Disparities Research and Education Act of 2000
- Department of Health and Human Services Title VI Regulations (1964)
- Department of Health and Human Services Inclusion Policy (1997)
- Healthy People 2010 (2000)
- Culturally and Linguistically Appropriate Services (2000)
- HHS Data Council Activities (ongoing)
- National Committee on Vital Health Statistics (ongoing)

Below is a list of 22 states that indicated they require the reporting of race/ethnicity:

Arizona	Louisiana	New Mexico	Tennessee
California	Maryland	New York	Texas
Connecticut	Massachusetts	Pennsylvania	Vermont
Delaware	Missouri	Rhode Island	Virginia
Florida	New Hampshire	South Carolina	Wisconsin
Georgia	New Jersey		

Source: Medstat and National Association of Health Data Organizations. "Nationwide Data Inventory of Statewide Encounter-Level Data Collection Activities." Report to the Agency for Healthcare Research and Quality (AHRQ). AHRQ Contract No. 290-00-0004. April, 2003.

Accreditation Requirements

In January of 2006, the Joint Commission issued a new standard requiring health care organizations to collect patient's primary language information. The Toolkit's online version links to documents on the Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards crosswalked to the Joint Commission's 2009 Standards.

Why Collect Data Using a Uniform Framework

The uniform framework provides a process improvement tool for health care organizations to systematically collect race, ethnicity, and primary language information from patients or their caregivers. Using this framework results in more accurate and complete data. Health care organizations with data from their own institutions may, in turn, use the information to reduce health care disparities, develop targeted initiatives to improve quality of care, and provide patient-centered care.

The elements of a uniform framework include:

1. A rationale for why the patient is being asked to provide information about his/her race, ethnicity, and primary language.
2. A script for staff to use each time so that they ask questions in a uniform fashion.
3. A method for allowing patients to self-identify their race, ethnicity, and primary language.
4. A standardized approach for "rolling up" granular responses to the Office of Management and Budget (OMB) categories for analytical and reporting purposes.
5. Assurances that the data will be held confidential and that a limited number of people will have access to the data, and a mechanism to guarantee this claim.

Current Practices

Hospitals

Hospitals play a major role in a community's health care delivery system. But their infrastructure for collecting and using race, ethnicity, and language data is underdeveloped, leading to problems of redundancy, inefficiency, and inaccuracy.

- 78% to 82% of hospitals report collecting race data.
- Far fewer collect ethnicity data.
- 66% of hospitals collect primary language data in the patient medical record.
- 38% maintain a database of patients' primary language, which can be tracked over time.
- 56% collect race/ethnicity data in more than one unit.
- Within the same hospital, different units use different categories.
- Over 50% of hospitals report collecting race/ethnicity data by observation.
- 86% provide limited categories.
- 13% provide a "write-in" response, but these text responses are often not used.
- 10% provide granular race/ethnicity categories tailored to their community's demographics.
- 25% report linking race/ethnicity and language data to quality of care measures.

Medical Group Practices

Little is known about the collection of data on race and ethnicity in medical group practices. Medical groups are less likely than hospitals to collect race and ethnicity data (Nerenz, Currier, and Paez 2004).

- Seventy-five percent (75%) of medical groups that responded to one survey did not collect race/ethnicity data because they thought it was unnecessary or that collection was potentially disturbing to patients.
- Medical groups that collected the data did so primarily for internal quality improvement or disease management purposes, and some were closely affiliated with hospitals that collected data on race/ethnicity as part of the inpatient registration process.
- Recognizing this gap is particularly important. We know far less about health care disparities in the outpatient setting as compared with the inpatient setting.

Community Health Centers (CHCs)

Perhaps because of the tremendous diversity of patients seen at CHCs and their mandate to have their boards of directors represent their communities, CHCs appear to be ahead of the curve in collecting information on patient's race and ethnicity.

- The Bureau of Primary Health Care (BPHC) has demonstrated success in collecting data in this setting. BPHC's Universal Data System stores data from 700 grantees at 3,000 health care sites.
- The BPHC has established specific racial, ethnic, and primary language data collecting and reporting requirements applicable to its network of CHCs.

The success of these programs provides evidence to other medical groups that this information can be routinely obtained from patients in outpatient practices.

Health Plans

In a study released by America's Health Insurance Plans (AHIP) and the Robert Wood Johnson Foundation, over half (53.5%) of 137 plans that were surveyed collect data that identifies the race or ethnicity of their enrollees.

- 78.2% of Medicaid health plans collect race and ethnicity data.
- 74.3% of Medicare plans collect race and ethnicity data.
- 50.9% of commercial plans collect race and ethnicity data.

Health plans report they collect such data to identify enrollees at risk for certain conditions, to support educational and other communication efforts directed to diverse populations, and to structure quality improvement efforts.

Standardization

We recommend the following practices for standardizing race, ethnicity, and primary language data collection in health care organizations:

Who provides the information

Information should always be provided by patients or their caretakers. It should never be done by observation alone.

When to collect

Collection should take place upon admission or patient registration to ensure appropriate fields are completed when the patient begins treatment (for plans, at enrollment).

What racial and ethnic categories should be used

Start with the U.S. Census or the Office of Management and Budget (OMB) categories. Health care organizations can provide more granular categories (to use for internal purposes), but these granular categories should have the capacity to be aggregated to the broader OMB categories for reporting purposes.

Where should data be stored

Data should be stored in a standard electronic format for easy linking to clinical data.

Patient Concerns

Concerns should be addressed up front and clearly, prior to obtaining information.

Staff training

Employers need to provide ongoing training and evaluation to staff.

Benchmarking

Benchmarking is necessary. Health care organizations need to know where they stand to see where they are going. For example, are quality improvement interventions making a difference? Should our organization be doing things differently?

Collecting accurate data helps your organization track progress over time. In addition, it allows for comparisons within organizations, across organizations, as well as at a national level. Most national level data are obtained from health care organizations. If the data your organization collects are accurate, it contributes to accurate comparisons and reporting at all levels.

Collecting the Data – The Nuts and Bolts

The National Research Council of the National Academies report *Eliminating Health Disparities: Measurement and Data Needs* (2004) recommends that hospitals, other health care providers, and health insurers collect standardized data on race and ethnicity using the Office of Management and Budget (OMB) standards as a base minimum. However, experts recognize that greater detail or granularity beyond the OMB categories may be more useful for hospitals and health care organizations in target improvements for diverse populations. We recognize that collecting granular level data at the organizational level may create challenges for reporting or for research. The Institute of Medicine's (IOM) recent report *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement* (2009) provides new recommendations to help facilitate and further standardize the collection of race, ethnicity, and primary language data. We recommend that health care providers collect race, Hispanic ethnicity, and granular ethnicity data separately and "roll up" or aggregate the granular ethnicities to the OMB race and Hispanic ethnicity categories as needed.

To access the IOM report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*, go to <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx>.

Who

We recommend collecting race and ethnicity information directly from patients or their caregivers. Race and ethnicity information should be collected only once and periodically validated. Repeated collection should be avoided to reduce the burden both for patients and for staff responsible for collecting the information. Once this information is collected, it should be stored in an electronic format when possible.

In addition, if a patient refuses to answer questions about their racial or ethnic background, the registration staff should move on with the registration process and record "declined" in the field indicating that the patient did not want to answer this question. Providing information about race and ethnicity is completely voluntary, and staff should recognize when people feel uncomfortable or explicitly state that they do not want to respond to these questions.

We have designed this Toolkit to serve as a resource for hospitals and health care organizations. The primary components of race and ethnicity data collection that should be considered standard practice include the following:

1. Collect data directly from the patient or from a designated representative.
2. Provide a rationale or reason for why this information is being collected.
3. Depending on the capacity of your organization, decide whether you will be providing broad or granular categories. If using predefined categories, decide whether you will be using the bare minimum, such as OMB, or whether you will be providing more granular categories. (*Information about both broad categories and granular categories is listed in the section "Which Categories to Use."*)

Where

Hospitals, Clinics, Group Practices

We recommend that this information be collected at the time of patient registration for hospitals, clinics, and medical group practices. This information can be collected face-to-face or over the telephone.

Health Plans

For health plans and insurers, we recommend that this information be collected at the time of enrollment, if possible. We realize that this may pose a challenge as some employers prohibit asking this information of their employees. America's Health Insurance Plans (AHIP) has developed a toolkit, *Tools to Address Disparities in Health: Data as Building Blocks for Change—A Data Collection Toolkit for Health Insurance Plans/Health Care Organizations.*

How

Always provide a rationale for why you are asking patients/enrollees to provide information about their race/ethnicity. Research shows that patients are most comfortable providing this information when told why it is being collected and how it will be used. We recommend that health care organizations and

health plans collect this information for quality monitoring purposes. Below is a sample rationale, which is easy to communicate and focuses on data collection for quality monitoring.

Rationale

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

In addition, it is important to state that the information is confidential:

"The only people who see this information are registration staff, administrators for the hospital, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law."

Which Categories to Use

Provided below are the OMB (broad categories) and CDC Race and Ethnicity Code Sets (granular categories that can be rolled up into the OMB categories for reporting or research purposes). As indicated, hospitals can choose to present patients/enrollees with a list of either broad or granular categories allowing patients/enrollees to self-identify their racial/ethnic background.

Broad Categories (OMB)

OMB Revised Standards (1997)

In 1997, the Office of Management and Budget (OMB) published revisions to the Standards for Classification of Federal Data on Race and Ethnicity. For detailed information about the OMB standards, go to http://www.whitehouse.gov/omb/fedreg_1997standards/.

The OMB revised standards includes separate race and ethnicity questions. See below for specific OMB recommendations.

First ask questions about ethnicity.

OMB Ethnicity

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino.

OMB Race

American Indian/Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black/African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian," "Dominican," or "Somali" can be used in addition to "Black or African American."

Native Hawaiian/Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Our recommended modifications to OMB include adding the following categories:

Some Other Race: (This category replaces the "Multiracial" category in the previous version of the Toolkit. It provides a response option for those Hispanics and others who do not relate to the current OMB race categories.)

Declined: (This category is an indication that the person did NOT want to respond to the question and should not be asked again during the same visit or during a subsequent visit.)

Unavailable: (This category is an indication that the person could not respond to the question and can be asked again during the same visit or during a subsequent visit.)

Collapsing Race and Ethnicity

Field research by HRET has shown that some health care organizations have only one field (for race) and do not have a separate field for ethnicity. Under these circumstances, we have collapsed race/ethnicity to facilitate recording both in one field. The recommended categories are:

African American/ Black	Native American
Asian	Native Hawaiian/Pacific Islander
Caucasian/White	Some Other Race
Hispanic/Latino/White	Declined
Hispanic/Latino/Black	Unavailable/Unknown
Hispanic/Latino/Declined	

Granular Categories

In addition to collecting data in the OMB race and ethnicity categories, organizations should also collect granular ethnicity data using categories that are representative of the population served. The IOM Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement recommends that granular ethnicity categories should be selected from a national standard set based on ancestry (e.g., Centers for Disease Control and Prevention [CDC]/Health Level 7 [HL7] Race and Ethnicity Code Set 1.0).

Not all organizations collecting granular ethnicity data will need to include the entire national standard set of categories in their databases or on their data collection instruments. Rather, organizations should select categories from the set that are applicable to their service population. Whenever a limited list of categories is offered to respondents, the list should include an open-ended response option of "Other, please specify: ___" so that each individual who desires to do so can self-identify.

When respondents do not self-identify as one of the OMB race or Hispanic ethnicity categories and provide only a granular ethnicity response, a process for rolling the granular ethnicity categories up to the OMB categories should be used. Ethnicities that do not correspond to a single OMB race category should be categorized as "no determinate OMB classification."

CDC Race and Ethnicity Code Set

The U.S. Centers for Disease Control and Prevention (CDC) have prepared a code set for use in coding race and ethnicity data. This code set is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the OMB described above and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census. The code set can be applied in both electronic and paper-based record systems.

Within the table, each race and ethnicity concept is assigned a unique identifier, which can be used in electronic interchange of race and ethnicity data. The hierarchical code is an alphanumeric code that places each discrete concept in a hierarchical position with reference to other related concepts. For example, Costa Rican, Guatemalan, and Honduran are all ethnicity concepts whose hierarchical codes place them at the same level relative to the concept Central American, which is the same hierarchical level as Spaniard within the broader concept Hispanic or Latino.

In contrast to the unique identifier, the hierarchical code can change over time to accommodate the insertion of new concepts. For more information on the granular code sets, see the Toolkit's online version.

IOM Subcommittee Proposed Template of Granular Ethnicity Categories

The IOM subcommittee has also created a template listing granular ethnicity categories from multiple sources including the CDC/HL7 list. Some of the granular ethnicities included in the template have already been assigned permanent five-digit unique numerical codes by CDC/HL7. Others still require permanent five-digit unique numerical codes. The Toolkit's online version provides a link to the subcommittee's template.

Language Categories

To simplify the collection of language data, most organizations should develop a list of common languages used by their service population, accompanied by an open-ended response option for those whose language does not appear on the list.

Locally relevant language categories should be selected from a national standard set such as that available from the Census list or IOM report. A sample list is as follows:

- African languages
- American Sign Language
- Arabic
- Armenian
- Chinese
- French
- French Creole
- German
- Greek
- Gujarathi
- Hebrew
- Hindi
- Hungarian

- Italian
- Japanese
- Korean
- Laotian
- Miao Hmong
- Mon-Khmer Cambodian
- Other native North American languages
- Persian
- Polish
- Portuguese
- Portuguese Creole
- Russian
- Scandinavian languages
- Serbo-Croatian
- Spanish
- Tagalog
- Thai
- Urdu
- Vietnamese
- Yiddish
- Availability of Sign Language or other auxiliary aids or services
- Other, please specify: _____
- Do not know
- Unavailable/Unknown
- Declined

These language categories address the specific language needs of the individual, including the needs of individuals who are deaf or hard of hearing.

How to Ask the Questions

As we suggested in the Collecting the Data section of the Toolkit, we recommend that health care organizations/health plans provide a rationale for why they are asking patients/enrollees for information about their racial and ethnic background. Suggested wording for the rationale is:

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

We have found that people feel comfortable responding to the question about race/ethnicity, but they sometimes have their own questions or want more clarity. And some people may prefer to not answer the question at all.

The Toolkit's online version includes a link to a response matrix that provides real world examples of questions people have asked as well as suggested responses. This response matrix is not all inclusive. You may encounter different scenarios, and you may not hear any concerns from patients after asking these questions. The response matrix serves as a tool for you and your staff, and it is excellent for facilitating dialogue during training sessions.

Race/Ethnicity

Using Broad (OMB) Categories

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

Ethnicity Question

(OMB recommends asking ethnicity before race.)

Do you consider yourself Hispanic/Latino?

Yes

No

Declined

Unavailable/Unknown

Race Question

Which category best describes your race?

American Indian/Alaska Native

Asian

Black or African American

Native Hawaiian/Other Pacific Islander

White

Some Other Race

Declined

Unavailable/Unknown

Using Granular Categories

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. I would like you to describe your race or ethnic background. You can use specific terms such as Korean, Mexican, Haitian, Somali, etc..."

You can provide all or some of the granular categories based on the community you serve. The Toolkit's online version includes links to the granular code sets.

Language

I. What language do you feel most comfortable speaking with your doctor or nurse?

African languages	Hungarian	Russian
American Sign Language	Italian	Scandinavian languages
Arabic	Japanese	Serbo-Croatian
Armenian	Korean	Spanish
Chinese	Laotian	Tagalog
English	Miao Hmong	Thai
French	Mon-Khmer	Urdu
French Creole	Cambodian	Vietnamese
German	Navajo	Yiddish
Greek	Other Native North American languages	Availability of Sign Language or other auxiliary aids or services
Gujarathi	Persian	Other
Hebrew	Polish	Do not know
Hindi	Portuguese	Unavailable
	Portuguese Creole	Declined

2. How would you rate your ability to speak and understand English?

- Excellent
- Good
- Fair
- Poor
- Not at all
- Declined
- Unavailable

3. Would you like an interpreter?

- Yes
- No
- Do not know
- Declined
- Unavailable

4. In which language would you feel most comfortable reading medical or health care instructions?

African languages	Hungarian	Russian
American Sign Language	Italian	Scandinavian languages
Arabic	Japanese	Serbo-Croatian
Armenian	Korean	Spanish
Chinese	Laotian	Tagalog
English	Miao Hmong	Thai
French	Mon-Khmer Cambodian	Urdu
French Creole	Navajo	Vietnamese
German	Other Native North American languages	Yiddish
Greek	Persian	Availability of Sign Language or other auxiliary aids or services
Gujarathi	Polish	Other
Hebrew	Portuguese	Do not know
Hindi	Portuguese Creole	Unavailable
		Declined

5. How satisfied are you with your ability to read English?

- Very satisfied
- Somewhat satisfied
- Satisfied
- Somewhat dissatisfied
- Very dissatisfied
- Declined
- Unavailable

How to Use the Data

Eliminating racial and ethnic disparities in health care is a central issue in overall efforts to improve quality of care. Information on racial and ethnic characteristics of the U.S. population is needed to target quality improvement efforts, identify the nature and extent of health disparities, and monitor progress. Measurement, reporting, and benchmarking are critical to improving care. In addition, certain state statutes and laws require reporting data by race and ethnicity to monitor discriminatory practices. Enforcement of laws that prohibit discrimination on the basis of race, color, national origin, and disability rely on data collection to monitor compliance. Ultimately, hospitals and other health care organizations need to be responsive to the communities they serve. A first step toward accomplishing this goal is understanding who the community is and working collaboratively to address problems and concerns.

The health system serves three critical functions (*Eliminating Health Disparities: Measurement and Data Needs*, National Research Council, 2004):

1. **Ensuring the health of the population.** This is the ability to provide consistent and reliable epidemiological data on the incidence and prevalence of various health conditions and related risk factors among different racial and ethnic populations.
2. **Ensuring equitable access to care.** Access to care is a prerequisite for entering and staying in the health care system. Available racial and ethnic data have been used to document important differences in access between racial and ethnic groups. More accurate data can also be used to document differences in access within racial groups (e.g., Puerto Rican, Mexican, Somali, Jamaican, etc.).
3. **Ensuring quality of care.** Language and cultural barriers can have a negative impact on quality of care. For example, African Americans were nearly twice as likely as whites to report being treated with disrespect during recent health care visits; Hispanics, regardless of language skills, were more likely than other patients to report having difficulty communicating with and understanding their doctors (Collins, Tenney, and Hughes, *The Commonwealth Fund*, 2002; Doty and Ives, *The Commonwealth Fund*, 2002). These findings underscore the importance of ensuring culturally competent care to patients by health care providers.

There are a number of disparity monitoring initiatives conducted by the federal government. Eliminating health care disparities is one of the primary goals of Healthy People 2010, a long-term national agenda aimed at improving health in the United States. In 1999, Congress required the Agency for Healthcare Research and Quality to develop an annual National Healthcare Disparities Report to track the extent of disparities in health care and monitor whether progress has been made toward eliminating them.

It is important to maintain a national focus on this issue to present national data to assess our progress in eliminating disparities in care. However, health care organizations need to also monitor the care they deliver within their own "backyards." Many experts have called for health care organizations to stratify their quality reports by race and ethnicity in order to undertake targeted interventions. Health care organizations should be able to stratify race, ethnicity, and language data by service quality indicators (patient satisfaction, wait times, etc.) as well as by technical quality indicators (clinical measures).

Linking to Clinical Quality Measures

As part of the Hospital Quality Alliance, over 4,000 hospitals are voluntarily reporting inpatient quality of care measures to CMS for a number of conditions. The Toolkit's online version provides a link to a document on the specific quality measures.

Linking to Patient Satisfaction Measures and Making Appropriate Resource Allocation Decisions

The American College of Physicians position paper on Racial and Ethnic Disparities in Health Care (2004) calls for an ongoing dialogue between hospitals and other health care organizations and surrounding communities to help integrate cultural beliefs and perspectives into health care practices and health promotion activities. Accurate information about race, ethnicity, and primary language can be used to ensure adequate interpreter services, provide relevant patient information materials, and understand dietary practices. Pressing problems in the communities, such as disparities in care, can be addressed more effectively if health care providers and practitioners build the trust of the community by documenting their accomplishments.

Complying with Civil Rights Laws

Routine monitoring of access, use of services, and outcomes of care by race, ethnicity, and primary language helps ensure compliance with civil rights laws. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and related statutes and their implementing regulations require that patients from different racial and ethnic groups and patients with disabilities have equal opportunity to access quality care.

Staff Training

To ensure that data are collected accurately and consistently, organizations need to invest in training staff. Staff should be partners in this process. The training should provide information about why it is important to collect these data, how to collect data, and how to answer questions or address concerns from patients.

Scripts

Although it is not necessary to have lengthy scripts, it is important to clearly communicate why you are asking patients to provide information about their race/ethnicity and language. Depending on what type of resources you have available, a script can be read directly from the computer screen or you can simply have it written on a laminated card to keep at your station. You will need to work with IT staff to ensure it is incorporated on the registration screen if you decide to go this route. The specific wording for how to ask the question is:

Remember to ask the patient or designated caregiver to self-identify their race and ethnic background:

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

Then ask:

"What is your race?"

(Please refer to How to Ask the Questions section for specific categories.)

If people express concern about confidentiality or who will see this information, state the following:

"The only people who see this information are registration staff, administrators for the hospital, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law."

Addressing Concerns from Patients

We have found that when you explain why you are asking people to report their racial and ethnic background and do so in a nonthreatening and polite manner, resistance to providing this information is minimized. There may be individuals who do not understand the question or do not want to respond to it. The response matrix in the Toolkit's online version provides you with some guideposts. It is very important to remember that if someone does not want to answer these questions, simply record "declined" and move on with the registration process.

Informing and Engaging the Community

Hospitals and other health care organizations are learning that when it comes to delivering health care, it is better to *not* go it alone. Whether your goal is to increase access to health care for specific populations, serve the uninsured, or target interventions in the community to improve care, it may be more effective if you collaborate with other organizations and stakeholders in the community. Collaboration can help you better align resources with needs, reduce competition, increase effectiveness, and make your results more sustainable. It requires that organizations work outside historical boundaries; dedicate people, skills, and energy to the effort; deal with a diversity of priorities and culture; and think of their organizational plans and operations as part of a system that needs to function seamlessly. (*The Collaboration Primer*, HRET, 2003.)

Communities can be defined by geographic boundaries, but they can also be defined by race, ethnicity, primary language, or immigration patterns. Community engagement allows health care organizations to work with community members and with other organizations. If your organization is about to embark on systematic collection of race, ethnicity, and primary language data, it is important to inform the community about this initiative, why you are undertaking it, what to expect, and how you will use the information. This will help to ensure that you consider community values and needs. It will facilitate the process of collecting data because the community will be an active and informed partner in this enterprise. Methods to engage the community include:

- Community meetings
- Focus groups
- Working with community-based organizations
- Newsletters
- Posters
- Brochures/informational pamphlets
- Reoccurring articles in community newspapers

Deaf and Hard of Hearing Populations

Effective communication for individuals who are deaf or hard of hearing is particularly critical in health care where miscommunication may lead to misdiagnosis and improper or delayed treatment. Because critical medical information is communicated at many points throughout a health care encounter, it is important that information on communication needs be collected at the earliest point possible, such as at patient registration/admission to a hospital or during registration. The U.S. Department of Justice has issued the ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings (www.ada.gov/.hospcnbrprt.pdf), which identifies situations in which providing auxiliary aids and or services may be needed to meet the deaf or hard of hearing individual's needs for effective communication. These include, but are not limited to, the following:

- Discussing a patient's symptoms and medical condition, medications, and medical history
- Explaining and describing medical conditions, tests, treatment options, medications, surgery, and other procedures
- Providing a diagnosis, prognosis, and recommendation for treatment
- Obtaining informed consent for treatment
- Communicating with a patient during treatment, testing procedures, and during physician's rounds
- Providing instructions for medications, post-treatment activities, and follow-up treatments
- Providing mental health services, including group or individual therapy, or counseling for patients and family members
- Providing information about blood or organ donations
- Explaining living wills and powers of attorney
- Discussing complex billing or insurance matters
- Making educational presentations, such as birthing and new parent classes, nutrition and weight management counseling, and CPR and first aid training

The following are auxiliary aids and services:

- Qualified interpreters
- Note-takers
- Computer-aided transcription services
- Written materials
- Telephone handset amplifiers
- Assistive listening devices
- Assistive listening systems
- Telephones compatible with hearing aids
- Closed caption decoders
- Open and closed captioning
- Telecommunications devices for deaf persons (TDDs)
- Videotext displays
- Other effective methods of making aurally delivered materials available to individuals with hearing impairments

People who are deaf or hard of hearing use a variety of ways to communicate with hearing people. Some rely on sign language interpreters or assistive listening devices. Some rely primarily on written messages. Many can speak even though they cannot hear. The method of communication and the auxiliary aids and services the health care provider must provide will vary depending upon the abilities of the person who is deaf or hard of hearing. It will also vary depending on the complexity and nature of the

communications that are required. It should be recognized that a person who may use written notes or lip-reading in day-to-day situations may need a different mode of visual communication when discussing medical or financial matters.

Interpreting services should be provided by a qualified interpreter, which means an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary. It is never appropriate to ask or rely on a family member or friend as an interpreter; however, if that is the request of the individual who is deaf or hard of hearing after having been informed of the availability of interpreting services, it may be considered. In certain circumstances, notwithstanding that the family member or friend is able to interpret or is a certified interpreter, the family member or friend may not be qualified to render the necessary interpretation because of factors such as emotional or personal involvement or considerations of confidentiality that may adversely affect the ability to interpret "effectively, accurately, and impartially."

The problems that may arise with having a family member or friend interpreting in a medical setting are considerable. There may be necessary information that the family member fails to communicate, in a misguided effort to shield the deaf patient. There may be questions the deaf person will not ask in the presence of the family member or friend. The family member or friend may be too emotionally upset by the medical situation to interpret correctly.

It is a common misconception that "sign language" is merely a pantomime of the English language and is therefore easily understandable in print if not through auditory means. "Sign language" is a term that describes a visually interactive language that uses a combination of hand motions, body gestures, and facial expressions. There are several different types of sign language, including those based on English (such as Cued Speech and Signed English). There are several versions of American Sign Language, and other countries have their own versions of sign language.

American Sign Language (ASL) is a manually communicated language distinct from English and whose idioms and concepts are not directly translatable into English. It uses different sentence structure, grammar, and syntax than English, and is as much a foreign language to English speaking persons as is French or German. Conversely, English is equally foreign to most deaf persons who rely on ASL for communication. ASL sentences do not follow English sequential patterns. As a result, direct translation of English, as with written notes, into an English-based sign system will not necessarily convey the intended message. Similarly, much of English idiomatic speech would be lost on the ASL user whose frame of reference for idiom is significantly different from the hearing person.

It should be noted that a relay interpreter also may be needed in situations where the individual who is deaf or hard of hearing uses the sign language of another country. See the ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings for more detailed information.

Tools and Resources

TOOLKITS

AHIP's Data as Building Blocks for Change: A Data Collection Toolkit for Health Insurance Plans/Health Care Organizations (PDF) (<http://www.ahip.org/content/default.aspx?docid=10761>) supplies health insurance plans and health care organizations with the building blocks to create change and improve the care for all Americans. This toolkit serves to expand the general knowledge about the issues

surrounding data collection and its potential impact for identifying disparities and measuring quality improvement.

Conducting a Cultural Competence Self-Assessment (PDF) (<http://erc.msh.org/provider/andrulis.pdf>), developed by Dennis Andrulis of SUNY/Downstate Medical Center, is a self-assessment for health care organizations wanting to conduct an audit of cultural competence. In addition to revealing opportunities for an organization to make itself more attractive to diverse populations, conducting the self-assessment is a statement to the workforce, patients, and community that the organization values diversity and desires to increase its cultural competence.

Language Services Action Kit – Interpreter Services in Health Care Settings for People with Limited English Proficiency (PDF) (http://www.accessproject.org/adobe/language_services_action_kit.pdf) National Health Law Program and the Access Project, February 2004, designed to support individuals working to ensure that people with limited English proficiency receive appropriate language services in health care settings.

Making Public Programs Work for Communities of Color: An Action Kit for Community Leaders (<http://www.familiesusa.org/resources/tools-for-advocates/kits/minority-health-tool-kit.html>) Minority Health Initiatives Department, Families USA, January 2006, provides community leaders with the information, tools, and resources necessary to engage in health advocacy and improve the health and well-being of their communities.

Patient-Centered Communication for Vulnerable Populations (<http://www.ama-assn.org/>) the Ethical Force Program, American Medical Association (AMA). This program provides a set of measures for health care organizations to address patient-centered communication for vulnerable populations.

GUIDELINES/STANDARDS

Joint Commission

Crosswalk of the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) and The Joint Commission's 2009 Standards for the Hospital Accreditation Program (PDF) (http://www.jointcommission.org/NR/rdonlyres/02E99D6E-E4EA-4F6A-A31F-4A10CAE691DC/0/OMH_JC_CLAS_Xwalk_2008.pdf)

Joint Commission 2006 Hospital Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care (PDF) (http://www.jointcommission.org/NR/rdonlyres/A2B030A3-7BE3-4981-A064-309865BBA672/0/hl_standards.pdf) Joint Commission on Accreditation of Healthcare Organizations, 2006.

U. S. Department of Health & Human Services, Office of Minority Health

ADA Business Brief: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings (PDF) (<http://www.ada.gov/hospcombrprt.pdf>) U.S. Department of Justice, Civil Rights Division, October 2003.

Civil Rights Clearance for Medicare Provider Certification (http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html) U.S. Department of Health & Human Services, Office for Civil Rights, last revised December 22, 2006.

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (PDF) (www.nrc.gov/about-nrc/civil-rights/ml040290722.pdf) U.S. Department of Health & Human Services, Office for Civil Rights, last revised October 4, 2006.

National Standards for Culturally and Linguistically Appropriate Services in Health Care (Final Report (PDF) (<http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>) U.S. Department of Health & Human Services, Office of Minority Health, March 2001.

GENERAL RESOURCES

Cultural/Ethnic/Racial

Bridging Cultures and Enhancing Care: Approaches to Cultural and Linguistic Competency in Managed Care (PDF) (<ftp://ftp.hrsa.gov/financeMC/bridging-cultures.pdf>) A 38-page report that highlights events of a national conference sponsored by the Health Resources and Services Administration and American Public Human Services Association. Includes write-ups, recommendations, and tips on the Effects of Race and Ethnicity on the Delivery of Quality Health Care, Building Cultural Competence in Organizations, and Cultural Competence and Linguistically Appropriate Services in the Clinical Setting.

National Healthcare Disparities Report 2009 (<http://www.ahrq.gov/qual/qdr09.htm>) provides an overview of disparities in health care among racial, ethnic, and socioeconomic groups within the U.S. The report also tracks the progress of activities made to reduce disparities.

Worlds Apart: A Film Series on Cross-Cultural Health Care (<http://www.commonwealthfund.org/Content/Resources/2004/Feb/Worlds-Apart---A-Film-Series-on-Cross-Cultural-Health-Care.aspx>) by Maren Grainger-Monsen, MD, and Julia Haslett, Stanford University Center for Biomedical Ethics (VHS, 47 min.)

Deaf and Hard of Hearing Populations

DeafLink (<http://www.deaflink.com/>)
Communication access for deaf America

Hearing Loss Association of America (<http://www.shhh.org/>)
This is the nation's largest organization for people with hearing loss. The Hearing Loss Association of America exists to open the world of communication for people with hearing loss through information, education, advocacy, and support.

Interpretek (<http://www.interpretek.com>)
American Sign Language interpreting for the 21st century

National Association of the Deaf (<http://www.nad.org/>)
This organization's mission is to promote, protect, and preserve the rights and quality of life of the deaf and hard of hearing through position and legal statements, advisory letters to federal agencies, as well as providing informational materials on the deaf and hard of hearing.

National Association of the Deaf Info Center (How Do I Become An Interpreter?) (<http://www.nad.org/>)
National Technical Institute for the Deaf Deaf Index (<http://www.ntid.rit.edu/terpref/index.htm>)

Pinky Tells the Real Story (<http://www.pinkythejuggler.com/videophone/>)
Videophone and Video Relay Service

Registry of Interpreters for the Deaf (<http://www.rid.org/>)
Registry of Interpreters for the Deaf Interpreter Service Locator (<https://www.rid.org/acct-app/index.cfm?action=search.ISA>)

Signs of Development CD-ROM Interpreter Training (<http://signs-of-development.org/>)

Interpreters/Language

Hablamos Juntos (We Speak Together) (<http://www.hablamosjuntos.org/>)
Affordable Language Services: Implications for Health Care Organizations (PDF)
(http://www.hablamosjuntos.org/resource_guide_portal/pdf/BriefLangSvc-21Sept.pdf) September 2005.
This brief provides an overview on the effects of language barriers on patient safety and quality of health care, including challenges health care organizations must address to effectively overcome such barriers.

"I Speak" Language Identification Flashcard (PDF)
(<http://www.usdoj.gov/crt/cor/Pubs/ISpeakCards2004.pdf>)
This document provided by the U.S. Department of Commerce Bureau of the Census contains a reference of 38 identified languages.

International Medical Interpreters Association (<http://www.mmia.org/>)
This organization acts as a clearinghouse for collecting and disseminating information regarding medical interpretation and translation, and promotes research into issues regarding cross-cultural communication within health care. As one of the largest and oldest medical interpreter associations within the country, this organization also provides interpreting services in over 70 languages.

The Interpreter's World Tour: An Environmental Scan of Standards of Practice for Interpreters (PDF)
(http://www.hablamosjuntos.org/resources/pdf/The_Interpreter's_World_Tour.pdf)
This document was prepared for the National Council on Interpreting in Health Care, funded by The Commonwealth Fund and the California Endowment, March 2005. It summarizes standards of practice in the areas of general interpreting, health care/medical interpreting, court and legal interpreting, community and liaison interpreting, and conference interpreting.

A National Code of Ethics for Interpreters in Health Care (PDF)
(hospitals.unm.edu/language/documents/ncihc.pdf) the National Council on Interpreting in Health Care (NCIHC), July 2004.

Point-to-Talk Booklets, Massachusetts General Hospital, 2002
(<http://www2.massgeneral.org/interpreters/pointtalk.asp>) Award-winning booklets to aid limited English proficient patients in communicating with their caregivers.

Providing Language Services in Small Health Care Provider Settings: Examples from the Field (PDF)
(http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf)
National Health Law Program, funded by the Commonwealth Fund, April 2005. Provides an eight-step plan to help providers develop a strategy to meet the needs of their LEP patients and the community.

What a Difference an Interpreter Can Make – Health Care Experiences of Uninsured with Limited English Proficiency (PDF) (<http://www.hhs.gov/ocr/lep/InterpreterDifference.pdf>) The Access Project, April 2002. Compares the perceptions and experiences of adults who got an interpreter with those who needed and did not get an interpreter.

ORGANIZATIONS/PROGRAMS

The American Hospital Association (AHA) (<http://www.aha.org/>) supports the national focus on eliminating racial and ethnic disparities within health care, and supports the Health Research & Educational Trust on research projects aimed in providing tools to collect race, ethnicity, and primary language in hospitals. This organization also sponsors the Institute for Diversity in Health Management (<http://www.diversityconnection.org/>)—designed to promote racial and ethnic diversity in management and executive levels within the health care industry.

Expecting Success (http://www.gwumc.edu/sphhs/institutescenters/expecting_success.cfm) is a national program of the Robert Wood Johnson Foundation (<http://www.rwjf.org/>) aimed at improving cardiac care for U.S. minority populations. The program consists of hospitals that are implementing quality improvement techniques to reduce health care disparities.

National Association of Health Data Organizations (NAHDO) (<http://www.nahdo.org/>) assists organizations on improving health care through collection, analysis, dissemination, public availability, and use of health data.

National Health Law Program (NHeLP) (<http://www.healthlaw.org/>) HIPAA and Language Services in Health Care, report funded by The California Endowment.

Language Access in Health Care Statement of Principles: Explanatory Guide, October 2006 (<http://www.healthlaw.org>)

Summary of State Law Requirements Addressing Language Needs in Health Care, updated January 2006 (<http://www.healthlaw.org>)

National Public Health and Hospital Institute (NPHHI)
Serving Diverse Communities in Hospitals and Health Systems From the Experience of Public Hospitals and Health Systems (PDF) (<http://www.naph.org/>) National Public Health and Hospital Institute (NPHHI), funded by the U.S. Department of Health and Human Services, Office of Minority Health, June 2004. Presents strategies from the various programs and approaches currently underway in National Association of Public Hospitals & Health Systems (NAPH) institutions.

Office for Civil Rights (<http://www.hhs.gov/ocr/index.html>)
This website provides information on the agency's initiatives to assist hospitals in communicating with people who are deaf, hard of hearing, or who are limited English proficient. This site also provides information on efforts to reach African American communities regarding health disparities and race discrimination.

Patient Race & Ethnicity: Improving Hospital Data Collection & Reporting (PDF) (http://www.njha.com/research/pdf/PatientRace-Full_Report.pdf) developed by the Health Research and Educational Trust (HRET) of New Jersey (an affiliate of the New Jersey Hospital Association) through a grant funded by the Robert Wood Johnson Foundation to improve hospital practices for collecting patient race and ethnicity data.

Frequently Asked Questions

1. **What are health care disparities?**

The word disparity can be defined as "the condition or fact of being unequal." Synonyms for disparity include inequality, unlikeness, and difference. Health care disparities can be delineated by describing differences in quality of and access to health care that lead to disparities in health outcomes and may be responsive to improvements in health care.

2. **Why is data collection of patients' race, ethnicity, and primary language important?**

Data currently available on patients' race, ethnicity, and primary language are quite limited or are inaccurate. However, these data are critical to documenting the nature of disparities in health care and developing strategies to eliminate disparities and improve quality of care.

3. **What is this Toolkit?**

This Toolkit is an easy-to-use resource for health care organizations to implement a systematic method of collecting race, ethnicity, and primary language data.

4. **What is the Toolkit designed to do?**

The Toolkit is designed to answer questions about race, ethnicity, and primary language data collection. It provides the answers to the "how to" questions and addresses concerns (legal, privacy, how to ask patients, how to address concerns) about data collection.

5. **How do I use the Toolkit?**

The Toolkit is set up to be user-friendly. The table of contents provides an outline of the type of information available on the Toolkit. On the online version, when you click on a topic area in the table of contents, you will be given a list of the resources available (PowerPoint presentations, categories to use, survey instruments, etc.). The Toolkit is designed to guide you through each step.

6. **How do I know if I need to implement this type of tool in my hospital?**

Given the changing demographics of many communities, we recommend that all hospitals and health care organizations implement a standard, systematic method of collecting race, ethnicity, and primary language data. In addition, many health care organizations need to collect these data for federal or state reporting purposes. In the near future, accreditation standards for the collection of these data may be established.

7. **How do we address patients'/family members' concerns such as, "*I have been coming here for years, don't you have that information already?*"**

You can use the following response or a modification of it:

"We may have the information already, but in some instances we do not. We want to make sure that we have the correct information for everyone so we can ensure that everyone is getting the best quality of care regardless of his/her race/ethnicity."

8. **Our system does not allow for splitting race and ethnicity as recommended by the Office of Management and Budget (OMB) 1997 revisions. How can we capture and report both these components?**

Hospitals may use one question format with ethnicity included in race if this meets their patient populations' needs. However, the race question must be asked. Hospitals may list race/ethnicity combinations as follows. (Also please go to **How to Ask the Questions** section of the Toolkit for details.)

Hispanic/Latino-White
Hispanic/Latino-Black or African American

9. **We already captured race/ethnicity using the OMB categories, but we have added other options in our registration screens. Do we have to change these to match OMB?**

It is fine to capture additional information or to add more granular categories.

10. **How do we report individuals who want to identify more than one race/ethnicity? Our registration system allows us to only select one category.**

You can add a multiracial category or, if your systems allow you to capture more than one category, record both.

11. **Does the Joint Commission currently have standards for collecting race, ethnicity, and primary language data?**

The Joint Commission does not currently have a standard for race/ethnicity data collection, but it did issue a new standard in January 2006 requiring the collection of primary language information from patients.

12. **Is it okay to first pilot test race/ethnicity/language data collection in one or two units?**

Yes, it is acceptable and recommended that you pilot your new data collection system. You may want to consider pilot testing in both inpatient and outpatient settings.

13. **When is the best time to start communicating these changes to the community and our patient population?**

As soon as possible. You can use your hospital newsletter, community meetings, e-mail, and other venues at your disposal. You may also want to develop an informational pamphlet (in conjunction with your community relations department) that registration staff can hand out to patients.

14. **Should we ask patients for their race/ethnicity/primary language each time they come to the hospital?**

If your hospital's patient registration screen can be flagged for each patient to show that the

race/ethnicity/language information was captured after the training and introduction of your new system, then you do not have to ask these questions every time. However, if you do not maintain a database (e.g., this information is purged every three months) or if your system does not allow for flagging, you may need to ask patients each time they come to the hospital. We recommend that you develop a system that enables you to capture the information only once with periodic updates (e.g., every two years).

15. What should we do if patients "refuse" or "decline" to answer the race/ethnicity questions?

It is best to flag these patients and NOT ask again. Record these as "declined." You do not want to offend patients or push the issue. Based on our experience, the percentage of refusals is very small.

16. Should the script for asking race/ethnicity/language questions be in paper or electronic format?

This decision is up to each hospital. It is easier for staff if the script is on the patient registration screen, but some hospitals have indicated that there is not enough room on their screens to accommodate this option. When the script cannot be placed directly on the screen, it is best to have laminated cards, with the script typed in large bold-faced font, at each registration station.

17. Is it okay to record race/ethnicity by observation when it is obvious to the staff and especially if the person has been coming to the hospital for years?

No. All information on race/ethnicity/language needs to be captured through self-report of the patient or his/her caregiver. Otherwise the person is recorded as either "declined" or "unavailable" (see definitions for specifications).

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Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals

June 2010



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INTRODUCTION

There is ample evidence showing that health care quality in the United States is poorer than it should be and that lapses in patient safety are common and preventable. Health care organizations have been investing significant resources to implement systems and processes to improve care quality, but must pursue these efforts strategically in order to maximize their effectiveness within an environment of growing resource constraints.

A considerable amount of information suggests that workforce practices may represent an important and underutilized resource for supporting quality improvement activities in health care organizations. The availability of a stable, capable health care workforce has been shown repeatedly to be critical to the efficient and effective delivery of health services. Although researchers are still investigating links between workforce practices and care quality, the findings so far suggest that several practices hold the potential to positively affect organizational outcomes.

The purpose of this guide is to provide hospital leaders and human resources staff a basic description of four high performance work practices (HPWPs) that hold the potential to improve an organization's capacity to effectively attract, select, hire, develop, and retain and deploy personnel in ways that best support a high-performing health care system, and to offer approaches and recommendations for implementing HPWPs in their organizations. These HPWPs fall into four categories.

HPWP Category 1: Organizational Engagement Practices

Practices that ensure all employees' awareness, understanding, and personal stake in the organization's vision, including its current level of success in pursuing that vision

Communicating mission, vision, and values

Sharing performance information

Involving employees in key decisions

Tracking and rewarding performance

HPWP Category 2: Staff Acquisition and Development Practices

Practices that build the quality of the organization's workforce through attention to attracting, selecting, and developing staff

Rigorous recruiting

Selective hiring

Extensive training

Career development

HPWP Category 3: Frontline Empowerment Practices

Practices that affect the ability and motivation of frontline staff to improve the quality of care that their teams provide

Employment security

Reduced status distinctions

Teams/decentralized decision making

HPWP Category 4: Leadership Alignment and Development Practices

Practices that develop leaders and align behavior with organizational goals.

Management training linked to organizational needs

Succession planning

Tracking and rewarding performance

Facilitators

These numerous HPWPs can be facilitated by the following actions, which will be expanded upon in a later section of this guide:

Commit to an organizational culture that focuses on quality and safety

Engage senior leadership support

Involve the human resource department in strategic planning

Identify opportunities for shared learning

Hire human resources professionals with training and experience in HPWPs

Involve employee representatives

Monitor progress

The implementation recommendations presented below were distilled from a review of peer-reviewed and gray literature covering health care and other industries, and from findings from case studies of five health care organizations that have been recognized for their successful workforce practices (e.g., *Fortune* magazine’s “Best Companies to Work For,” Baldrige National Quality Award). Page 15 contains a checklist for readers to document and assess the extent to which HPWPs are used in their organizations.

HPWP CATEGORY I: ORGANIZATIONAL ENGAGEMENT PRACTICES

Organizational engagement practices are designed to enhance employees’ awareness and personal stake in the organization’s vision and its current level of success in pursuing that vision. Four HPWPs fall under the heading of Organizational Engagement.

1. Communicating mission, vision, and values

Description: Practices that communicate the organization’s scope and purpose to employees, and clarify their role in supporting that purpose.

Implementation Recommendations:

- Incorporate the organization’s mission and values into new employee orientation.
- Incorporate the organization’s values into performance reviews; have employees “sign off” on the mission as part of their annual review.
- Discuss mission and values at the start of all internal meetings; discuss management decisions in the context of mission and vision; present the organization’s mission on the first slide for presentations.

2. Sharing performance information

Description: Practices that communicate organizational performance and other information affecting employees’ jobs and job performance.

Implementation Recommendations:

- Hold town hall meetings and other open forums to provide overviews of organizational and departmental performance.
- Share performance “report cards” regularly and widely.
- Communicate news to employees through multiple channels (e-mail and voicemail bulletins, intranet, newsletters).
- Monitor the effectiveness of communication strategies designed to reach different audiences.

3. Involving employees in key decisions

Description: Practices supporting employees' ability to influence the "decisions that matter."

Implementation Recommendations:

- Create employee councils or committees and empower them to influence key decisions.
- Hold town hall meetings and other open forums during which staff can interact with leadership.
- Develop suggestion systems.
- Use a quality/process improvement model that empowers employees to implement system improvements (e.g. Baldrige National Quality Award criteria, *Lean* training).

4. Tracking and rewarding performance

Description: Policies and practices that provide formal rewards/recognition for employees' success in achieving organization-supportive goals.

Implementation Recommendations:

- Provide recognition awards to individuals and/or teams that are tied to actions supporting the organization's mission and vision. Criteria for individual awards should consider employees' contribution to teams.
- Award spot bonuses when employees go "above and beyond" demonstrating organization's values.
- Provide annual bonuses based on organizational performance using balanced scorecards.

Organizational Engagement in Action

Several years ago, an academic medical center in the Midwest launched a large project focused on integrating the organization's mission, vision, and values (MVV) into the work and culture of the organization. The project, led by the organization's chief operating officer, was adopted because of the belief that strong MVV can lead to greater employee engagement and better organizational outcomes. The goal of program during the first year was simply MVV awareness. All employees received an hour of training on the organization's MVV, and the training was incorporated into new employee and manager orientations. A survey of employees following these trainings showed that the trainings were effective in increasing awareness of the MVV.

The second year of the program focused on engagement. The HR department developed several tools for managers to increase the focus on MVV within their departments and to foster an environment in which the values would flourish. Specifically, managers were instructed on how to establish goals for

employees that align with the organization’s MVV and to incorporate MVV into the annual performance reviews. The goal of the third year of the project was adoption. Each month, the HR department developed events and programs that focused on a different core value of the organization. For example, “collaboration” was a value selected for one month, and the HR department arranged for employees to create large greeting cards to show appreciation for the work done by different teams.

The project is overseen by a Work Culture Committee that includes the CEO, CFO and vice president of HR, and two positions were added to support the project. Progress of the project is tracked through a periodic staff survey that consists of a single question, “Would you rather work at this hospital than any other hospital in the area?” Since the start of the project, the percent of employees who responded affirmatively to the question has steadily increased. Results also indicate a strong correlation between employees’ positive responses to the question and their ability to identify their performance goals and how these relate to the organization’s goals.

Leaders of the Work Culture project offered three recommendations for implementing the project at other sites:

1. Engage senior executives. Grassroots activities are important, but rolling them out and maintaining them organization-wide requires high-level support.
2. Coordinate timing so that the initiative does not conflict with other significant efforts. If executives and employees are focused on other projects (e.g., electronic health record implementation), it will be difficult to get their attention.
3. “Slow and steady wins the race.” Incremental change brings small steps that lead to steady progress.

HPWP CATEGORY 2: STAFF ACQUISITION AND DEVELOPMENT PRACTICES

The four HPWPs in this category focus on building the quality of the organization’s workforce through attention to attracting, selecting, and developing staff.

I. Rigorous recruiting

Description: Activities and outcomes associated with outreach to attract new employees.

Implementation Recommendations:

- Identify your strengths as an employer. Survey your employees to learn the reasons why they choose to work with you rather than other employers, and search for ways to further strengthen those attributes.

- Use your strengths to proactively cultivate the image of your organization as a highly desirable place to work. This could be accomplished through, for example, communicating the mission-driven focus of your staff, the quality of work life you offer, attractive benefits, flexible working arrangements, competitive pay (e.g., 50th percentile for most jobs, 65% for managers, 75% for hard-to-fill positions).
- Develop highly efficient and targeted strategies for recruitment for your high-volume and hard-to-fill positions, such as nurses and pharmacists. For example, form partnerships with local schools and develop special pages on your website for recruitment of hard-to-fill positions.
- Continuously evaluate your recruiting systems against industry best practices. For example, review best recruiting practices offered by the American Society for Healthcare Human Resources Administration (ASHHRA).

2. Selective hiring

Description: Practices associated with ensuring that open positions are filled with the highest-quality candidates available from the applicant pool.

Implementation Recommendations:

- Use pre-screening tools for high-volume applicant positions.
- Adopt validated selection tools (e.g., objective assessments, behavior-based interviewing) that tie selection to the knowledge, skills, and attitudes that directly contribute to quality, safety, and other performance goals.
- Assess candidates' fit within the culture of the organization through peer interviewing and team selection processes.

3. Extensive training

Description: Activities involving a more-than-mandated, more-than-typical investment in developing staff in order to achieve greater organizational effectiveness.

Implementation Recommendations:

- Develop internal conferences and workshops around organizational goals and skill development needs.
- Encourage continuing education activities that are aligned with organizational goals through organizational sponsorships, and hold attendees accountable for “bringing back” what they learn to their parts of the organization.
- In areas where skills are not present in-house, consider bringing in outside speakers, rather than (or in addition to) sending individuals out to conferences.

4. Career development

Description: Practices which focus on identifying career opportunities and pathways for current employees, as well as providing training to support those opportunities. Practices related to career development also include an emphasis on internal labor pools for filling open positions.

Implementation Recommendations:

- Emphasize opportunities to develop and recruit from within.
- Encourage flexibility to move within the organization to departments or units that best fit employees' interests and skills.
- Provide educational support (e.g., tuition assistance) for employees to pursue career paths within your organization.

Staff Acquisition and Development Practices in Action

Five years ago, a large safety net hospital launched a system transformation to improve quality. One component of that transformation involved matching the right people to the right positions. The organization's CEO and other senior leaders embraced concepts from the book *Good to Great*, which holds that it is easier to teach, correct, or remediate skill gaps than it is to address talent or attitudinal gaps. Based on a strong recommendation from the head of a leading firm in a non-medical service industry and with the help of an outside firm, the organization adopted a talent assessment and selection process for new recruits and applicants requesting a promotion.

The structured selection process represented a significant change from hiring based solely on clinical skills, training, credentials, and experience. The process involves a systematic interview, which assesses candidates' abilities in several behavioral areas (for example, ability to manage change and difficult situations, or ability to build relationships), with the goal of selecting people who will support the desired culture of the organization. The selection system is managed by an external provider, who monitors the protocol to ensure the process provides valid predictions for areas of importance for the organization.

Fifteen people within the organization have been trained to conduct the structured interviews for entry-level and managerial positions, and two consultants lead the interviews for director-level and above positions. Retention rates among those who were hired under the new process are higher than those who were not. To further evaluate the process, the organization is now in the process of investigating the links between their selection process and both absenteeism and patient satisfaction.

Although the organization has now embraced the new selection process, it has also created some challenges. The interviews have to be scored, which adds 1–2 weeks to the hiring process. Also, a hiring manager might not be able to select his or her top candidate if the candidate does not score well on the interview. There is an appeal process that will, in some cases, allow the manager to “override”

the decision. There are also concerns that the interview may not be culturally sensitive. Organizations considering the adoption of a formal selection process should always consider evidence of validity prior to implementation, and involve end-users in the implementation process.

HPWP CATEGORY 3: FRONTLINE EMPOWERMENT PRACTICES

The three HPWPs in this category are those that most directly affect the ability and motivation of frontline staff, clinicians in particular, to influence the quality and safety of their care.

1. Employment security

Description: Policies and practices that ensure employees greater-than-mandated security in their positions.

Implementation Recommendations:

- Develop a commitment to preventing the need for layoffs, and pursue organizational policies that provide for alternatives.
- Employ policies that protect employees from repercussions for “speaking up” about quality and safety concerns.
- Train staff on methods that will support and empower staff to speak up when they observe potential problems with quality and safety.
- Reinforce appropriate examples of speaking up and supporting patient safety by communicating and disseminating the examples.

2. Reduced status distinctions

Description: Practices that emphasize egalitarianism across employee roles.

Implementation Recommendations:

- Have managers and organization leaders model openness and availability to receive feedback from employees.
- Discourage the use of formal titles in team conversations (e.g., use first names).
- Provide training and policies that encourage teamwork and minimize hierarchy.

3. Teams/decentralized decision making

Description: Practices of formalizing/defining employee roles according to teams, and providing those teams (and the individuals in them) greater latitude in decision making related to how their work is organized and completed.

Implementation Recommendations:

- Implement shared governance and staff practice councils.
- Hold regular team huddles to discuss current status and concerns.
- Provide opportunities for teams to participate together in training.
- Involve members of departments/units in setting performance goals and metrics.
- Consider employees' contribution to teamwork in performance reviews

Frontline Empowerment Practices in Action

Lean/Toyota Production System (TPS) is well-recognized as an effective approach to reducing waste and inefficiency in health care. Lean is also an example of several HPWPs, including the decentralization of decision making and the reduction of status distinctions.¹

A safety net hospital in a large metropolitan area selected Lean as its primary method of quality improvement, integrating it into 15 areas of the organization, including human resources, finance, and clinical care. Senior executives of the organization, particularly the CEO, are strong supporters of Lean, and described waste as disrespectful because it squanders scarce resources, makes employees do work with no value, and makes patients endure processes with no value.

The hospital has a Lean department that employs 8 facilitators. With guidance from an outside consultant (a “sensei”), the facilitators oversee approximately 120 rapid improvement events (RIE) per year within the organization. During a RIE, a team of 8-10 staff spend a week focuses on improving a particular process or area. They spend the first two days mapping out the current process and identifying possible improvements. By the third day, the team implements the improvements; on the fourth day they turn the improvements into standard work; and on the fifth and final day they report the results to executive staff.

Front-line employees and executives work together on the RIE teams, which helps reduce status distinctions within the organization. Front-line staff find RIEs to be empowering because they serve as a vehicle for expressing ideas and implementing change. Through the RIE process, the teams develop production boards and matrices that they then post on the walls. The postings facilitate communication and transparency about the changes occurring.

At this organization, two hundred staff received additional Lean training and have earned the designation of “black belt.” The black belts are tasked with developing an idea for improvement every other month

and are expected to generate \$30,000 in cost savings each year. The CEO reviews monthly reports on their progress, and this accountability creates considerable competition around finding ways to eliminate waste.

Surveys of employee engagement at this organization show that staff who are involved in RIEs are more engaged than those who have not participated. The organization estimates that it has saved over \$27 million through improvements resulting from applications of Lean since the inception of the program.

HPWP CATEGORY 4: LEADERSHIP ALIGNMENT/DEVELOPMENT

The three HPWPs in this category are those that develop leaders and align behavior with organizational goals.

I. Management training linked to organizational needs

Description: Practices involving the alignment of leadership development resources with the strategic direction of the organization.

Implementation Recommendations:

- Use corporate goals to prioritize training, assessment, and feedback programs provided to managers.
- Use new or existing leadership forums as vehicles to provide opportunities for skills development in areas of organizational need.
- Enlist managers to help employees connect their work to the goals and vision of the organization. Encourage managers to make sure their employees' goals align with the organization's goals.

2. Succession planning

Description: Proactively identifying and planning for future leadership needs.

Implementation Recommendations:

- Use talent assessments to identify employees with potential for promotion ahead of time.
- Require managers to create career development plans for the individuals reporting to them.
- Provide support for the development of high-potential future leaders through mechanisms such as mentoring programs, stretch assignments, and job rotations.

3. Tracking and rewarding performance

Description: Policies and practices that provide formal rewards/recognition for leaders' success in supporting organizational goals.

Implementation Recommendations:

- Provide annual bonuses based on objective measures of organizational performance.
- Support the appropriate use of incentives by implementing balanced scorecards that are relevant to the individual leader's scope of work.
- Provide other mechanisms for recognizing leaders who have modeled support of the organization's mission and goals through their own actions.

Leadership Development in Action

Executives at a large not-for-profit health system recognized that identifying and developing leaders is key to achieving organizational goals. They implemented several education and training strategies, one of which was a leadership development series. Every quarter, all department managers, directors, and even leaders above that level—1400 people in all—participate in a day of learning. The day begins with an address by the CEO focusing on the system's performance indicators and highlighting progress toward meeting performance targets. New leaders are introduced, and then a speaker gives a presentation aligned with the organization's goals. The afternoon includes exercises that reinforce the messages conveyed by the speaker, and at the end of the day, leaders are asked to integrate the learning into their departments' action plans. There is an accountability grid with measureable outcomes that the leaders are expected to achieve by the end of the quarter, and leaders are accountable to their supervisors for progress toward these outcomes.

In addition, the organization offers leadership boot camps, which are smaller workshops for new leaders and leaders who need or want additional training in a given area, for example, in building relationships with employees or in hiring new employees. Approximately 1,000 leaders attend a boot camp each year, and the camps range in size from 10 to 40 attendees. All of the presentations and tools from the leadership development series and the boot camps are available on the organization's intranet. The boot camp sessions are advertised on the site.

FACILITATING THE ADOPTION OF HIGH-PERFORMANCE WORK PRACTICES

Findings from the literature review and case studies suggest that there are several actions that can facilitate the adoption of HPWPs. We offer the following recommendations for the adoption of HPWPs:

- 1. Commit to an organizational culture that focuses on quality and safety.* Use HPWPs to support that culture.
- 2. Engage senior leadership support.* Ensure that top and mid-level leaders are involved in the planning and implementation of HPWPs and that they reinforce the purpose and importance of HPWPs in communications with employees.
- 3. Involve the human resource department in strategic planning.* Implementation of HPWPs should be tied to the strategic decision-making process of the organization from the beginning. The best way to accomplish this is for HR to have a direct voice in strategic planning.
- 4. Identify opportunities for shared learning.* Help the people who are accountable for HPWP implementation find colleagues at other organizations that have implemented such practices successfully. Sources for these contacts could include professional associations (e.g., American Society for Healthcare Human Resources Administration, state hospital associations) as well as other shared learning collaboratives.
- 5. Hire human resources professionals with training and experience in HPWPs.* Make sure your organization has a critical mass of professionals who have the training and experience to understand, implement, and evaluate these best practices.
- 6. Involve employee representatives.* Ensure that both senior leaders and labor representatives understand the purpose and goals of HPWPs, and involve both groups in overseeing their implementation.
- 7. Monitor progress.* Include a review of HPWP implementation progress along with organizational progress on quality, safety, and efficiency goals.

CONCLUSION

Health care organizations invest considerable resources to improve quality and other dimensions of organizational performance. To cope with growing resource constraints, systems must make strategic choices about which improvement initiatives to pursue and how best to implement these initiatives. Personnel requires the single largest expense associated with health services delivery, so strategic management of human resources can help organizations leverage multiple opportunities to promote quality improvement and improve performance.

ORGANIZATIONAL ASSESSMENT

The following checklist may be used to assess the extent to which your organization has adopted high-performance work practices. The goal of the assessment is to create awareness of the areas in which your organization may direct future efforts.

	Yes, we currently use this practice	We have a plan in place to implement this practice	No, we do not currently use this practice
Organizational Engagement Practices			
1. Communicate mission, vision, and values			
2. Share performance information			
3. Involve employees in key decisions			
4. Track and reward performance			
Staff Acquisition and Development Practices			
1. Rigorous recruiting			
2. Selective hiring			
3. Extensive training			
4. Career development			
Frontline Empowerment Practices			
1. Employment security			
2. Reduced status distinctions			
3. Teams/decentralized decision making			
Leadership Alignment/Development			
1. Management training linked to organizational needs			
2. Succession planning			
3. Tracking and rewarding performance			

RESOURCES

Collins, J. (2001). *Good to Great: Why some companies make the leap... and others don't*. New York: Harper Collins.

Collins led a team of people to investigate how eleven companies successfully moved from good to great. They identified several traits that were present in all eleven companies, but largely absent from a group of comparison companies. Collins presents these traits, and organizes them into a framework. The book includes many stories and examples geared toward leaders interested in moving their organizations from good to great.

Executive Pay and Quality: New Incentive Links — National Survey Results. Minneapolis, Minnesota: Integrated Healthcare Strategies; 2007.<http://www.ihstrategies.com/pdf/NewIncentiveLinks.pdf>
The report presents findings from a survey of hospital CEOs and human resource executives from 119 organizations regarding the motivations, levels, metrics, and methods of incentive pay for hospital physician and administrative leaders during the summer of 2007.

Eaton, S. (2000). Beyond 'unloving care': linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management*, 11(3), 591-616.
Through case studies of 20 long term care organizations, the author concludes that low quality care is linked to employees' low quality jobs and work environments. The author provides examples of innovative human resource management practices and work structures that have resulted in high quality long-term care, and observes that these promising structures require change in work organization and HR. She describes common barriers to the diffusion of promising structures and offers a 'high performance' model of nursing home organization.

Denver Health. (2002). *A Toolkit for Redesign in Healthcare*. AHRQ Publication No. 05-0108-EF, prepared by Denver Health under Contract No. 290-00-0014. Agency for Healthcare Research and Quality, Rockville, MD. (Available at: <http://www.ahrq.gov/qual/toolkit/>).

This toolkit presents an approach for comprehensively redesigning and transforming hospital care, based on the experience of Denver Health. The Toolkit describes the factors that compel a hospital to begin a transformation, and provides planning steps, strategies for proposing implementation projects, and metrics for the implementation phase. The Toolkit enables readers to identify the attributes of their systems that are similar to or different from those of Denver Health, and assess how these attributes may influence their approach to the redesign described.

Frankel, A.S., et al. (2006). Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability. *Health Services Research*, 41(4), 1690-1709.
The authors observed that industries outside of health care have improved reliability by applying innovative concepts to interpersonal relationships and administrative hierarchical structures. The authors introduce and describe three initiatives that can serve as a cornerstone for improving reliability in health care organizations: (1) a Fair and Just Culture, (2) teamwork training and communication, and (3) leadership walk rounds. They argue that the three initiatives are critical and related requirements for safe and reliable care, and offer many implementation examples.

Keroack, M.A., et al. (2007). Organizational factors associated with high performance in quality and safety academic medical centers. *Academic Medicine*, 82(2), 1178-1186.
The authors used qualitative methods to identify organizational factors at academic medical centers that distinguished superior performers from average ones. Common qualities shared by top performers included a shared sense of purpose, a hands-on leadership style, accountability systems for quality and safety, a focus on results, and a culture of collaboration.

Kotter, J. P. (2007). Leading change: Why transformation efforts fail. *Harvard Business Review*, 96-103. Based on observations of more than 100 companies' efforts to remake themselves into better competitors, Kotter describes eight critical success factors, including forming a powerful guiding coalition, creating and communicating the vision, and empowering others to act on the vision. He also offers two general lessons learned from more successful cases: (1) change process goes through a series of phases that usually require a considerable length of time, and (2) critical mistakes in any phase can have a devastating impact, slowing momentum and negating hard won gains.

Martin LA, Nelson EC, Lloyd RC, Nolan TW. *Whole System Measures*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org) The authors present 13 measures that can be used to examine quality at the system level. The measures can be a useful framework for organizing measures of care quality and can contribute to an organization's balanced scorecard or dashboard of strategic performance measures. The authors offer guidance for implementing the whole system measures, including roles for specific individuals.

McAlearney, AS. (2008). Using Leadership Development Programs to Improve Quality and Efficiency in Healthcare. *Journal of Healthcare Management*, 53(5), pp 319-331. The author uses data from three qualitative studies of leadership development to describe the ways in which leadership development programs can improve quality and efficiency. Analyzing data from 200 interviews conducted between 2003 and 2007 with health system managers and executives, academic experts, consultants and others, the author identifies four opportunities for these programs to improve quality and efficiency: (1) by increasing the caliber of the workforce, (2) by enhancing efficiency in the organization's education and development activities, (3) by reducing turnover and related expenses, and (4) by focusing organizational attention on specific strategic priorities.

Meyer, J.A., et al. (2004). Hospital quality: Ingredients for success – overview and lessons learned. (Available on www.Commonwealthfund.org). The authors summarize findings on the key ingredients that contribute to the success of quality improvement strategies, based on site visit and interviews with four top performing hospitals. They describe four key elements for success: developing the right culture, attracting and retaining the right people to promote quality, devising the right processes for QI, and giving staff the right tools for the job.

Nolan TW. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org). In many organizations, quality improvement began with individual improvement projects. Over time, quality improvement has become part of the strategic plans of many health care organizations. Based on interviews with health care and non-health care organizations and their experience at IHI, the authors offer a framework for executing strategic initiatives to achieve system-wide results. The framework contains three interrelating parts: system-level aims, pervasive local improvement, and continuous development of people's capabilities to lead improvement and attain system-level results.

Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available on www.IHI.org) Based on learnings from *100,000 Lives*, *5 Million Lives*, and other IHI initiatives, the authors offer seven tasks "Leverage Points" for leaders to achieve results in quality and safety at the level of entire organizations and care systems. The seven Leverage Points will help leaders get started with quality initiatives, and prioritize actions. The

white paper offers several examples of the field application of each leverage point and also includes a self-assessment tool to help administrative, physician, and nursing leaders design and plan their work using the Seven Leadership Leverage Points.

Tzafir SS and Gur, A. (2007). HRM Practices and Perceived Service Quality: The Role of Trust as a Mediator. *Research & Practice in Human Resource Management*, 15(2), pp 1-16.

Organizational practices are among the most important drivers of employee satisfaction. The authors collected data from 411 employees and managers of an Israeli health care organization and found that human resource management practices have a direct impact on employee perceptions of service quality.

ⁱ The origins of Lean stem from the work of W. Edwards Deming, who called for improvements in quality by focusing on improving the production process, building quality into the product at the forefront instead of relying on later inspections. Taichi Ohno of Toyota adopted and extended Deming's work for the design of their manufacturing process, the Toyota Production System (TPS). The TPS is focused on establishing a customer-focused environment, making continuous improvements, correcting problems as they arise, and eliminating waste. "Lean" was a term developed in the 1980s to describe the TPS.

Lean/TPS has been described as a philosophy, a management strategy, and a set of tools or practices (AHRQ 2007; Jimmerson et al 2005; IHI 2005). As a philosophy, Lean calls for bringing value to the customer and eliminating waste in the production process. The Lean management strategy is focused on streamlining processes to reduce cost and improve the quality and timeliness of products. Lean practices range from material flow in a factory, to equipment design, to human resource practices. Overall, the goal of Lean/TPS is to produce the desired amount of product at the highest level of quality, using as few resources as possible (Sobek and Jimmerson 2003).



Signature Leadership Series

Health Care Leader Action Guide to Reduce Avoidable Readmissions

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Executive summary

Reducing avoidable hospital readmissions is an opportunity to improve quality and reduce costs in the health care system. This guide is designed to serve as a starting point for hospital leaders to assess, prioritize, implement, and monitor strategies to reduce avoidable readmissions.

Steps for hospital leaders to reduce avoidable readmissions

Recognizing that hospitals may be at different points in the process, this guide follows a four-step approach to aid hospital leaders in their efforts to reduce avoidable readmissions. The four steps are:

- 1 Examine your hospital's current rate of readmissions.**
- 2 Assess and prioritize your improvement opportunities.**
- 3 Develop an action plan of strategies to implement.**
- 4 Monitor your hospital's progress.**

Major strategies to reduce avoidable readmissions

This guide is meant to address readmissions that are avoidable and not all readmissions. Many readmissions, in fact, could represent good care; such as those that are part of a course of treatment planned in advance by the doctor and patient, or readmissions that are done in response to trauma or a sudden acute illness unrelated to the original admission. Neither public policy nor hospital actions should deter these readmissions from occurring. Instead, this guide is meant to better equip hospitals to address the readmissions that are unplanned and potentially the result of missteps in care either during the hospitalization or in the period immediately following the hospitalization. Hospitals should focus on these potentially avoidable readmissions to see if they can act – or they can encourage others to act - in such a way as to reduce their occurrence. This document suggests strategies that hospitals could pursue at different stages of the care continuum to reduce avoidable readmissions.

The strategies on the tables below are the foundational actions in the different interventions to reduce avoidable readmissions.

Table 1: During Hospitalization

- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use “teach-back” to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

Table 2: At Discharge

- Implement comprehensive discharge planning
- Educate patient/caregiver using “teach-back”
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

Table 3: Post-Discharge

- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

Why readmission rates matter

Hospitals' avoidable readmission rates have come under close scrutiny by payers and policymakers because of the potential of high savings associated with them. According to a recent study, unplanned readmissions cost Medicare \$17.4 billion in 2004.ⁱ The study found that 20 percent of Medicare fee-for-service patients were readmitted within 30 days of discharge. In addition to having financial implications, avoidable readmissions are increasingly viewed as a quality issue by payers, health care organizations, and patients, with some research showing that readmission rates may be correlated with quality of care.ⁱⁱ Not all readmissions are entirely preventable, and thus, constitute a quality issue. However, a portion of unplanned readmissions that are related to the original reason for admission could be prevented by taking actions that address the processes that led to the readmission. Certain patient-level factors such as patient demographics (elderly, dually eligible Medicare enrollees), clinical conditions (cardiovascular conditions, stroke, and depression), race, and gender may be predictors of readmissions.ⁱⁱⁱ The strategies proposed in this guide directly or indirectly address these factors.

Addressing the issue of potentially avoidable readmissions requires a community approach with input from various actors across the continuum of care. Better health care outcomes are not only dependent on receiving better care in the hospital, but increasingly, on receiving better care at home. The current fragmentation of the US health care system makes this a challenging concept. While most of the efforts to reduce avoidable readmissions focus on factors that are often outside of the hospital's control—empowering patients, consumers, families, and caregivers to navigate their way around community support services and organize their care at home—there are still actions that hospitals can take to make a difference. Hospital leaders will also benefit from positioning their organizations to succeed in the face of financial penalties and other payment reforms suggested in recent legislative proposals to address avoidable readmissions. The step-by-step actions in this guide provide a springboard for hospital leaders to proactively address avoidable readmissions.

“Success in reducing readmissions lies in effectively partnering to not only achieve better outcomes but also to reduce the fragmentation and lack of support that so often comes with transitions between providers and care settings.”

- Amy Berman, Program Officer, The John A. Hartford Foundation

Steps for hospital leaders to reduce avoidable readmissions

Several interventions have been developed to reduce avoidable readmissions. Whereas some interventions are supported by a robust evidence-base, others require evidence to support their effectiveness in reducing avoidable readmissions. A detailed chart of these interventions is included in Table A in the Appendix. Recognizing that not every hospital has the resources or need to implement the entire suite of strategies recommended by the interventions, we identified the crosscutting strategies in these interventions that hospitals could implement. Even though there is no evidence supporting the ability of individual strategies to reduce avoidable readmissions, each of these strategies could help address the underlying reasons for readmissions such as improper transitions and lack of communication between care providers and patients. Health care leaders may need to implement several of these strategies or augment the actions that are already underway in their facilities to see a reduction in avoidable readmissions. The steps for hospital leaders included in this guide are:

- 1 Examine your hospital's current rate of readmissions.**
- 2 Assess and prioritize your improvement opportunities.**
- 3 Develop an action plan of strategies to implement.**
- 4 Monitor your hospital's progress.**

1

Examine your hospital's current rate of readmissions.

First, hospitals need to compile information on their readmission rates. Payers, legislators, and other health care stakeholders are focusing on readmissions data as evidenced by the reporting of 30-day readmission rates for heart attacks, heart failure, and pneumonia on *Hospital Compare* (www.hospitalcompare.hhs.gov). Knowing the readmission rates and trends in their facilities could aid hospital leaders to better target strategies for reducing them. One approach for gathering data is for hospitals to track and review data on patients being readmitted to their facility. In areas where the data is available, hospitals may also want to review other hospitals' readmissions data provided by state agencies and local payers. Hospitals could examine readmissions data for the following trends:

- **Readmission rates for different conditions:** To the extent feasible, examine readmission rates by diagnosis and significant co-morbidities, and look for correlation with the patient's severity.
- **Readmission rate by practitioners:** Examine the rates by physician to determine if the patterns of readmissions are appropriate or if any type of practitioner is associated with unexpected readmissions.
- **Readmission rates by readmission source:** Examine the rates by readmission source (for example, home, nursing home, etc.) to determine the places from which patients are most often being readmitted.
- **Readmission rates at different time frames:** Examine readmissions within a given time period such as 7, 30, 60, and 90 days. Examining a shorter timeframe may bring to light issues more directly related to hospital care or flaws in the process of transitioning the patient to the ambulatory setting. Examining the longer timeframe may reveal issues with follow-up care and patients' understanding of self care.

To supplement the internally and externally reported data on readmissions, health care leaders and practitioners should seek to more deeply understand readmissions in their facilities. An effective way of doing this is to review the charts of a few patients who have been admitted repeatedly from various sources. In reviewing the charts, hospitals should follow the trajectory of patient's care to understand why the patient was readmitted and what could have been done to prevent the readmission. Analyzing individual cases of readmitted patients will help health care leaders and front line clinical staff to understand the underlying failures that occurred in the care process and also witness firsthand the detrimental impact of the readmission.

"Hospitals are constantly assessing and improving quality of care and implementing better patient safety systems that are transparent to the community. The growing interest in hospital readmissions will provide us opportunities to both improve the quality of care and reduce costs."

- Rich Umbdenstock, President & CEO, American Hospital Association

In addition to the analyses recommended above, hospitals should examine the impact of avoidable readmissions on their finances, specifically, the current revenues and costs associated with readmissions. Recent legislative proposals seek to reduce payments to hospitals that have relatively high readmissions rates for certain conditions and establish a pilot program to test bundling payments for an episode of care, combining payment for initial and subsequent hospitalizations. Understanding the financial implications of readmissions will better position hospitals for future legislation tying reimbursement to readmissions and for potential reductions in revenues resulting from decreased readmission rates. Specifically, hospitals could examine whether reducing avoidable readmissions would affect their volume and potentially alter patient-mix.

2

Assess and prioritize your improvement opportunities.

Once hospital leaders determine the rates and trends of avoidable readmissions in their facilities, the second step is to prioritize their areas of focus. The prioritization process should capitalize on immediate opportunities for improvement for the hospital. Hospital leaders may follow one or more of the following approaches:

Focus on specific patient populations: If it is identified that readmissions rates are especially high for certain conditions or for specific patient populations, hospitals could focus on those conditions or patient populations. For example, for older adults who tend to be multiply co-morbid, hospitals could institute a more rigorous risk-assessment process to determine and address risk factors upon admission and at discharge.

Focus on stages of the care delivery process: Similarly, if it is identified that patients are readmitted for the same reasons, it could point to areas for improvement in the care delivery process. For example, discharge processes could be strengthened to include a component of patient/caregiver education to empower them to take charge of their care post-discharge.

Focus on hospital's organizational strengths: Hospitals could also address the issue of readmissions by harnessing the resources available to them. For example, hospitals serving ethnically diverse patients could harness the language skills of a multilingual staff in communicating care plans or discharge instructions to patients and caregivers. Similarly, a facility with a comprehensive electronic health record system could use the components of the system to coordinate patient care in their efforts to reduce readmissions.

Focus on hospital's priority areas and current quality improvement initiatives: Mandatory and voluntary quality improvement programs in which hospitals are currently involved could serve as a vehicle for prioritizing readmissions focus. As identified in Table B in the Appendix, several past and current quality improvement programs include a redesign of fundamental care processes that could be harnessed to concurrently reduce readmissions. By reviewing hospitals' current priorities, leaders could seamlessly incorporate readmissions goals into existing initiatives and assess progress.

3

Develop an action plan of strategies to implement.

A detailed chart of some interventions that have been successfully implemented in various clinical settings is included in Table A in the Appendix.^{iv} To facilitate hospital leaders' understanding of these interventions to reduce readmissions, the third step of this guide attempts to synthesize the foundational strategies in the interventions. The strategies are summarized in Tables 1, 2, and 3 on the following page. To effectively implement the strategies identified in the three tables, hospitals may need to involve key stakeholders in the care delivery process: patients, physicians, pharmacists, social services, nutritionists, physical therapists, and the community.

“Rehospitalization is a system issue and the problem does not lie with one organization or one provider, but with the community and the local health care system. Addressing this issue will require organizations and providers to work together.”

- Anne-Marie Audet, VP, The Commonwealth Fund

Getting the health care team on board to address the issue

Since practitioners drive health care delivery, their active participation is needed in strategies to reduce avoidable readmissions. In some cases, hospitals may have to identify and overcome barriers to interdisciplinary/multidisciplinary care practices. Hospitals may also need to circumvent misalignment of hospital and physicians' incentives to obtain physician buy-in on the hospital's quality improvement goals. A proven approach for engaging practitioners is to pull together a core team of hospital staff (physicians, nurses, quality specialists, case managers, and pharmacists) to champion the hospital's work on readmissions, and then roll out the efforts to the medical staff.

Developing community connections to eliminate barriers to successful care transitions

Addressing the issue of avoidable readmissions requires hospitals to build partnerships with other health care providers as well as with public and private support groups in their communities. These partnerships will help facilitate the transition of patients back into the community by leveraging partners to ensure continuity of care for patients following hospitalization. Partners are able to ensure that the next care provider is aware of the patient's status and care information, and to direct at-risk patients such as low-income populations and elderly or frail patients to needed care following hospitalization. Community partners are also sometimes equipped to address non-medical factors that could lead to readmissions such as behavioral, health literacy, and cultural issues. In places where these partnerships already exist, hospitals could focus on strengthening and maximizing their benefit.

Engaging patients, families, and caregivers in addressing the issue

Even though patients and their families are active participants in the health care system, their feedback is often not sought in addressing health care delivery issues. Successfully reducing readmissions rates may depend on patients'

ability to understand three things: their diagnosis, the care they receive, and their discharge instructions. Hospitals could successfully engage patients in care delivery by establishing hospital-based patient advisory councils or by partnering with existing patient advocacy groups.^v Patients' ability to engage in their care is influenced by several factors such as their clinical, physical, and emotional status, the support system available to them, their ability to organize care and medications, and language and cultural barriers. Patients' families and caregivers could be effectively engaged in patient care to help overcome some of these behavioral, cultural, and literacy factors. Another proven strategy to improving patients' health literacy is the use of the "teach-back" technique. Practitioners, families, and caregivers can be assured of patients' level of comprehension by asking them to repeat or demonstrate what they have been told.

Major strategies to reduce avoidable readmissions

The strategies in the three tables below are organized by the level of effort required to implement them. In general, implementation will require process changes in hospitals. However, strategies requiring "low effort" can be implemented using the hospital's existing resources. "Medium effort" strategies may require hospitals to acquire additional resources, especially human resources, while "high effort" strategies may necessitate the installation of complex and sometimes costly systems. In addition to considering the level of effort involved in implementing these strategies, health care leaders should also consider the value conferred by these strategies. The amount of effort required to implement a strategy may not correspond with its value in health outcomes and cost savings. For example, a multisite randomized controlled trial found that coordinating patient care across a multidisciplinary care team, a high effort activity, coupled with other activities, demonstrated annual average savings of \$4,845 per patient after accounting for the cost of the intervention.^{vi} High effort systems, such as, telehealth, electronic medical records, and remote monitoring could also be leveraged to achieve several patient safety and quality improvement goals, therefore warranting the higher initial investment. The strategies are grouped by the stages of care where they can be applied as presented in Tables 1, 2, and 3 below:

- Table 1: During hospitalization
- Table 2: At discharge
- Table 3: Post-discharge

Using the priority areas identified in the previous steps, hospital leaders can check off strategies in the tables below that their facilities can focus on to reduce their rates of avoidable readmissions.

Table 1: During Hospitalization

- Risk screen patients and tailor care
- Establish communication with PCP, family, and home care
- Use "teach-back" to educate patient about diagnosis and care
- Use interdisciplinary/multidisciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

Table 2: At Discharge

- Implement comprehensive discharge planning
- Educate patient/caregiver using "teach-back"
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

Table 3: Post-Discharge

- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

Upon admission and during hospitalization, opportunities exist for hospitals to enhance the care that patients receive to facilitate discharge planning and post-discharge care. The strategies identified in Table I are primarily hospital-based and can be performed by nurses, physicians, caseworkers, or other hospital staff.

Table I: During Hospitalization—Strategies to Prevent Readmissions

Strategies ^{vii}	Level of Effort	Actions	Selected Interventions that Use Strategies ^{viii}
<input type="checkbox"/> Risk screen patients and tailor care	Low	<p>Proactively determining and responding to patient risks</p> <p>Tailoring patient care based on evidence-based practice, clinical guidelines, care paths, etc.</p> <p>Identifying and responding to patient needs for early ambulation, early nutritional interventions, physical therapy, social work, etc.</p>	<p><i>Colorado Foundation for Medical Care and Partners (Care Transitions Intervention (CTI))</i></p> <p><i>Guided Care</i></p> <p><i>HealthCare Partners Medical Group</i></p> <p><i>Heart Failure Resource Center</i></p> <p><i>INTERACT</i></p> <p><i>John Muir Health (CTI)</i></p> <p><i>Kaiser Permanente Chronic Care Coordination</i></p> <p><i>Novant Physician Group Practice Demonstration Project</i></p> <p><i>Project BOOST</i></p> <p><i>Summa Health System</i></p> <p><i>Transitional Care Model</i></p> <p><i>Transitions Home for Patient with Heart Failure: St. Luke's Hospital</i></p> <p><i>Visiting Nurse Service of New York</i></p>
<input type="checkbox"/> Establish communication with PCP, family, and home care	Low	<p>PCP serving as a core team member of patient care delivery team</p> <p>Family or home care agency is informed of patient care process and progress</p>	<p><i>Commonwealth Care Alliance: Brightwood Clinic</i></p> <p><i>Guided Care</i></p> <p><i>Project BOOST</i></p> <p><i>Transitional Care Model</i></p> <p><i>Visiting Nurse Service of New York</i></p>
<input type="checkbox"/> Use “teach-back” to educate patient about diagnosis and care	Low	<p>Clinician educating patient about diagnosis during hospitalization</p>	<p><i>Novant Physician Group Practice Demonstration Project</i></p> <p><i>Project BOOST</i></p> <p><i>Re-Engineered Discharge/RED</i></p> <p><i>STAAR</i></p> <p><i>Transitional Care Model</i></p>
<input type="checkbox"/> Discuss end-of-life treatment wishes	Medium	<p>Discussing terminal and palliative care plans across the continuum</p>	<p><i>Blue Shield of California</i></p> <p><i>Evercare™ Care Model</i></p> <p><i>St. Luke's Hospital</i></p> <p><i>Transitions Home for Patient with Heart Failure: St. Luke's Hospital</i></p> <p><i>Transitional Care Model</i></p>
<input type="checkbox"/> Use interdisciplinary/ multidisciplinary clinical team	Medium	<p>Team including complex care manager, hospitalists, SNF physician, case managers, PCPs, pharmacists, and specialists</p> <p>Team including bilingual staff and clinicians (where needed)</p>	<p><i>Commonwealth Care Alliance: Brightwood Clinic</i></p> <p><i>Guided Care</i></p> <p><i>HealthCare Partners Medical Group Kaiser Permanente Chronic Care Coordination</i></p> <p><i>Transitional Care Model</i></p>
<input type="checkbox"/> Coordinate patient care across multidisciplinary care team	High	<p>Using electronic health records to support care coordination</p> <p>Using transitional care nurse (TCN) (or similar role) to coordinate care</p>	<p><i>Commonwealth Care Alliance: Brightwood Clinic</i></p> <p><i>Guided Care</i></p> <p><i>Home at Home</i></p> <p><i>Sharp Reese-Stealy Medical Group</i></p> <p><i>Transitional Care Model</i></p> <p><i>Visiting Nurse Service of New York</i></p>

The actions identified to be performed at discharge could also be performed by other practitioners such as the primary care provider, home health agencies, long term care facilities, as well as caregivers, and community social networks for patients. Hospitals could however initiate these actions at discharge as described on Table 2 below.

Table 2: At Discharge—Strategies to Prevent Readmissions

Strategies ^{ix}	Level of Effort	Actions	Selected Interventions that Use Strategies ^x
<input type="checkbox"/> Implement comprehensive discharge planning	Medium	Creating personalized comprehensive care record for patient, including pending test results and medications Hospital staff communicating discharge summary to PCP or next care provider Reconciling discharge plan with national guidelines and clinical pathways Providing discharge plan to patient/caregiver Reconciling medications for discharge Standardized checklist of transitional services	<i>Project BOOST</i> <i>Re-Engineered Discharge/RED</i> <i>STAAR</i> <i>Transitional Care Model</i>
<input type="checkbox"/> Educate patient /caregiver using “teach-back”	Medium	Reviewing what to do if a problem arises Focusing handoff information on patient and family	<i>St. Luke’s Hospital</i> <i>Guided Care</i> <i>John Muir Health</i> <i>Re-Engineered Discharge/RED</i> <i>STAAR</i> <i>St. Luke’s Hospital</i> <i>Transitional Care Model</i> <i>Transitions Home for Patient with Heart</i> <i>Visiting Nurse Service of New York</i>
<input type="checkbox"/> Schedule and prepare for follow-up appointment	Medium	Transmitting discharge resume to outpatient provider Making appointment for clinician follow-up	<i>Care Transitions Program (CTI)</i> <i>Colorado Foundation for Medical Care and Partners(Care Transitions Intervention (CTI))</i> <i>John Muir Health (CTI)</i> <i>Re-Engineered Discharge/RED</i> <i>Sharp Rees-Stealy Medical Group</i> <i>St. Luke’s Hospital</i> <i>Transitional Care Model</i> <i>Visiting Nurse Service of New York</i>
<input type="checkbox"/> Help patient manage medication	Medium	Managing patient medication with help of a transition coach	<i>Care Transitions Program (CTI)</i> <i>Colorado Foundation for Medical Care and Partners(Care Transitions Intervention (CTI))</i> <i>St. Luke’s Hospital</i> <i>John Muir Health(CTI)</i> <i>Project BOOST</i> <i>Re-Engineered Discharge/RED</i> <i>Transitions Home for Patient with Heart</i> <i>Transitional Care Model</i> <i>Visiting Nurse Service of New York</i>
<input type="checkbox"/> Facilitate discharge to nursing homes with discharge instructions and partnerships with nursing homes	Low–High	Using standardized referral form/transfer form Using nurse practitioner in nursing home setting	<i>Evercare™ Care Model</i> <i>STAAR</i> <i>Summa Health System</i> <i>Transitional Care Model</i>

Maintaining community connections is especially important for strategies of interventions implemented post-discharge to reduce avoidable readmissions. Practitioners serving a predominant subset of patients such as the elderly or immigrants could benefit from community partnerships with outpatient physician offices, nursing homes, and home health agencies in their efforts to reduce avoidable readmissions through the strategies identified in Table 3 below.

Table 3: Post-Discharge—Strategies to Prevent Readmissions

Strategies ^{xi}	Level of Effort	Actions	Selected Interventions that Use Strategies ^{xii}
□ Promote patient self management	Low	Using tools to help patient manage care plan post-discharge	Care Transitions Program (CTI) Guided Care Transitional Care Model Visiting Nurse Service of New York
□ Conduct patient home visit	Medium	Conducting home and nursing home visits immediately after discharge and regularly after that	Care Transitions Program (CTI) Colorado Foundation for Medical Care and Partners (Care Transitions Intervention (CTI)) Commonwealth Care Alliance: Brightwood Clinic HealthCare Partners Medical Group Home Healthcare Telemedicine Hospital at Home St. Luke's Hospital Transition Home for Patients with Heart Failure: St. Luke's Hospital Transitional Care Model Visiting Nurse Service of New York
□ Follow up with patients via telephone	Medium	Calling 2–3 days after discharge to reinforce discharge plan and offer problem solving Offering telephone support for a period post-discharge Calling to remind patients of preventive care	Care Transitions Program (CTI) Colorado Foundation for Medical Care and Partners (Care Transitions Intervention (CTI)) Commonwealth Care Alliance: Brightwood Clinic Evercare™ Care Model Kaiser Permanente Chronic Care Coordination Project BOOST Re-Engineered Discharge/RED Sharp Rees-Stealy Medical Group St. Luke's Hospital STAAR Transitional Care Model Transition Home for Patients with Heart Failure: St. Luke's Hospital Visiting Nurse Service of New York
□ Use personal health records to manage patient information	High	Including information on patient diagnosis, test results, prescribed medication, follow-up appointments, etc. on PHR	Care Transitions Program (CTI) Colorado Foundation for Medical Care and Partners John Muir Health (CTI) Re-Engineered Discharge/RED
□ Establish community networks	High	Developing public/private partnerships to meet patients needs	Community Care North Carolina Guided Care Summa Health System Transitions Home for Patient with Heart Failure: St. Luke's Hospital
□ Use telehealth in patient care	High	Monitoring patient progress through telehealth, e.g., electronic cardiac monitoring, remote patient telemonitoring	Heart Failure Resource Center Home Healthcare Telemedicine John Muir Health Sharp Rees-Stealy Medical Group

4***Monitor your hospital's progress.***

The key to sustaining efforts to reduce readmissions is for hospital leaders to monitor their facilities' progress. This fourth step is especially critical since this guide is structured to encourage hospitals to pick individual strategies to implement. Monitoring the hospital's progress will inform hospital leaders of the efficacy of these strategies and perhaps guide them in implementing additional strategies. Monitoring the hospital's progress should be done regularly, as determined by hospital leadership, and focus on the trends identified in step 1 of this guide:

- Readmission rates for different conditions
- Readmission rate by practitioners
- Readmission rates by readmission source
- Readmission rates over different time frames.

Finally, to sustain organizational efforts on reducing avoidable readmissions, data on readmissions could be included in the key quality indicators tracked and reported to hospital boards, other quality committees, and front line clinical staff. In addition to monitoring progress made in reducing avoidable readmissions, hospitals should also monitor possible unintended consequences from efforts aimed at reducing readmissions.

Appendix

Table A: Selected List of Interventions to Reduce Preventable Readmissions Organized by Level of Supporting Evidence^{xiii,xiv,xv}

Organization & Intervention	Target Population	Actions Included	Key Players	Where
Interventions with Very Strong Evidence of Reduction in Avoidable Readmissions^{xvi}				
Boston Medical Center <i>Re-Engineered Discharge/RED</i> http://www.bu.edu/fammed/projectred/	All adult BMC patients	Patient education; comprehensive discharge planning; AHCP; post-discharge phone call for medication reconciliation	Nurse discharge advocate, clinical pharmacist	Hospital and home (phone only)
<i>Care Transitions Program</i> http://www.caretransitions.org/	Community-dwelling patients 65 and older	Care Transitions Intervention (CTI); medication self-management; patient-centered record (PHR); follow-up with physician; and risk appraisal and response	Transitions coach	Home
<i>Evercare™ Care Model</i> http://evercarehealthplans.com/about/evercare.jsp%3bjsessionid=NNDDDJJFMEBB	Patients with long-term or advanced illness, older patients or those with disabilities	Primary care and care coordination; NP care in nursing home; personalized care plans	Nurse practitioner or care managers	Home and nursing home
<i>Transitional Care Model (TCM)</i> http://www.transitionalcare.info/	High-risk, elderly patients with chronic illness	Care coordination; risk assessment; development of evidence-based plan of care; home visits and phone support; patient and family education	Transitional care nurse (TCN)	Hospital and home
Interventions with Some Evidence of Reduction in Avoidable Readmissions^{xvii}				
<i>Commonwealth Care Alliance: Brightwood Clinic^{xviii}</i>	Low-income Latinos with disabilities and chronic illnesses	Primary care and behavioral health care coordination; reminder calls for preventive care; multidisciplinary clinical team; follow-up; health education and promotion; support groups; bilingual staff; non-clinician home visits	Nurses, nurse practitioners, mental health and addiction counselors, support service staff	Community
<i>Community Care North Carolina</i> http://www.communitycarenc.com/	Medicaid patients	Local network of primary care providers: DM for asthma, HF, diabetes; ED; pharmacy initiatives; case management for high-risk/ high-cost patients	Primary care providers	Community
<i>Heart Failure Resource Center</i> http://www.innovativecaremodels.com/care_models/15	Outpatient care for chronically ill patients with heart failure	Evidence-based clinical care protocols; remote patient telemonitoring	Advanced practice nurse and physician (for consultation)	Home and outpatient setting
<i>Home Healthcare Telemedicine</i> http://www.innovativecaremodels.com/care_models/18/key_elements	Recently discharged with congestive heart failure or COPD	Telehealth care; telemonitoring; in-home visits,	Telemedicine nurse and traditional home health nurse	Home
<i>Kaiser Permanente Chronic Care Coordination</i>	Patients with four or more chronic illnesses; recently	Multidisciplinary chronic care team; needs-based care plans; patient communications	Specially trained nurses, licensed clinical social	Hospital and long-term care

Organization & Intervention	Target Population	Actions Included	Key Players	Where
http://www.innovativecaremodels.com/care_models/13/overview	discharged; high ED utilization or recently discharged from a SNF	via phone	workers	settings
IHI Transition Home for Patients with Heart Failure: St. Luke's Hospital http://www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm	Patients with congestive heart failure	Admission assessment for post-discharge needs; teaching and learning; early post-acute care follow-up; patient and family-centered handoff communication	Multidisciplinary team, including nurses, clinicians, and hospital executives	Hospital and home
Novant Physician Group Practice Demonstration Project http://www.cfm.org/caretransitions/files/Care%20Transitions%20presentation%202%2008b.pdf	Medicare fee-for-service beneficiaries	Implement Comprehensive, Organized Medicine Provided Across a Seamless System (COMPASS); for providers: evidence-based practice standards, education and inpatient to outpatient systems; For patients: chronic and preventive care guidelines, education, and disease management	Physicians, staff	Community
Promising Interventions Requiring Additional Data^{xix}				
Guided Care http://www.cfm.org/caretransitions/files/Ouslander%20Care%20Transitions%20Call%20Presentation%20030308.pdf	Patients 65 or older deemed to be high risk for hospitalization or other cost-intensive care	Patient self-management; care coordination; patient/caregiver education; access to community services; evidence-based "care guide"	Specially trained nurses	Primary care offices
Hospital at Home http://www.innovativecaremodels.com/care_models/20	Patients over 65 years old requiring hospital admission for COPD, CHF, cellulitis, or community-acquired pneumonia	Daily physician visits; care coordination; multidisciplinary team	Registered nurse	Home
INTERACT http://www.cfm.org/caretransitions/files/Ouslander%20Care%20Transitions%20Call%20Presentation%20030308.pdf	Nursing home patients	Care paths, communication tools, advance care planning tools, risk appraisal	Nurses, physicians, nurse practitioners, physician assistants	Hospital and nursing home
Project BOOST http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm	Older adults	Medication reconciliation; general assessment of preparedness (GAP); teach-back; patient/caregiver education; communication; phone follow-up	Multidisciplinary care team	Hospital and home
Other Relevant Interventions^{xx}				
Blue Shield of California Patient-Centered Management (PCM) ^{xxi}	Complex patients with advanced illness. Piloted with CalPERS enrollees in Northern California	Patient education; care coordination; end-of-life management in seven care domains	ParadigmHealth team, including case manager and team manager, both	Home

Organization & Intervention	Target Population	Actions Included	Key Players	Where
			nurses, and MD consultant	
Colorado foundation for Medical Care (CFMC) <i>Care Transitions Intervention (CTI)</i> , pilot project http://www.cfmc.org/	Elderly clinic patients, medical beneficiaries who have been hospitalized	Hospital visit, home visit, and follow-up calls by coach, focusing on the four CTI pillars	Transitions coaches (nurses)	Hospital and home
HealthCare Partners Medical Group http://www.healthcarepartners.com/	Uses risk assessment to stratify patients and match to four levels of programs; special programs for frail patients	Self-management and health education; complex case management; high-risk clinics; home care management; disease management	Multiple interdisciplinary staff members	Hospital, home, SNFs
John Muir Physician Network <i>Transforming Chronic Care (TCC) Program</i> http://www.johnmuirhealth.com/index.php/chronic_care_referral_program.html	Eligible frail patients—most have heart failure, COPD, or diabetes	CTI; complex case management; disease management	Transition coaches, case managers, both with multiple backgrounds	Hospital and home
Sharp Rees-Stealy Medical Group http://www.sharp.com/rees-stealy/	High-risk patients, including all discharged from hospital or ED	Continuity of Care Unit (CCU); Telescale for HF patients; Transitions program for those near end-of-life	CCU: nurse case manager; Transitions: nurse	Hospital and home
St. Luke's Hospital, Cedar Rapids, IA <i>Transitions Home for Patients with Heart Failure</i> http://www.innovations.ahrq.gov/content.aspx?id=2206	Heart failure patients in pilot	Patient education using “teach-back”; home visit; post-discharge phone call; outpatient classes	Advanced practice nurse, staff nurses	Hospital and home
State Action on Avoidable Rehospitalizations (STAAR) http://www.ihl.org/IHL/Programs/StrategicInitiatives/StateActiononAvoidableRehospitalizationsSTAAR.htm	All patients	Enhanced assessment of post-discharge needs; enhanced teaching and learning; enhanced communication at discharge; and timely post-acute follow-up	Hospital-based care team, representatives from skilled nursing facilities, home health agencies, patients, family caregivers, etc.	Hospital, home, and other post-acute/long-term care setting
Summa Health System, Akron, OH http://www.summahealth.org/	Low-income frail elders with chronic illnesses in community-based long-term care	Risk appraisal; integrated medical and psychosocial care based on Naylor and Coleman models	Interdisciplinary teams, including RN care manager, APN, AAA staff, etc.	Hospital, home, PCP office visits
Visiting Nurse Service of New York (VNSNY) http://www.vnsny.org/	Nursing Home patients post-hospitalization	Risk assessment with stratified interventions; self-management support, etc.	NPs; home nurses; home health aides	Hospital (for some patients) and home

Linking readmissions strategies to other national efforts

Hospitals may currently be or previously have been involved in care delivery and patient safety initiatives that could serve as vehicles for implementing strategies to reduce preventable readmissions. By coordinating efforts in various priorities, hospitals are able to reap the most benefit for their investment, avoid duplicative work, and minimize burden on practitioners as they strive to improve the care that they deliver. The following table outlines strategies in some of the initiatives that could facilitate implementation of strategies to reduce avoidable readmissions:

Table B: Linking Readmissions Strategies to Current National Strategies

Initiative	Description	Overlap with Readmissions Strategies
AHA Hospitals in Pursuit of Excellence (HPOE) ^{xxii}	<p>Topic Areas:</p> <ul style="list-style-type: none"> • Care coordination—focus on the discharge process and care transitions to reduce readmissions • Reduce hospital-acquired conditions such as: <ul style="list-style-type: none"> ○ surgical infections and complications; central line-associated blood stream infections; methicillin-resistant Staphylococcus aureus; clostridium difficile infections; ventilator-associated pneumonia; catheter-associated urinary tract infections; adverse drug events from high-hazard medications, and pressure ulcers • Implement health information technology (HIT)—focus on leadership and clinical strategies to effectively implement HIT • Medication management—use of HIT and performing medication reconciliation • Promote patient safety • Patient throughput—improving patient flow in ED, OR, and ICU 	<ul style="list-style-type: none"> • Risk screening of patients & tailored care • Establishing communication with PCP • Use of interdisciplinary/ multidisciplinary team • Care coordination • Patient education • Comprehensive discharge planning • Patient /caregiver education using “teach-back” • Scheduling and preparing for follow-up appointment • Discussions about end-of-life treatment wishes • Facilitate discharge to nursing homes • Home visit • Follow-up call • Medication management • Personal health records • Establishing community networks • Patient self management
IHI Campaigns (<i>100K and 5 Million Lives</i> campaigns)	<p>Components for the <i>100K Lives</i> campaign:</p> <ul style="list-style-type: none"> • Deploy Rapid Response Teams • Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction • Prevent Adverse Drug Events (ADEs) by implementing medication reconciliation • Prevent Central Line Infections • Prevent Surgical Site Infections • Prevent Ventilator-Associated Pneumonia 	<ul style="list-style-type: none"> • Risk screening of patients & tailored care • Care coordination • Patient education • Comprehensive discharge planning • Patient /caregiver education using “teach-back” • Medication management

Initiative	Description	Overlap with Readmissions Strategies
	<p>Principles for the <i>5 Million Lives</i> campaign (plus principles from <i>100K Lives</i> campaign:</p> <ul style="list-style-type: none"> • Prevent Harm from High-Alert Medications (focus on anticoagulants, sedatives, narcotics, and insulin) • Reduce Surgical Complications • Prevent Pressure Ulcers • Reduce Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) infection • Deliver Reliable, Evidence-Based Care for Congestive Heart Failure...to avoid readmissions • Get Boards on Board so that they can become far more effective in accelerating organizational progress toward safe care 	
Joint Commission Speak Up™ initiatives	<p>Current initiatives:</p> <ul style="list-style-type: none"> • Help Prevent Errors in Your Care • Help Avoid Mistakes in Your Surgery • Information for Living Organ Donors • Five Things You Can Do to Prevent Infection • Help Avoid Mistakes With Your Medicines • What You Should Know About Research Studies • Planning Your Follow-up Care • Help Prevent Medical Test Mistakes • Know Your Rights • Understanding Your Doctors and Other Caregivers • What You Should Know About Pain Management • Prevent Errors in Your Child's Care 	<ul style="list-style-type: none"> • Patient education • Patient /caregiver education using “teach-back”
Patient-Centered Medical Home (PCMH) ^{xxiii}	<p>Characteristics of the Patient-Centered Medical Home(PCMH):</p> <ul style="list-style-type: none"> • Personal physician—for each patient • Physician directed medical practice—has collective responsibility for the ongoing care of patients • Whole person orientation—includes care for all stages of life; acute care; chronic care; preventive services; and end-of-life care led by personal physician. • Care is coordination—across all elements of the health care system (subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (family, public and private community-based services). 	<ul style="list-style-type: none"> • Establishing communication with PCP • Use of interdisciplinary/ multidisciplinary team • Care coordination • Patient education • Comprehensive discharge planning • Scheduling and preparing for follow-up appointment • Discussions about end-of-life treatment wishes • Facilitate discharge to nursing homes • Follow-up call • Medication management • Personal health records

Initiative	Description	Overlap with Readmissions Strategies
	<ul style="list-style-type: none"> • Quality and safety—includes the following: <ul style="list-style-type: none"> ○ care planning process ○ Evidence-based medicine and clinical decision-support tools ○ Active patients and families participation ○ Information technology ○ Patients and families participate in quality improvement activities at the practice level. <p>Enhanced access—<i>used through open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff</i></p>	<ul style="list-style-type: none"> • Establishing community networks • Patient self management

Contact Information for Some Interventions

1. Care Transitions Program

<http://www.caretransitions.org/>

Eric A. Coleman, MD, MPH

The Division of Health Care Policy and
Research
13611 East Colfax Avenue, Suite 100
Aurora, CO 80045-5701
Phone: 303-724-2523
Fax: 303-724-2486

2. Project RED (Re-Engineered Discharge)

<http://www.bu.edu/fammed/projectred/index.html>

Brian Jack, MD
Principal Investigator
Brian.Jack@bmc.org

3. Project BOOST (Better Outcomes for Older adults through Safe Transitions)

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm

Mark V. Williams, MD, FHM
Principal Investigator
Advisory Board Co-Chair
Professor & Chief, Division of Hospital
Medicine
Northwestern University Feinberg School of
Medicine
Chicago, IL
BOOST@hospitalmedicine.org

4. Transitional Care Model

<http://www.transitionalcare.info/>

Mary D. Naylor, PhD, RN, FAAN
Marian S. Ware Professor in Gerontology
Director, NewCourtland Center for
Transitions & Health
University of Pennsylvania School of Nursing
Claire M. Fagin Hall, 3rd Floor (RM341)
418 Curie Boulevard
Philadelphia, PA 19104-4217
naylor@nursing.upenn.edu

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- i Jencks, Stephen F., Williams, Mark V., and Coleman, Eric A. 2009. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *N Engl J Med* 360 (14):1418-1428.
- ii Benbassat, J., Taragin, M. 2000. Hospital readmissions as a measure of quality of health care: advantages and limitations. *Archives of Internal Medicine* 160 (8):1074-1081.
- iii Minott, J. Reducing Hospital Readmissions. 2008. AcademyHealth. Accessed online at: http://www.academyhealth.org/files/publications/Reducing_Hospital_Readmissions.pdf on December 17, 2009.
- iv Boutwell, A. Griffin, F. Hwu, S. Shannon, D. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. Cambridge, MA: Institute for Healthcare Improvement; 2009.
- v Leonhardt K, Bonin K, Pagel P. *Guide for Developing a Community-Based Patient Safety Advisory Council*. Prepared by Aurora Health Care, Wisconsin. AHRQ Publication No. 08-0048. Rockville, MD: Agency for Healthcare Research and Quality. April 2008. Accessed on 11/16/2009 at: <http://www.ahrq.gov/qual/advisorycouncil/advisorycouncil.pdf>
- vi Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc*. 2004;52:675-684.
- vii Not all of the actions listed for this particular strategy may correspond to the resource intensity identified.
- viii The interventions listed here, though not comprehensive, represent some of the commonly used and referenced interventions for reducing avoidable readmissions. Details on the intervention are listed on Table 1 in the Appendix.
- ix Not all the actions listed for this particular strategy may correspond to the resource intensity identified
- x The interventions listed here, though not comprehensive, represent some of the commonly used and referenced interventions for reducing avoidable readmissions.
- xi Not all the actions listed for this particular strategy may correspond to the resource intensity identified
- xii The interventions listed here, though not comprehensive, represent some of the commonly used and referenced interventions for reducing avoidable readmissions.
- xiii Kanaan, S.B. *Homeward Bound: Nine Patient-Centered Programs Cut Readmissions*. California Healthcare Foundation; 2009.
- xiv Information on this table is culled from the California HealthCare Foundation publication, *Homeward Bound: Nine Patient-Centered Programs Cut Readmissions*, and supplemented with other resources.
- xv The interventions listed here, though not comprehensive, represent some of the commonly used and referenced interventions for reducing avoidable readmissions.
- xvi Boutwell, A. Griffin, F. Hwu, S. Shannon, D. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. Cambridge, MA: Institute for Healthcare Improvement; 2009.
- xvii Boutwell, A. Griffin, F. Hwu, S. Shannon, D. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. Cambridge, MA: Institute for Healthcare Improvement; 2009.
- xviii Bachman SS, Tobias C, Master RJ, Scavron J, Tierney K. A managed care model for Latino adults with chronic illness and disability. Results of the Brightwood Center intervention. *Journal of Disability Policy Studies*. 2008;18(4):197-204.
- xix Boutwell, A. Griffin, F. Hwu, S. Shannon, D. *Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions*. Cambridge, MA: Institute for Healthcare Improvement; 2009.
- xx Interventions based on one or more of the models described in the other categories
- xxi Sweeney, L. Halpert, A., Waranoff, J. Patient-centered management of complex patients can reduce costs without shortening life. *American Journal of Managed Care*. February 2007.
- xxii American Hospital Association. *About Hospitals in Pursuit of Excellence*. Accessed at <http://www.hpo.org/about> on 10/28/2009.
- xxiii *Joint Principles of the Patient Centered Medical Home*. Developed by AAFP, AAP, ACP, and AOA. Accessed at <http://pcpcc.net/node/14> on 10/28/2009.



Health Care Leader Action Guide on Implementation of Electronic Health Records

July 2010

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About HRET

Founded in 1944, the Health Research and Educational Trust (HRET) is a private, not-for-profit organization involved in research, education and demonstration programs addressing health management and policy issues. HRET, an American Hospital Association affiliate, collaborates with health care, government, academic, business and community organizations across the United States to conduct research and disseminate findings that shape the future of health care. Visit HRET's Web site at www.hret.org.

About CHIME

The College of Healthcare Information Management Executives (CHIME) is an executive organization dedicated to serving chief information officers and other senior health care IT leaders. With more than 1,400 CIO members and over 70 healthcare IT vendors and professional services firms, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate the effective use of information management to improve the health and health care in the communities they serve. For more information, please visit www.cio-chime.org.

Disclaimer: This guide is intended for educational purposes only. Consult a qualified expert when implementing an electronic health record.

EXECUTIVE SUMMARY

The purpose of this guide is to provide hospital chief executive officers and other members of the executive team with a basic understanding of the challenges of implementing an electronic health record. The guide is organized into high-level categories that executive teams should consider in planning and implementing an EHR.

This guide does not fully address the EHR selection process or meaningful use certification. When the meaningful use final rule is announced and fully understood, CHIME and the AHA will provide more specific guidance that will complement the information in this guide. For specific questions, please contact hpoe@aha.org or staff@cio-chime.org.

The high-level categories that CEOs should consider include:

Gather the Executive Team

The success of any EHR implementation hinges on an inclusive executive team, including a CIO, CMO, CNO, CFO and COO. Many organizations are creating new positions of chief medical/nursing information officers to gain clinician acceptance.

Develop a Strategic Plan

Information technology should be considered as a tool to achieve organizational goals. Leaders need to look at their overall strategic plan and include technology as a way to achieve objectives.

Perform Gap Analysis

To plan for implementing an EHR, the organization should measure where it currently stands in implementing technology and where it needs to go.

Develop a High-Level Project Plan

Committee members can drill down and establish timelines for implementation.

Initiate Culture Change

Culture change can make or break an EHR implementation. Having individuals own a piece of the plan can enlist their support of an electronic health record system implementation project.

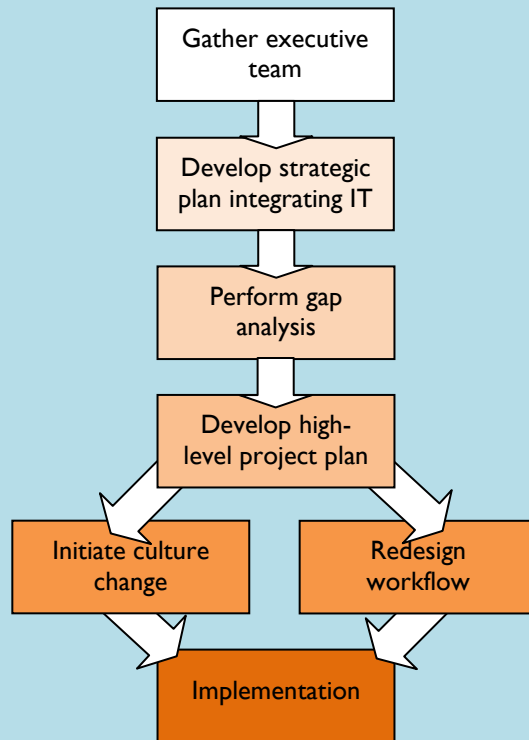
Redesign Workflow Processes

An EHR should not automate already broken processes. This is an opportunity to establish new processes to improve overall patient care.

Implementation

Training and ongoing support will smooth the transition from paper to electronic health records. Upfront planning is crucial for successful implementation.

Implementation Roadmap — EHR Implementation



TIPS

Tips on Gathering a Team

- While the CIO is the point person to achieve meaningful use objectives, HIT initiatives will affect all aspects of hospital operations. Thus, there is an obvious need for visible backing from the CEO and other senior executive team members to assure success.
- The CIO and CFO should form a close working relationship. The IT needed to achieve meaningful use will require large capital outlays and involve ongoing support expenses.
- Encourage CIOs to participate in educational activities that increase their understanding of HITECH/ARRA provisions. In addition to federal initiatives, state plans are also expected to vary, so CIOs should be urged to get involved in initiatives that help them stay abreast of specific rules for their state.
- The senior IT executive should play a lead role in authoring and updating an IT strategic plan that supports overall organization strategic operating plans, including necessary components for meaningful use.
- The CIO also should be involved in efforts to keep the entire organization informed about the progress of a new system and progress toward achieving meaningful use. For example, the CIO can develop a task force charged with attaining meaningful use and grants, and have them report directly to the board.

TIPS (continued)

Planning Tips

- The IT plan is part of the foundation for the organization's pillars—quality, service, finance, people, growth, community.
- Use existing committees, such as an EHR steering committee, in assessing the current state and creating a desired future state. Or form a cross-functional committee, such as a meaningful use subcommittee, to address achievement of these objectives. One hospital organization has gone so far as to create a meaningful use czar and team dedicated only to this task.
- Task senior executives to get involved in aspects of the assessment where appropriate – for example, the chief medical officer can help assess current clinical systems and what needs to be done to improve them.
- Conducting gap analysis is not merely determining what technology is or isn't in place. It also involves assessment of corporate readiness for change, and requires a game plan to assess people and processes.
- Measure progress, gaps and work to be done on a scorecard or "readiness matrix" that visually presents the work that lies ahead.

Culture Tips

- Communication from the CEO sets the tone of the project, lays out the projected steps, and links it to the overall vision of the hospital.
- Project champions should be tasked with communicating progress to their departments.
- Physician communication requires special attention and effort. For familiarization and information briefings, use staff newsletters, focused e-mail, handouts, meetings with medical staff and office managers, and office visits.
- Absolute transparency and honesty are critical to maintaining credibility.
- Organizations need to provide a non-threatening way of providing feedback after implementation.
- Milestone events, such as go-lives and achieved targets, merit celebrations.

INTRODUCTION

For more than a decade, hospitals and health systems have been working to realize the promise of health information technology (HIT) to provide safer, more effective and less expensive care. While there have been numerous success stories, many organizations are still in the early stages of implementing HIT to improve care and lower costs. Realizing the true promise of HIT, especially electronic health records (EHRs), is harder than it looks.

The Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvestment Act (ARRA) of 2009 established a set of incentives and penalties for adoption and use of certified EHR systems. The ultimate vision is to improve the quality and value of American health care. In essence, however, HITECH has created a 2015 deadline for hospitals and physician offices to implement a certified EHR system and meet a set of “meaningful use” requirements to avoid Medicare payment penalties. Before 2015, HITECH provides Medicare incentive payments for those hospitals that can demonstrate meaningful use of a certified EHR system. Some hospitals and physicians may also be eligible for Medicaid incentive payments that will be administered by the states. CMS has estimated that between \$14 and \$27 billion in incentive payments will be distributed over ten years. The actual spending, however, will depend on the number of hospitals and physicians that qualify.

Even before HITECH, hospitals were building EHR systems and recognizing their potential to improve patient safety and efficiencies in care delivery. Implementing these systems is a time- and resource-intensive process. Thus, the timelines established by HITECH and the regulatory requirements for implementation may prove challenging for hospitals.

In addition, most of the incentive payments will be made retrospectively. Because of this, many health IT leaders are warning hospital CEOs that federal funding should not be the primary goal of implementing an EHR.

“We developed a seven-year strategic IT plan back in 2007,” says Kimberly Kalajainen, vice president and chief information officer, Lawrence & Memorial Hospital, New London, Conn. “After careful analysis, we plan to stay the course and not attempt to rush our implementations in a hasty attempt to receive incentive payments. The total cost of our project (clinical and business IT solutions) is \$32 million. The ARRA reimbursement is estimated at \$6 million. The ROI is about \$3 million. Hence, we are staying the course and not looking to accelerate.”

Separate incentive payments are available for hospitals and physicians.

What is an Electronic Health Record?

The Electronic Health Record is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter—as well as supporting other care-related activities directly or indirectly via interface—including evidence-based decision support, quality management and outcomes reporting.

Healthcare Information and Management Systems Society's EHR definition

After the original legislation was passed, Congress approved additional legislation that extends the incentives to hospital-based ambulatory-care physicians. Other hospital-based physicians that provide primarily inpatient services, such as radiologists, pathologists and anesthesiologists, are still excluded.

As with any government program that promises federal funds, a number of conditions must be met to qualify for payments:

- Payments can be made only to eligible hospitals and eligible providers, as defined by legislation. Expanding eligibility to cover other providers will take additional legislation.
- Providers must use certified technology to qualify for payments. Separately, the federal government has issued rules that establish a temporary certification program. This temporary program will be replaced by a permanent certification program. Only EHRs certified through this new federal process, which will begin in the fall of 2010, will qualify.
- Providers will be required to demonstrate “meaningful use” of electronic health records. CMS has proposed requirements in each of five areas:
 - To improve quality, safety and efficiency, and reduce health disparities;
 - Engage patients and families in their health care;
 - Improve care coordination;
 - Improve population and public health; and
 - Ensure adequate privacy and security of health information.

The proposed version of the rule establishes a standard of what constitutes meaningful use of electronic health records, involving 23 objectives for hospitals and 25 objectives for physicians. The proposed rule also included new quality measures that must be calculated using EHR systems. Among the proposed objectives are:

- use of computerized physician order entry;
- maintaining up-to-date problem and medication lists;
- providing patients with an electronic copy of their health information upon request
- having the capability to exchange clinical information with other providers of care; and
- having the capability to provide electronic syndromic surveillance data to public health agencies.

The objectives are expected to increase in difficulty over time, with additional requirements added in 2013 and 2015. The final rule on meaningful use was not available at the time of publication of this guide, but is expected by August.

As noted above, payments made through the Medicare program will be made retrospectively, after a provider has already borne costs in purchasing and installing the EHR system and supporting infrastructure. For some hospitals and physicians, funds will also be available through state Medicaid programs, including funds in the first year to support adoption, installation, and upgrading of certified EHRs without having to meet the meaningful use requirements. The Medicaid program, however, is optional for states and is limited to hospitals and physicians that meet specific thresholds of Medicaid patient volume.¹

¹ The Medicaid patient volume thresholds are generally 30 percent for physicians (less for pediatricians) and 10 percent for hospitals (less for children’s hospitals). Be sure to consult the final rule to verify the thresholds that apply to you.

HITECH also approved a number of grant programs to facilitate adoption of health IT and health information exchange (HIEs). Two of those programs will be implemented primarily at the local level. Regional Extension Centers (RECs) will provide technical assistance to primary care physicians and some small, rural hospitals on how to select and implement an EHR. The state-level HIEs will promote and guide development of exchange models within individual states.

It is very clear that the implementation of electronic health record systems and the fulfillment of federal requirements to receive stimulus funds will be complicated. CEOs and other senior executives will need to work together to successfully adopt the technology and manage the changes that these systems bring to an organization.

Where to Begin

Implementing an EHR may seem like a daunting task. After all, such systems are expensive. Also, HITECH payments will be made retrospectively, so providers cannot count on these funds for such upfront costs as purchase, implementation and training.

Furthermore, the EHR affects nearly all aspects of care delivery. EHRs should be viewed as a tool to revolutionize care systems through workflow redesign and optimization. Workflow redesign will require change, which requires a clear vision linked with strong leadership and a shared commitment to action by all users—nurses, physicians, pharmacists, lab, radiologists, and even patients.

To successfully implement EHRs, hospital leaders, especially those in the C-suite, should focus on the strategic direction of the hospital and incorporate EHRs where and how they provide the most benefit. They need to “rally the troops” to gain buy-in and user engagement. And they need to secure proper funding. Successful implementation of EHRs must be built on a solid foundation of planning and execution, along with discipline across the entire organization for several years.

This guide outlines an implementation roadmap that can assist hospital leaders in taking a disciplined approach to EHR planning.

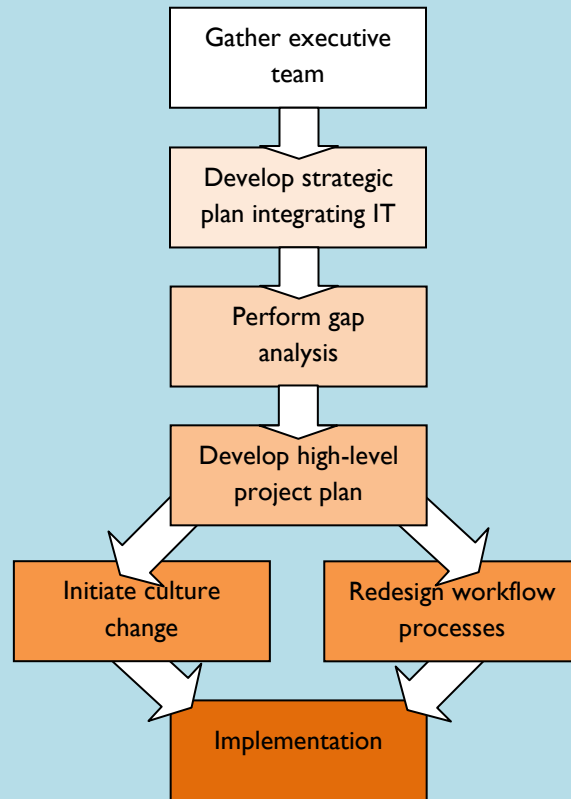
“We do not focus on the ‘meaningful use’ requirements as a separate initiative. We have merged those requirements into our larger advanced clinical systems strategy and simply highlighted those areas that address meaningful use. The meaningful use requirements are the ‘low water mark’ for advanced clinical systems.”

Mary Carroll Ford
Vice President and Chief Information Officer
Lakeland Regional Medical Center, Lakeland, Fla.

“The creation of the HITECH Programs will ‘build the foundation for every American to benefit from an electronic health record, as part of a modernized, interconnected and vastly improved system of care delivery.’”

U.S. Department of Health and Human Services HIT
Website

Implementation Roadmap — EHR Implementation



Source: Adapted from *Rules of Engagement: Proven paths for instilling, then installing a CPOE approach that works*. © 2006 NAHIT publication

GATHER THE EXECUTIVE TEAM

Because the electronic health record is a massive investment and changes the way care is delivered in hospitals, the CEO needs to start with two important steps at the very beginning of the EHR journey:

1. Educate the board to gain necessary support.
2. Create an executive team to formulate and communicate the EHR vision.

Board support is essential because an EHR implementation requires a tremendous amount of capital, time and culture change. In addition to understanding the general provisions of the federal meaningful use and certification requirements, trustees need to be regularly updated on implementation progress. They also should understand that the EHR investment is not a typical IT investment. The CEO needs to communicate how this investment will improve quality of care, create efficiencies and help the organization meet its overarching vision.

In implementing an EHR system that achieves meaningful use objectives, the biggest risk to organizations is that leaders will rush to implement systems. In their haste, many essential aspects of planning and strategizing may be overlooked. Shifting an organization to a new mode for capturing, sharing and maintaining patient information requires extensive involvement of the entire senior executive team from the very beginning. Gathering this group—including the chief operating, financial, medical, nursing, information and human resources officers—to define the EHR vision is essential because this team will be responsible for communicating with and engaging employees and physicians.

An EHR will affect most workflows in an organization and, therefore, all entities must have input at the very beginning of planning. Each of the executive officers must have a role in connecting the electronic health record's value to the organization's overall vision. Planning should focus on improving the quality of care; technology should be viewed as a tool to achieve this goal.

The National Center for Healthcare Leadership offers some examples of value statements that can be used in communicating the value of EHRs across the organization:

- Enhanced access to and improved continuity of care
- Physician connectivity and support to physicians in maintaining a work/life balance
- Reductions in malpractice liability exposure
- Protection of patients from harm
- Improvements in operational efficiency
- Support of facility and service expansion

It is crucial that the full executive staff has an overall view of the organization's IT strategic direction and knowledge of EHR implementation so that they can provide support to the CIO, coordinate efforts effectively across the organization, interface with the board and other constituencies within the hospital, be an advocate with the medical staff, and be able to discuss the organization's vision and tactics involving EHRs intelligently in public.

Role of the CIO

The CIO will be at the apex of your organization's drive to achieve meaningful use. "Senior management is counting on meeting meaningful use [objectives] in the first year," noted a CIO at a New Jersey hospital. "It is my responsibility to make that happen."

CIOs play a key role in analyzing an organization's readiness to meet meaningful use objectives, determining a game plan and claiming as much of the HITECH stimulus reimbursement as possible. With meaningful use objectives coming into focus, CIOs have a better idea of what they specifically have to do to achieve these targets for using electronic health records. Planning has become clearer as a result and has grown both more complicated and crucial.

For example, the linkage of meaningful use to reimbursement will involve financial considerations, and CIOs will need to interact with the financial office to understand cost report timing and to minimize the impact of EHR purchases on cash flow, which could hamper many organizations because of the large expenditures involved.

Other areas of concern for CIOs in the meaningful use era include:

- HITECH and HIPAA security regulations, which will raise the ante on protecting sensitive patient information.

- IT strategic planning updating, as needed, to achieve meaningful use.
- Vendor communication to ascertain where IT suppliers are in providing products that will meet meaningful use objectives.

Many CIOs also are their organization's experts on meaningful use requirements, not only understanding their implications for the organization, but also being able to frame any discussions and facilitate plans to achieve objectives. Shifting responsibilities make this an exciting time for CIOs, who find they have new expectations in reporting to other senior executives and the CEO. Growth in responsibilities also is moving some CIOs out of their comfort zones, particularly those who are more task-oriented. The current environment requires top information executives to embrace new responsibilities, many of which will require additional training, and tighter integration with and support from the CEO.

New Roles—CMIO and CNIO

The enormity of the challenges involved in implementing electronic health records— particularly the need to gain clinician participation and support—is prompting some organizations to create positions for specialized executives who can work in both the caregiver and IT realms.

Many organizations are turning to a chief medical information officer (CMIO). In addition, some are looking to add a chief nursing information officer (CNIO). Estimates suggest that about 2,000 hospitals or health care organizations have CMIOs; similar data are not available for CNIOs.

Key job responsibilities for CMIO and CNIO roles include:

- Serving as a liaison between IT and clinicians to communicate issues and challenges
- Involving clinicians with the IT process, including vendor selection, gaining their support
- Acting as a change catalyst, motivating and reinforcing clinician behavior change
- Assisting in education
- Designing and testing information systems
- Improving workflow by developing order sets, standardizing care plans and designing clinical decision support
- Facilitating and managing design validation and implementation support
- Reporting (outcomes and quality) based on digital records
- Documenting and broadcasting realized clinical benefits

CMIO and CNIO roles can help organizations implement EHRs under the tight timelines hospitals will face in meeting meaningful use objectives. However, organizations can successfully implement EHRs if they have a CMO or CNO who is open to taking on some informatics responsibilities or if an organization has several physician champions, sponsors or partially funded roles in IT to provide critical insight, feedback and leadership.

Organizations with one or both of these positions say they meet different needs. CMIOs assist organizations with physician adoption and leadership, while CNIOs help organizations achieve success in outcomes reporting, quality reporting, workflow improvements and data assessment, and generally allowing the nurses' voice to be heard in the implementation process. The CMIO role, in particular, has evolved over the years, away from merely serving as a liaison between medical and IT staffs. Now, CMIOs are getting more involved in technology decisions and helping use data derived from clinical records to develop improvements in care delivery.

Whether these executives hold formal CMIO/CNIO titles or not may not be important if an organization has talented, credible clinicians who happen to have significant IT knowledge. In any event,

hospitals will need to have a plan in place for bringing clinician involvement and support to its EHR implementation.

Some hospitals have decided not to create CMIO or CNIO positions. Yet where CMIOs or CNIOs have not been added, organizations generally agree that a key to success is having physician and nursing leadership, typically provided by named individuals regardless of title. Many hospital executives say that CMIO or CNIO roles are invaluable because they provide additional leadership that increases clinicians' willingness to use EHRs. CMIOs and CNIOs bring the most value to an organization when they partner with the information systems department to enable the transition from paper to digital records.

Strong proponents of the CMIO position say it is crucial in implementing an EHR, and that small hospitals should try to fill the role, even if only on a part-time basis. These proponents say the CMIO is a key leader and officer for the entire organization and plays a key role in workflow design and optimization, which provide the bulk of return on an EHR investment.

“Our executive team has been very supportive of my efforts to make this IT project the number one priority for the entire health system. That decision was the defining moment for this organization’s ability to meet the developing requirements for national health care reform. I work closely with the CEO and the rest of the executive team on all of the communications to the medical staff and employees. Being part of the executive team is necessary to enable this type of success.”

Dave Roach
Vice President and Chief Information Officer
Kadlec Health System, Richland, Wash.

Team Tips

- While the CIO is the point person to achieve meaningful use objectives, HIT initiatives will affect all aspects of hospital operations. Thus, there is an obvious need for visible backing from the CEO and other senior executive team members to assure success.
- The CIO and CFO should form a close working relationship. The IT needed to achieve meaningful use will require large capital outlays and involve ongoing support expenses.
- Encourage CIOs to participate in educational activities that increase their understanding of HITECH/ARRA provisions. In addition to federal initiatives, state plans are also expected to vary, so CIOs should be urged to get involved in initiatives that help them stay abreast of specific rules for their state.
- The senior IT executive should play a lead role in authoring and updating an IT strategic plan that supports overall organization strategic operating plans, including necessary components for meaningful use.
- The CIO also should be involved in efforts to keep the entire organization informed about the progress of a new system and progress toward achieving meaningful use. For example, the CIO can develop a task force charged with attaining meaningful use and grants, and have them report directly to the board.

DEVELOP A STRATEGIC PLAN

Strategizing about EHRs includes examining current organizational strategic plans. The implementation of EHRs cannot be viewed as simply a project or the work of the information technology department. Rather, it needs to be the foundation of an organization's pillars—quality, service, finance, people, growth, community. The strategic role of EHRs in the organization needs to be explicitly spelled out so that everyone in the organization is aware of the connection. Concrete metrics need to be attached. Further, the executive team needs to understand the connection so they can communicate and engage staff and physicians.

With the executive team assembled, leaders need to develop the plan of how the EHR will help an organization achieve its goals. An EHR won't improve patient safety on its own, but it will help improve communication, which then can be linked to improved safety. A clear connection needs to be developed to achieve a successful implementation.

EHRs also are expected to affect many health care business relationships in communities, as physicians increasingly look to hospitals for help in adopting EHR systems and as organizations face increased demands to share health care information with other providers and with patients. How these goals fit into the organizational plan needs to be examined.

Further, meaningful use objectives can provide a general guide for hospitals that want to determine where they need to be to qualify for stimulus funds under the HITECH Act. However, organizations must consider different routes before arriving at that final destination – many are using different approaches in implementing IT, depending on their individual strategies, cultures, markets and structures. For example, an academic medical center in a competitive metropolitan market is likely to have different applications, infrastructure, vendor-supporting and technology management practices than a freestanding suburban hospital with different mission-centric objectives, community and medical staff dynamics, and abilities to fund IT.

With the convergence of HITECH planning as well as health care reform, many hospitals are aware of the increased stakes involved in health care IT. They are dedicating more resources to support assessments of the current IT state, what the organization wants to achieve in the coming years, and the IT resources that are needed to get there.

In sum, the push to implement electronic health records will cause significant change in many aspects of care delivery, and the cost of implementation and degree of coordination required to achieve success will involve regular attention and participation from an organization's CEO and senior executives. Provider success in achieving meaningful use will serve as a foundation for upcoming payment reform.

PERFORM GAP ANALYSIS

Hospitals typically have a wide variety of applications in place, and leaders need to assess what they have and what meaningful use will require of them. It is essential for an organization to determine where it is in the journey to implement electronic health records and how much further it needs to go.

Conducting a gap analysis – assessing the difference between the current state of readiness and the future ideal state – is sometimes viewed as purely a function of IT, with top information systems

personnel leading the analysis and then quantifying current and future technology needs that will be required to meet organizational goals.

For many organizations, it is natural for the chief information officer to take the lead role in conducting an assessment of current technology. In many cases, an organization's top IT executives interact with or lead steering committees that provide broader guidance for EHR direction in an organization.

However, CEOs are playing a variety of roles in this assessment phase. At the very least, IT executives should report their findings to the CEO and the board on a regular basis. In other organizations, CEOs are aligning themselves as key partners in the process, and other members of the senior executive team are brought in to provide feedback and increase buy-in. Having responsibility for IT discussions reside with an oversight committee, defining meaningful use as part of a larger initiative, or blending it into a strategic plan helps to place meaningful use discussions into a larger context.

Oversight committees may take on various forms, and there may be several active groups in which dialogue occurs with the intent to form consensus among different EHR stakeholders. HITECH may be viewed as its own program for progress tracking, or it may be seen as tactical requirements that are handed off to EHR-related project managers. Clinical adoption through meaningful use, in its broadest sense, is the key success factor of all EHR-related initiatives, and organizational change efforts to support it should be pervasive.

DEVELOP A HIGH-LEVEL PROJECT PLAN

It is not just a simple matter of determining what technology needs to be in place to meet objectives and qualify for stimulus fund payments. Increasingly, the term “governance” is being linked to overall IT implementation, maintenance and management. IT planning is attempting to answer the following questions:

- What is the governance model?
- What is the capacity for change?
- What are the idiosyncrasies that are unique to our organization?
- What are our particular needs and political landscape?
- How do these needs align or compete with other needs?
- Does our portfolio align to our mission and current business and clinical objectives?
- What can we do to manage risk with such a “busy” portfolio?

The perception and history of successes, accomplishments and failures; the relationships that are in place or not in place; and the skills within IT are all important components of any planning that occurs in getting EHRs to a particular future state.

This is also the time to identify project champions representing each population that will be affected by an EHR implementation—nursing, pharmacy, radiology, clinical services. These individuals will spend a significant portion of their time on the project, identifying roadblocks and keeping executive management updated. Getting these individuals engaged at this point gives them the ownership necessary to implement upcoming changes.

Selecting an EHR

The first step in selecting an EHR vendor is to examine current IT capabilities and infrastructure in the organization and then develop a list of needs. Again, involving physicians and other clinicians early in the

selection process is essential to prevent user resistance. Further, being transparent with updates and decisions with other employees will go a long way toward easing anxiety and frustration.

There are numerous factors to consider when selecting a system, so doing the proper preparation is necessary. User demonstrations are necessary and will highlight any clinical assumptions built into the product. A thorough examination of current hardware and what will be required to make the system functional with clinicians will need to be examined. Items such as handhelds, tablets or desktops should be included.

“My current senior team expects a game plan and review of where we are today and what we still need to do to make meaningful use a reality in 2011. The most important role I currently have is to maintain the IS strategic plan, provide leadership, change as needed, be cost-effective and stay focused so the plan is executed in a successful manner.”

Richard Mohnk
Chief Information Officer
HealthAlliance Hospitals
Fitchburg and Leominster, Mass.

Planning Tips

- The IT plan is part of the foundation for the organization’s pillars—quality, service, finance, people, growth, community.
- Use existing committees, such as an EHR steering committee, in assessing the current state and creating a desired future state. Or form a cross-functional committee, such as a meaningful use subcommittee, to address achievement of these objectives. One hospital organization has gone so far as to create a meaningful use czar and team dedicated only to this task.
- Task senior executives to get involved in aspects of the assessment where appropriate – for example, the chief medical officer can help assess current clinical systems and what needs to be done to improve them.
- Conducting gap analysis is not merely determining what technology is or isn’t in place. It also involves assessment of corporate readiness for change, and requires a game plan to assess people and processes.
- Measure progress, gaps and work to be done on a scorecard or “readiness matrix” that visually presents the work that lies ahead.

INITIATE CULTURE CHANGE

After the technology goals are aligned with the strategic plan and the executive team is assembled, it is time to work on culture and workflow processes, two essential steps that will determine the success of an EHR implementation.

Organizational culture embodies everything in an organization — assumptions and beliefs, values, models of behavior, rituals, practices, symbols, heroes, artifacts and technology. With IT implementation, especially an effort as all-encompassing as an EHR, hospital CEOs and other members of the C-suite will need to spend a significant amount of their time on culture change. Their job will be to help employees and physicians connect the dots between the EHR and the actual goals it will achieve. This is why it is

essential that the C-suite team have input in the change management activities that will take place. If they are invested in the change process, then they will be much more effective in convincing other staff of the possibilities.

Before embarking on any change management plan, CEOs need to conduct a readiness assessment to identify a starting point. Questions should address the following issues:

- Staff knowledge and understanding of patient safety and clinical effectiveness issues
- Current levels of automation in existing workflows
- Current levels of users' computer skills
- Other organizational initiatives under way that could compete for time and resources²

Change is facilitated by trust and concern for other people, flexibility and innovation, policies, procedures and information management. If a group believes the specific technology effectively supports values that are significant to it, the group is more likely to support that technology. Conversely, if the group believes the technology will have a negative effect on its goals, the group will oppose the change. A general approach that emphasizes goals, guiding principles, fundamental concepts and principles of design process may make it easier to adopt the technology and tweak it as necessary.

At first, C-suite members need to focus on communicating the message and creating the sense of urgency for change, two of Kotter's eight steps in the change process (see box).

Employees and physicians need to be convinced of the benefits of the EHR system and its impact on efficiency and goal achievement. Similar to any implementation that has the potential for creating a great deal of change in an organization, the key to success is having every user believe that they own the technology.

Board members and the CEO should be broadcasting the importance of the EHR in achieving the organization's vision. Other members of the C-suite team are responsible for communicating the message to their division/department leaders and gathering their input about how to achieve EHR goals. If the

Eight Steps to Transforming an Organization

- Create urgency
- Form powerful coalition
- Create vision for change
- Communicate the vision
- Remove obstacles
- Create short-term wins
- Build on change
- Anchor the changes in the corporate climate

Source: Kotter, John P., (1996) *Leading Change*, Harvard Business Press

“The technology champion is a manager who lobbies for project acceptance and who lobbies for resources needed for implementation. The activities of a successful technology champion reduce employee resistance to the innovation and obtain access to resources.”

Linton, J., *Implementation Research State of the Art and Future Directions*, Technovation, Vol. 22, Issue 2, Feb. 2002, p64-79.

² Adapted from *Rules of Engagement: Proven paths for instilling, then installing a CPOE approach that works.* (2006) NAHIT publication

board, CEO and C-suite team are successful, they should have created an army of managers who are excited about EHR possibilities. Out of this group, project champions should be identified in each division/department.

Clinician Buy-in

Many EHR capabilities will change the way nurses, pharmacists and technicians currently perform their work. Therefore, success depends on their acceptance of the EHR into their daily work lives. Most people have established preferences for the ways they do their work, and variation from these preferred practice patterns will take more time, at least in the beginning.

Leaders need to be completely honest about the upcoming learning curve. Executive leaders need to communicate to staff that new processes take time to learn, but also make the connection between the new processes and the benefits, such as improved care, more time with patients, and better work/life balance. As with any work, satisfaction comes with knowing that the work has purpose and meaning.

Any type of change runs into roadblocks at some point. This is why clinical champions need to be identified. These individuals will play a key role in conveying the benefits of change. At the beginning of project planning, they should provide input into designing new workflow processes and providing support to other employees. Senior management needs to communicate with this group through emails, newsletter and face-to-face meetings. Communication efforts need to be ongoing and their concerns need to be taken seriously. Failure to engage and keep champions engaged will almost certainly spell disaster. Each champion from every division should own the EHR.

Physician Buy-in

Because of the unique relationship between hospitals and its physicians, getting physicians to accept and utilize new technology is often a challenge. Yet, their cooperation is essential to success.

Communication and transparency will go a long way in making the case for new technology, as does trust. Electronic health records will change the way in which all physicians practice, so leaders must involve them from the beginning, obtain their ongoing input and feedback, and incorporate their views and preferences into new workflow processes.

The physician champion must be a trusted medical staff colleague. He or she must remain a “practical zealot” throughout the most challenging of times during the EHR implementation lifecycle. At the same time, he or she needs to be a key change agent, knowing how to demonstrate empathy while motivating physician behavior change in ways that are in tune with the organizational culture, and have the authority to act.

“We use regularly recurring ‘town hall’ meetings with proper time allotted for questions and answers. We also try to be absolutely transparent to all employees who are curious or anxious about the changes. On the hospital and clinical side, we try to listen more to their concerns and needs and ‘back in’ those inputs into our ongoing planning sessions.”

Curt Kwak
Chief Information Officer
Providence Health & Services, 26 hospitals located in Alaska, California, Montana, Oregon and Washington

Communication is Key

An essential tool for gaining staff buy-in is communication. Hospital leaders should use every vehicle at their disposal—newsletters, emails, intranets, and town-hall and smaller meetings. Open lines of communication will promote the transparency necessary to gain staff EHR ownership. Leaders need to be honest upfront and address issues, such as increased staff time to learn the new system. An effective

communication plan should be aimed at various audiences over the entire span of a project—from initial communication with the board, to ongoing publicity throughout the organization, from implementation announcements to reports of follow-up enhancements and additional training.

Initial messaging from the CEO, board and others in the C-suite sets the tone for the importance of an EHR project, and they should continue to emphasize that message throughout the duration of the project. IT leaders can also participate in the larger effort of communicating with the staff, physicians and community. Marketing and communication staff can augment EHR communication efforts.

Frontline users crave communication that reinforces the perception that IT staff or project team members will be available when the switch is turned on for a new system. Communication needs to continue after implementation so that concerns and issues can be addressed.

Culture Tips

- Communication from the CEO sets the tone of the project, lays out the projected steps, and links it to the overall vision of the hospital.
- Project champions should be tasked with communicating progress to their departments.
- Physician communication requires special attention and effort. For familiarization and information briefings, use staff newsletters, focused e-mail, handouts, meetings with medical staff and office managers, and office visits.
- Absolute transparency and honesty are critical to maintaining credibility.
- Organizations need to provide a non-threatening way of providing feedback after implementation.
- Milestone events, such as go-lives and achieved targets, merit celebrations.

REDESIGN WORKFLOW PROCESSES

Much focus needs to be placed on workflow redesign as IT will create the impetus to improve current processes. An EHR should not just automate paper charts. Rather, improved processes should be created and then automated. The processes will reflect the IT results; sub-optimal processes will create sub-optimal results.

A key element in workflow redesign involves understanding the steps in each process and how they connect with one another and relating that back to the organization's goals. It starts with process mapping to determine the actual workflow; don't assume that just because a process is written out on paper that it is actually performed that way by the caregivers. Unseen barriers may have created workarounds that are the new "standard" workflow. Observing the actual processes will help to implement changes that make sense to the frontline worker.

After the steps in the actual workflow are identified, it is time to redesign the processes, keeping in mind how IT can be used as a tool to automate certain steps. At this point, the Plan-Do-Check-Act

cycle can be effective because it uses data to understand the problem, evaluates and refines the solution over time, and standardizes the new processes.

When redesigning the steps in the workflow, it is imperative to get input from frontline workers. Ideally, clinicians, employees and physicians should design the new processes, with the IT team giving input on what the technology can automate and what needs to be included in the EHR to qualify for meaningful use. The team should try to develop a new system of doing things through the use of HIT.

Examine each major process—medication refills, appointment requests, lab reviewing, prescription writing, patient demographics and so on—and write its current steps out on a flow diagram. Then, examine the capabilities of the EHR system and how it can improve the process. Teams should challenge all assumptions and limitations. Some existing workflows will not be needed, and some others may be added. The front-line user needs to understand why processes are added or removed and how it will help them achieve the organization’s goals.

Not all EHR processes will be quicker and more efficient. Don’t insist that people switch from an efficient paper process to a less-efficient HER-based process just for the sake of automation. Sometimes, however, a slower EHR process can pay off in other ways. For example, progress note documentation with an EHR is slower than using dictation. However, by documenting directly in an EHR, notes are readily available to be shared with patients or consultants, or the notes can be used for immediate review of those patient-care questions that arise before a dictation would normally be ready. Additionally, while some processes may take longer, the time can be recouped in terms of quality of care. Physicians may be able to access data from their homes in the middle of the night, enabling them to make better, timely decisions.

Finally, all processes need to be redesigned with the customer in mind—the patient. Don’t design for efficiency because the unintended consequence will be that you are removing steps that add value to the patient. In hospitals, patient value comes from having the right information at the right time to assist the clinicians in making the best decision regarding the patient. Implemented correctly, an EHR can dramatically improve communication among providers.

IMPLEMENTATION

After workflow analysis is done and a change management plan is started, it is time to start training and then implement the actual IT component. The communication plan needs to stress that while some new work processes might take longer or are more cumbersome with the EHR system, patient care will be improved. Training and support must be provided in order to overcome resistance and problems.

Training

Different people have different levels of comfort with IT. From early adopters to laggards, training needs to accommodate for the differences. There will be a lot of anxiety when a hospital or physician practice begins to use an electronic health records system. Tasks that were once done intuitively now become a labor of mouse clicks and keystrokes that seem to involve a secret code. Data easily found in a paper chart seems hidden somewhere on a computer screen.

In any health care setting, training in advance of using a new EHR system and tangible support for the implementation in its first days and weeks of use are critical success factors for facilitating the deployment.

There is wide diversity of opinion about how to gain the greatest benefit from training and make education efforts effective. In an informal survey of CHIME members, several overarching themes on training emerge:

- At some point during training, learners must break away to participate in training sessions outside of their normal work environment and away from their day-to-day duties.
- Effective training uses several approaches that attempt to cover the variety of learning styles and preferences of a diverse hospital staff.
- In addition to being offered in classroom settings, training programs need to take advantage of other avenues for getting knowledge to people – workbooks/user guides, quick reference guides, Web-based instruction, one-on-one trainers and “super-user” assistance.
- When well-designed, computer-based training modules offer the ability to train both inside and outside of the classroom. Further, questionnaires and EHR-based “practice sessions” enable closed-loop measurement of trainees’ comprehension and retention. Further, the information garnered from closed-loop tests may help identify those who could serve as super-users and support their co-workers, and they also can show those who may need additional support before and during go-live efforts.
- Workforce members are likely to retain only a percentage of what they learn in training in advance of actually using a new system. Thus, training and support is critical the day of go-live, and in the days and weeks that follow.
- As users’ knowledge base grows, they can be further trained to incorporate systems’ advanced functionality and to take a fresh look at how workflows and processes can be improved.

Going Live

Choosing between a rapid or a staged implementation depends on how much upfront planning has been completed. Rapid deployment requires significant planning and change management. Organizations must have the resources available to deal with problems as they emerge and provide support to staff. A staged implementation allows organizations to discover and solve problems before system-wide implementation. However, it requires organizations to maintain an electronic and paper-based system until full implementation can occur.

Either implementation style requires clear communication about timelines, training and support. Clinician and physician champions can provide support and encourage laggards and slow adopters. Additionally, ongoing support must be provided during the first few months after the go-live date.

CONCLUSION

An EHR system has the potential to transform the ways in which care is delivered. It should not be viewed as an IT application, but rather an asset or tools that can assist in achieving organizational goals. However, EHR implementation is not an easy feat. Strategizing and upfront planning take strong leadership and commitment. Additionally, it requires ongoing support and training. Large-scale changes, such as an EHR system, present big challenges, but also significant opportunity to achieve safe, effective, efficient, patient-centered care.

TERMS AND DEFINITIONS

ARRA

American Recovery and Reinvestment Act of 2009

http://www.recovery.gov/About/Pages/The_Act.aspx

A response to the economic crisis, the Recovery Act has three immediate goals:

- Create new jobs and save existing ones
- Spur economic activity and invest in long-term growth
- Foster accountability and transparency in government spending

HITECH

Health Information Technology for Economic and Clinical Health Act

<http://www.cms.gov/EHRIncentivePrograms>

The HITECH Act established programs under Medicare and Medicaid to provide incentive payments for the meaningful use of certified EHR technology. The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs begin in federal FY 2011. These incentive programs are designed to support providers in this period of HIT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

RECs

Regional Extension Centers

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2>

This federal extension program consists of Health Information Technology Regional Extension Centers (RECs) and a national Health Information Technology Research Center (HITRC). The HITRC will gather information on effective practices and help the RECs work with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support. RECs are designed to make sure that primary care clinicians get the help they need to use EHRs. A list of websites and emails for each REC is featured on the REC web site. RECs will:

- Provide training and support services to assist doctors and other providers in adopting EHRs
- Offer information and guidance to help with EHR implementation
- Give technical assistance as needed
- Provide outreach and support services to at least 100,000 priority primary care providers within two years.

ONC has funded 60 RECs throughout the United States to ensure plenty of support to health care providers in communities across the country.

ONC

<http://healthit.hhs.gov/portal/server.pt>

The Office of the National Coordinator for Health Information Technology (ONC) is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of national coordinator was created in 2004 through an executive order and legislatively mandated in the HITECH Act of 2009.

EHR RESOURCES

AHA Health Information Technology Advocacy – Meaningful Use

<http://www.aha.org/aha/issues/HIT/I00226-hit-meaningful.html>

This web page features advocacy updates, bulletins, issue papers and a calculator for measuring incentive payments (*for AHA members only*).

American Academy of Family Physicians

www.centerforhit.org

The Center for Health Information Technology at the AAFP features a variety of tools and resources.

American Medical Association

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/health-information-technology/hit-resources-activities.shtml>

AMA comments and updates are featured on this web page.

Association of Medical Directors of Information Systems

<http://www.meaningfuluse.org/>

This website features link to the latest news, information and blogs on meaningful use.

Centers for Medicare & Medicaid Services

<http://www.cms.gov/EHRIncentivePrograms>

The official web site for the Medicare and Medicaid EHR Incentive Programs.

CHIME ARRA/HITECH

<http://www.cio-chime.org/advocacy/stimulus/index.asp>

This web page features white papers, advocacy statements and summaries of regulations.

HIMSS

<http://www.himss.org/EconomicStimulus/>

The Healthcare Information and Management Systems Society (HIMSS) provides a variety of resources on meaningful use, certification criteria and standards, and the HHS certification process.



American Hospital
Association

Bundled Payment

AHA RESEARCH SYNTHESIS REPORT

MAY 2010

American Hospital Association
Committee on Research

AHA Research Synthesis Reports are periodic reports that synthesize literature on key issues related to the 2010 to 2012 AHA Research Agenda. The AHA Committee on Research developed the 2010 to 2012 AHA Research Agenda, which was approved by the AHA Board in November 2009.

For more information, contact Maulik Joshi at mjoshi@aha.org or 312-422-2622.



Bundled Payment – AHA Research Synthesis Report

Bundled Payment – AHA Research Synthesis Report

Executive Summary

Introduction

The first in a series of periodic reports, this *AHA Research Synthesis Report* examines the current evidence base on the design and impact of bundled payments and identifies knowledge gaps that still need to be answered as both the public and private sectors actively pursue this payment approach as a solution to current care delivery and quality issues.

Evidence on the Impact of Bundled Payments

The models of bundled payment that have been tested in the public and private sectors have yielded promising results. However, the models focus on specific conditions, such as those with defined timeframes, defined services, and isolated episodes, and are based in specific care settings, such as integrated delivery systems and academic medical centers.

Despite the limitations of the current knowledge base on bundled payment, current literature indicates that:

- 1. Bundled payment could potentially reduce spending on an episode of care.** For example, during the five-year Heart Bypass Center Demonstration, Medicare saved \$42.3 million, or roughly 10 percent of expected spending, on coronary artery bypass graft (CABG) surgery at the seven participating hospitals. Geisinger's ProvenCare was able to reduce hospital costs by 5 percent.
- 2. Providers' readiness to participate in bundled payment programs varies.** Of the 734 hospitals that expressed interest in Medicare's Heart Bypass Center Demonstration, 209 submitted pre-applications. Within a year of the introduction of Blue Cross Blue Shield of Massachusetts' Alternative QUALITY Contract (BCBSMA AQC), about 20 percent of eligible providers have signed up for the payment program.
- 3. Bundled payment can spur quality improvement.** This is especially true when bundled payment is paired with defined quality metrics. ProvenCare was coupled with 40 best practice steps based on the American Heart Association and the American College of Cardiology guidelines, and BCBSMA AQC has a performance incentive linked to a variety of nationally-recognized measures. ProvenCare reduced average length of stay (LOS) for CABG by 0.5 days and 30-day readmission rates by 44 percent over 18 months.

Key Issues for Consideration

Before bundled payment can be widely implemented, several key questions need to be addressed:

1. To which conditions should bundled payments be applied?
2. What providers and services should be included in the bundled payment?
3. How can provider accountability be determined?
4. What should be the timeframe of a bundled payment?
5. What capabilities are needed for an organization to administer a bundled payment?
6. How should payments be set?
7. How should the bundled payment be risk-adjusted?
8. What data are needed to support bundled payment?

Introduction

One of the top four research questions in the 2010 to 2012 AHA Research Agenda is:

What is the role of the hospital in a new community environment that provides more efficient and effective health care (e.g., what are the redesigned structures and models, the role and implementation of accountable care organizations, the structures and processes needed to implement new payment models such as bundled payments, and how do organizations transition to this new role)?

This *AHA Research Synthesis Report* provides a review of the literature on one aspect of this transition—*reviewing what is known and unknown about bundled payment.*

Bundled payment has been proposed as a means to drive improvements in health care quality and efficiency. Although there is great interest in this payment reform approach, there is currently limited data on how to design and administer bundled payments. Despite a few real-world applications of bundled payment, several questions remain. Among them is how payments for the physician and non-physician components of care will be determined under bundled payment.

The purpose of this research synthesis is to present an overview of bundled payment, including evidence of impact from public and private sector application, and the questions that must be considered as policymakers and delivery organizations move forward with this concept.

What is Bundled Payment?

Under a system of bundled payment, or episode-based payment, reimbursement for multiple providers is bundled into a single, comprehensive payment that covers all of the services involved in the patient's care. The goal of the bundled payment approach is similar to that of the Institute of Healthcare Improvement's (IHI) "Triple AimTM" objectives of improving population health, boosting the patient care experience, and reducing cost. As with the five components identified by IHI to fulfill its triple aims, bundled payment aims to control cost, integrate the care delivery system, and restructure delivery of primary care.

Bundled payment is touted as a viable option to meet payers and providers goals because of the potential improvements it presents over the Medicare fee-for-service system of reimbursement and the capitation model of payment. Medicare's current diagnosis-related group (DRG) system of reimbursing providers can be considered a form of bundled payment involving only one provider type. Likewise, the capitation model of payment adopted by several managed care organizations is also a type of bundled payment. However, both of these payment approaches are on the extreme ends of the bundled payment spectrum. Under the DRG system, the insurer assumes full financial risk of the patient acquiring the condition and any treatment costs associated with that episode; under capitation, the provider assumes most of the financial risks. The spectrum of services included in the DRG payment is very limited, compared to capitation, which is broader in scope. The appeal of recent models of bundled payment is that they ensure that financial risks of treating a patient are shared by both the payer and the provider and allow for flexibility in defining the scope of the bundled payment (e.g.,

timeframe, services included, and other considerations). Bundled payment may cover a certain clinical episode or a defined time period (Pham et al. 2010). For example, a single payment under a bundled payment system might cover:

- Hospital and physician services for acute episodes such as hip replacement or cardiac catheterization
- Physician, hospital, and support services associated with the management of a patient's congestive heart failure for one year

If the costs of care during the episode or timeframe are less than the bundled payment amount, the providers keep the difference. Conversely, if costs exceed payment, providers absorb the loss. In some proposed models of bundled payment, such as the accountable care organizations (ACOs) framework, savings are shared by all entities involved. Bundled payment has been proposed to address some of the shortcomings of the current fee-for-service payment system, such as overuse of well-reimbursed services and fragmented, uncoordinated care delivery. Proponents of bundled payment believe that it will lead to more judicious use of health services and improved care quality.

Bundled Payment and Health Reform

The idea of bundled payment has been gaining traction for many years, and the recent health reform law includes a provision pertaining to bundling. The law calls for the establishment of a national pilot program on payment bundling for the Medicare program by 2013 and a Medicaid bundling demonstration program by 2012. The pilot, which will be administered by a new Center for Medicare and Medicaid Innovation (CMI), is a voluntary, five-year pilot program that will test bundle payments. Pilots may involve hospitals, including Long Term Care Hospitals and inpatient rehabilitation facilities, physician groups, and skilled nursing facilities and home health agencies for an episode of care that begins three days prior to a hospitalization and spans up to 30 days post-discharge.

The stated purpose of the program is to improve the coordination, quality, and efficiency of services around a hospitalization in connection with one or more of eight conditions to be selected by the Secretary of Health and Human Services. The health reform law holds a lot of promise for the expansion of bundled payment by authorizing the Secretary to expand the program after the pilot phase, based on performance. Expansion of previous federal bundled payment demonstrations has been curtailed by the congressional approval process. The law also eliminates the budget-neutrality requirement for the expansion of previous demonstration programs and hints at the possibility of aligning Medicare payment programs with private sector initiatives.

Evidence on the Impact of Bundled Payment

Evidence of the impact of bundled payment is limited but promising. To date, only a handful of models have been implemented, and they offer some insight into the feasibility and impact of bundled payment (Box 1). However, all of these programs are either narrow in scope or have been implemented in highly integrated systems with a broad array of services, such as large

hospitals or academic medical centers. Therefore, their design and results are not necessarily generalizable on a wide scale and to small, medium-sized, and rural hospitals. Also, as shown in the summary chart in the Appendix, the major bundled payment programs implemented do not address key gaps in the design of bundled payment. The chart summarizes the publicly-available published data on components of the programs such as, the conditions of focus, the providers and services involved in the bundled, strategy for holding providers accountable for care provided, timeframe for the bundled payment, organizational capabilities of the entity receiving the payment, and how payments were determined and adjusted.

Box 1 – Sample Bundled Payment Programs

Medicare’s Participating Heart Bypass Center Demonstration: Under this demonstration, which ran from 1991 to 1996, seven hospitals received a single payment covering hospital and physician services for coronary artery bypass graft (CABG) surgery. The participating hospitals received a single payment and determined how they would share the amount with physicians. The payment rate was also updated based on the Medicare hospital prospective payment and physician fee schedule rates.

Medicare’s Cataract Surgery Alternate Payment Demonstration: From 1993 to 1996, this demonstration project used a negotiated bundled payment option for all services routinely provided within an episode of outpatient cataract surgery, including physician and facility fees, intraocular lens costs, and the costs of selected pre- and postoperative tests and visits. Payment rates were determined by competitive bidding and were 2 to 5 percent lower than the non-demonstration payment rates.

Geisinger Health System’s ProvenCare: Under this program, which began in 2006, payment is bundled for all non-emergency coronary artery bypass graft (CABG) procedures including the preoperative evaluation, all hospital and professional fees, and management of any complications (including readmissions) occurring within 90 days of the procedure.

Dr. Johnson and Ingham Medical Center: In 1987, an orthopedic surgeon partnered with a local hospital to offer a fixed price for knee and shoulder arthroscopic surgery, which included all related physician and hospital charges for surgery and any subsequent service for two years after surgery.

Medicare’s Acute Care Episode Demonstration: Beginning in 2009, Medicare pays the five participants a flat fee to cover hospital and physician services for cardiac care (CABG, valves, defibrillators, pacemakers, etc.) and orthopedic care (hip and knee replacement). The participating sites have the discretion to reward clinicians and other hospital staff who meet certain quality and efficiency goals.

PROMETHEUS Payment, Inc.: With grants from the Commonwealth Fund and the Robert Wood Johnson Foundation, PROMETHEUS is developing a bundled payment system to cover a full episode of care for acute myocardial infarction, hip and knee replacements, CABG, coronary revascularization, bariatric surgery, and hernias. PROMETHEUS was implemented in three sites in 2009.

Fairview Health Services: Fairview Health Services in Minnesota is currently working with Target, 3M, and other large, self-insured employers to develop flat fee "care packages" around specific chronic conditions, such as diabetes and asthma. Employers and patients can use online tools to purchase a package that best fits their needs.

Blue Cross Blue Shield of Massachusetts (BCBSMA): The Alternative QUALITY Contract (AQC): In 2009, BCBSMA introduced the AQC to provider and hospital groups in Massachusetts. As of November, 2009, 20 percent of the BCBSMA provider network had signed on to the AQC. The AQC is a global payment system tied to nationally accepted measures of quality. The payment rate is set for all services and costs associated with a patient's care, is risk-adjusted for patients' health status, sex, and age, and is updated annually for inflation. The AQC is the most comprehensive bundled payment model to date because it covers all conditions that a BCBSMA member may present with, includes all services that the member may require across the continuum of care, and rates performance based on a detailed list of process, outcome, and patient experience measures. The contract also includes a pay for performance component where providers are eligible for an additional 10 percent of total payment if they meet certain quality benchmarks.

1. Bundled payment could potentially reduce spending on an episode of care, so payers, providers, and patients may benefit.

Cost reduction and quality improvement in the bundled payment system results from several factors such as provider adherence to guidelines (ProvenCare), elimination of waste and utilization reduction (Heart Bypass Center Demonstration), and physician-hospital alignment. However, it is still unclear which of these factors has the greatest impact on cost reduction and quality improvement. During the five-year Heart Bypass Center Demonstration, Medicare saved \$42.3 million, or roughly 10 percent on CABG surgery at the seven participating hospitals, compared to expected spending. Eighty-six percent of the savings came from negotiated discount rates for patient services. The hospital negotiated rates applied to four physician specialties involved in bypass admission: surgeons, anesthesiologists, cardiologists, and radiologists, in addition to the allowable Medicare payment for consulting physicians. In addition to savings to Medicare, three of the four hospitals initially included in the demonstration experienced an average cost reduction of 2 to 23 percent by changing physician care practices and hospital processes (Bertko and Effros 2010). Specifically, the cost reductions were attributed to reduction in nursing intensive care unit hours, thus resulting in fewer nursing days per patient, reduced pharmacy cost from generic drug substitutions, and efficient use of the catheter lab. All four original hospitals included in the demonstration enjoyed profits. Beneficiaries saved \$7.9 million in coinsurance payments (Cromwell et al. 1997).

The fixed price for CABG under Geisinger's ProvenCare was set at the cost of a typical hospitalization plus 50 percent of the average cost of post-acute care over 90 days. An evaluation of the program found that hospital costs dropped 5 percent (Casale et al. 2007). Average length of stay (LOS) for CABG fell by 0.5 days, and the 30-day readmission rate fell 44 percent over 18 months.

Medicare's cataract surgery demonstration was also successful in reducing Medicare spending by \$500,000 for approximately 7,000 procedures.

Dr. Johnson and Ingham Medical Center's two-year project covering 111 patients also resulted in a lower price per case than in the comparable fee-for-service model. Profit margins for the surgeon and the hospital increased, and the payer (an HMO) saved more than \$125,000 (Johnson and Becker 1994).

Empirical work conducted by researchers at RAND lends further support to the notion that bundled payment can reduce health care spending. They constructed a model to compare the potential cost-saving impact of twelve policy options (e.g., establishing medical homes, decreasing resource use at end of life, expanding value-based purchasing), and bundled payment was shown to have the greatest potential to reduce health spending (Hussey et al. 2009). As outlined by the Medicare Payment Advisory Commission (MedPAC 2008), savings will result from efficient use of physician and hospital resources during hospitalization and reduction in post-discharge complications and costs (MedPAC 2008).

2. Providers' readiness to participate in bundled payment programs varies.

Prior to the start of the Heart Bypass Center Demonstration, the Health Care Financing Administration mailed solicitations to 734 hospitals. Of those, 209 submitted pre-applications, suggesting that many hospitals can work with their medical staffs to develop a single price for the service (Cromwell et al. 1997). However, provider interest in the cataract surgery demonstration was lower. Only 3.7 percent of eligible providers indicated a willingness to participate (Abt Associates Inc. 1997). Based on the success of ProvenCare for CABG, Geisinger has expanded the model to develop similar programs for hip replacement, cataract surgery, and percutaneous coronary intervention (Paulus et al. 2008).

3. Bundled payment can spur quality improvement.

The change in payment under ProvenCare was coupled with a pay-for-performance system that included 40 best practice steps based on American Heart Association and American College of Cardiology guidelines. Initially, 59 percent of patients received all 40 best practices. Six months after the start of the program, 100 percent of patients received all best practices (Casale et al. 2007). ProvenCare is estimated to have reduced all complications by 21 percent, sternal infections by 25 percent, and readmissions by 44 percent, and decreased hospital length of stay by half a day (Steele et al. 2008).

Hospitals participating in the Medicare Participating Heart Bypass Center Demonstration reduced mortality in CABG patients included in the demonstration (Cromwell et al. 1997). Dr. Johnson and the Ingham Medical Center's orthopedic surgery project resulted in a decline in potentially avoidable complications and reoperations (Johnson and Becker 1994).

Key Issues for Consideration

Before widespread implementation can be achieved, a number of operational and design questions must be addressed. Several questions are listed in Box 2 below and followed by additional detail for each question.

Box 2 – Key Questions

1. To which conditions should bundled payments be applied?
2. What providers and services should be included in the bundled payment?
3. How can provider accountability be determined?
4. What should be the timeframe of a bundled payment?
5. What capabilities are needed for organizations to administer a bundled payment?
6. How should payments be set?
7. How should the bundled payment be risk-adjusted?
8. What data are needed to support bundled payment?

1. To which conditions should bundled payments be applied?

Historically, Medicare's bundled payment demonstrations have been applied to conditions with a defined timeframe from diagnosis to recovery such as CABG and cataract surgery. Also, bundled payments have been proposed for conditions requiring defined types of services such as end stage renal disease. Similarly, Geisinger initially applied their bundled payment system, ProvenCare, to CABG and then extended it to other conditions such as hip replacement, cataract surgery, and obesity surgery. The Commonwealth Fund recently recommended the development of bundled payments for both acute and chronic conditions. Therefore, the trigger for bundled payment could occur before or even in the absence of hospitalization.

The focus of the previous bundled payment models may suggest that some conditions are better suited for bundled payment than others. For example, isolated acute care episodes with a clear beginning and end will better facilitate the development of a flat payment for an episode (Miller 2008). Also, conditions should have well defined clinical definitions so that it is clear which patients are eligible for bundled payment. Conditions with established clinical guidelines will help with the development of benchmarks and goals for providers. Feasibility may also be enhanced for episodes of care that have little variation in utilization and cost (Pham et al. 2010). For example, the care needed by patients with chronic heart failure is highly variable. The progression of the condition may, to a large extent, be outside the control of providers, and the service needs are often unpredictable.

Previous bundled payment models offer little insight into how bundled payments can be scaled up to include more conditions without being mired in administrative complexities. Lessons from the BCBSMA AQC could be instructive on how bundled payments can be structured for a wide variety of conditions and at the same time minimize the administrative burden for both providers and payers.

2. What providers and services should be included in the bundled payment?

Past demonstration and pilot projects have centered on bundling payments for services provided by the hospital and physicians. For example, previous projects have often focused on surgical procedures (e.g., CABG or cataract surgery) where the largest expenditure for the payer is often concentrated in the acute care hospital and includes hospital-based physician services. As bundled payment is proposed for other medical, chronic, or long-term conditions, it will necessitate that other providers be included in the bundled payment, including but not limited to: primary care physicians, home health, nursing home, long-term acute care, rehabilitation, and other providers across the full continuum of care. Within the hospital setting, there may be an opportunity to link ancillary services such as laboratory work, emergency services, and other diagnostic services to the bundled payment. The engagement of multiple service providers will present an opportunity for optimal financial management. Establishing linkages between different types of providers and providers from different organizations will be a challenge. Similarly, determining actual payments to the physician and non-physician components of care within the bundle will also be challenging as the limited models of bundled payment do not present a precedent for future application.

The information available from previous applications of bundled payment might indicate that the broader the scope of providers and services included in the bundle, the more opportunities there are for cost savings and quality improvement. For example, some of the sites in the Medicare Participating Heart Bypass Center reduced spending by generic substitution, in addition to other practice changes. The BCBSMA AQC could offer some insight on the range of providers and services along the continuum of care that should be included in a bundled payment.

3. How can provider accountability be determined?

A related consideration is how to attribute provider responsibility for care in an episode. For example, most hip fracture episodes involve four or more care settings, and it may be challenging to determine the extent to which each provider is responsible for the outcomes of an episode (Hussey et al. 2009). This is an important question because bundled payment provides incentives for providers to reduce unnecessary utilization. One potential unintended consequence is that necessary care may also be reduced.

Assignment of responsibility for quality and payment purposes is easier for some conditions than others. For example, it is easier to determine the relative involvement of hospitals and post-acute care facilities, specialists, and other physicians for a hip replacement than a heart attack because hip replacements have more predictable care assignments (Pham et al. 2010). The orthopedic surgeon and hospital could be assigned primary accountability for the patient. For other conditions, it will be difficult to assign clear responsibility to a small number of providers to keep payment and quality control issues simple and transparent.

Unfortunately, the data on bundled payment provide limited guidance on how provider accountability for care was enforced in their models. For example, the sites included in Medicare's Participating Heart Bypass Center were at liberty to allocate the bundled payment between participating providers reduced as they deemed necessary. Medicare's Acute Care Episode Demonstration allows participating sites to reward clinicians and other hospital staff

who meet certain quality benchmarks. Another possible approach for fostering provider accountability is to allocate the bundled payment based on the share of what providers' fees would have been, thereby holding each provider accountable for delivering efficient care and controlling their costs.

4. What should be the timeframe of a bundled payment?

Available literature provides several examples of different durations for bundled payments. For example, in determining the financial risk impact of bundled payment on hospitals, researchers used 60 day post-discharge as the post-acute period to define the duration of the bundle (Welch 1998). The Commonwealth Fund proposal favors bundling payment for services provided from the time of admission through 90 days post-hospitalization (The Commonwealth Fund 2007). The president's proposed budget for 2010 suggests bundling payment for hospitalization and post-acute care that occurs within 30 days after hospitalization (Office of Management and Budget [OMB] 2008).

Geisinger's ProvenCare bundled payment for hospitalization and the 90-day period following CABG surgery. However, none of the literature presents evidence in support of any defined post-acute timeframe. It is important to note that the duration of the bundle will determine the types and amount of services included in the bundle. An appropriate post-acute timeframe should also allow patients enough time to fully recover from a condition. This is an especially important consideration for bundling payments for chronic conditions that often span a patient's lifetime. In an analysis of Medicare data, one study found that many patient episodes are captured within 30 days. However, for a sizeable minority of patients, a 30-day episode would not capture their multiple visits and hospital days for their complex health condition needs (Avalere 2010).

5. What capabilities are needed for organizations to collect and administer a bundled payment?

Bundling payments for episodes of care presents the administrative challenge of identifying the appropriate entity to collect and dispense income from the bundle as well as oversee the efficient delivery of care within the episode. This entity would need to have the administrative capacity to act as a third-party administrator in some respect and determine what patients' continuing care needs may be and how much each provider should be reimbursed for care. Acute care facilities, ACOs, and other organizations have been proposed as the appropriate entities to receive bundled payments on behalf of all providers and facilities involved in an episode of care.

In order to successfully undertake the function of care coordination, the entity would have to effectively work with hospitals, physicians, and other care providers to hold them accountable for high quality and efficient care delivery. Currently, few organizations have the infrastructure and influence to undertake this function. Additionally, the entity would need information technology systems to track and manage processes, especially if it is receiving bundled payments from multiple payers and there is no uniform definition or consensus on what is included in the bundle. Regardless of the reimbursement structure for bundled payments, it will

have to ensure that all care facilities and providers involved in an episode of care have equal bargaining power in the arrangement.

In most of the models of bundled payment implemented to date, such as PROMETHEUS, Geisinger's ProvenCare, and Medicare's Participating Heart Bypass Center program, the hospital or hospital system received the bundled payment and determined how to allocate the money among physicians and other providers. Sites in the Medicare's Participating Heart Bypass Center program expressed billing and collection challenges, especially at the onset of the program while they determined internal procedures and acquired appropriate technology. An important takeaway for future expansion of bundled payment is that the participating sites in Medicare's Participating Heart Bypass Center program would have liked to have been reimbursed for the initial investment.

6. How should bundled payments be set?

Once assignment of responsibility for patient care is established and the appropriate entity for payment is identified, another challenge is setting the appropriate payment amount. If a bundled payment program includes only a small number of episode types or a small number of providers, payers could negotiate payment amounts (Pham et al. 2010), which is what Medicare has done (and continues to do) under its demonstration programs. However, there are several other ways in which payers may set bundled payment rates. For example, payment rates could be based on historical costs (e.g., average fee-for-service cost minus five percent) or standard of care guidelines (i.e., the estimated costs assuming providers delivered only recommended care).

The PROMETHEUS payment model uses evidence-based case rates that are based on resources required to provide care under well-established clinical guidelines. Geisinger's ProvenCare rates were negotiated and based on historical cost and reimbursement data. The rate for CABG assumed that readmission and complication rates would be cut in half as providers followed evidence-based care guidelines. Regardless of the method used, payers will also have to periodically revisit and update payment rates over time as more data on program outcomes become available. BCBSMA's AQC will be updated annually for inflation, and Medicare's Participating Heart Bypass Center program was updated based on the existing inpatient prospective payment and physician fee schedule rules.

7. How should the bundled payment be risk-adjusted?

Bundling payments for care received in the acute and post-acute care settings needs to factor adequate case-mix adjustment for the severity of illness of different patient populations. This will ensure that providers will not turn away the sickest patients for fear of being liable for more expensive treatments (RAND COMPARE). Also, social determinants such as language, socioeconomic status, and availability of social support should factor in risk-adjusted bundled payment, since they could influence patient health outcomes. Finally, to ensure that the bundling payment approach does not pose additional financial risk to providers and facilities, the payments would have to closely match the combined costs of acute and post-acute care (Welch 1998).

The bundled payment approach that provides a clear direction for risk-adjustment is BCBSMA's AQC. The global payments made to providers are risk adjusted for the age, sex, and health status of the patients. Other models may have alternative or additional ways to risk-adjust payment; however, that information is not readily available in the literature. Insurers commonly cite 100,000 as the appropriate patient population size to adequately diversify risks. It will be important to analyze if such thresholds should apply for risk-adjusting bundled payment.

8. What data are needed to support bundled payment?

Most current studies on bundled payment use episode groupers (software packages that search medical claims and records to identify whether patients meet the criteria of an episode, when the episode began and ended, and the services received) (Pham et al. 2010). However, in order for the groupers to be effective, data must contain accurate information on patient diagnoses and co-morbidities; dates, types, and cost of services; and patient and provider identifiers. Although many of these data are currently available, there is often limited detail because the data collection systems were designed for fee-for-service payment approaches. Electronic medical records may permit more comprehensive data collection.

Conclusion

While the concept of bundled payment is appealing, implementation is complex. It is telling that so few bundled payment programs have been established over the past 20 years. However, current political support for bundled payment coupled with the growing evidence base may lead to more experimentation with bundled payment in the near future. Further advancement of bundled payment will depend on the will of payers and providers to collaborate in a new way and to address several challenging operational issues.

Key References

Proposals

1. Senate Finance Committee (2009) *Description of Policy Options: Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*. Retrieved from:
<http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf>

Summary: This proposal advocates for a bundled payment to be made for acute services and post-acute services occurring or initiated within 30 days of discharge from a hospital. This approach would involve a three-phase implementation, separated by two years. In phase one, bundled payments would be applied to the top 20 percent of post-acute spending; in phase two, bundled payments would be applied to the next 30 percent of post-acute spending; and in phase three, bundled payments would be applied to the last 50 percent of post-acute spending. Bundled payments will total inpatient MS-DRG amount plus post-acute care costs for the same MS-DRG and will be paid to an established legal entity, including a hospital.

2. Office of Management and Budget (2009) *A New Era of Responsibility: Renewing America's Promise*. Retrieved from:
http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf

Summary: The president's budget proposes bundled payments as an approach to reducing preventable rehospitalizations. The bundled payments will cover hospitalizations as well as post-acute care 30 days after the hospitalization. Additionally, hospitals with a high rate of readmissions within the 30-day period will be paid less.

3. Guterman, S., Davis, K., Schoen, C., and Stremikis, K. (2009) *Reforming Provider Payment: Essential Building Block for Health Reform*. (Fund Publication # 1248). Retrieved from the Commonwealth Fund:
http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Mar/1248_Guterman_reforming_provider_payment_essential_building_block_FINAL.pdf

Summary: This proposal suggests a global fee for hospitalization and a "specified set of services for 30 days following discharge." This approach would be phased in starting in 2010; the first stage would involve bundled payment for hospital costs associated with initial hospitalization and any readmissions that occur within 30 days of discharge and follow up care for the patient. The second stage would involve bundled payments for acute and post-acute care, and the final stage would involve a bundled payment for acute care, physician services, post-acute care, and emergency room care.

4. MedPAC (2008) A path to bundled payment around a hospitalization. In *Report to Congress: Reforming the Delivery System* (pp. 83-103). Retrieved from:
http://www.medpac.gov/documents/Jun08_EntireReport.pdf

Summary: MedPAC proposes a bundled payment for services rendered by a single entity, defined as a hospital and its affiliated physicians. The payment will cover costs associated with an episode of hospitalization. The commission recommends a phased-in approach: in phase one, hospitals and physicians will be confidentially informed of their utilization patterns for hospitalization episodes. In the second phase, occurring two years after the first, the confidential information will be made publicly available. In phase three, the bundled payment system will be implemented. The commission also recommends that Medicare reduces payment to hospitals with high readmission rates.

5. Miller, H. D. (2008) *From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-Driven Health Care. Issues for Discussion and Resolution at the 2008 NRHI Healthcare Payment Reform Summit.* Retrieved from: <http://www.nrhi.org/downloads/2008NRHIPaymentReformSummitFramingPaper.pdf>

Summary: This framing paper prepared for the 2008 Network for Regional Healthcare Improvement (NHRI) Summit on Healthcare Payment Reform describes key issues and options for advancing payment reform in the U.S. The paper proposes episode-of-care payments as a middle ground between fee-for-service and capitation model of payment. One of the issues covered by the framing paper is the type of provider structures needed for bundled payments. According to the author, an integrated delivery system (IDS) is well-positioned to be such an entity. Outside of an IDS, a special organizational entity that includes a physician group and a hospital could also receive the bundled payment on behalf of all providers involved in an episode of care.

6. Congressional Budget Office (2008) *Budget Options Volume 1: Health Care.* Retrieved from: <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

Summary: This proposal advocates for bundled payments for acute and post-acute care provided in both the hospital and non-hospital setting within 30 days of patient discharge. The bundled payment rate would be equal to the amount paid for the MS-DRG plus post-acute cost associated with that MS-DRG. According to the proposal, hospitals would have a greater involvement in the patient's post-discharge care and would probably reduce post-acute care under this payment approach. An alternative approach proposed by the CBO is bundling payment for hospital and physician services.

7. The Commonwealth Fund (2007) *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending.* Retrieved from : http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2007/Dec/Bending%20the%20Curve%20Options%20for%20Achieving%20Savings%20and%20Improving%20Value%20in%20U%20S%20Health%20Spending/Schoen_bendingthecurve_1080%20pdf.pdf

Summary: The Commonwealth Fund Commission on a High Performance Health System proposes bundling payments for hospitalizations for acute-care episodes. Under this approach, Medicare would bundle payments for all inpatient, physician, and related services provided from the time of admission within 90 days post-hospitalization. The approach would also be applied to healthy and chronically ill patients in the outpatient setting.

Evaluation of Demonstration Projects

8. Paulus, R. A., Davis, K., and Steele, G. D. (2008) Continuous Innovation in Health Care: Implications of the Geisinger Experience. *Health Affairs*, 27:1235-1245.

Summary: Geisinger created the ProvenCare model for coronary artery bypass graft (CABG). As part of the model, the organization established best practices across the episode of care and developed a risk-based price for care, which included hospital costs and subsequent readmissions. Through ProvenCare, Geisinger was able to increase the percentage of CABG patients receiving recommended care, as measured by the forty measures, to 100 percent.

9. Cromwell, J., Dayhoff, D. A., McCall, N. T., Subramanian, S., Freitas, R. C., and Hart, R. J. (1998) Medicare Participating Heart Bypass Center Demonstration: Final Report. *Health Economic Research, Inc.*

Summary: In 1988, the Health Care Financing Administration negotiated contracts with four hospitals to pay them bundled payments for heart bypass with or without catheterization. The demonstration project lasted from 1991 through 1996, including a two year extension. The evaluation found that the demonstration saved Medicare \$42.3 million on bypass patients and saved beneficiaries \$7.9 million in Part B coinsurance payments. Participating hospitals also saved on treating bypass patients. Some of the cost savings were a result of generic drug substitutions reported by pharmacists. The range of hospital savings was between \$1.7million and \$15 million. Patients discharged from participating hospitals also had on average, an 8 percent decline in mortality rates. The evaluators also noted that patients received appropriate care at participating hospitals.

Other Published Literature

10. Mechanic, R. and Altman S. (2010) Medicare's Opportunity to Encourage Innovation in Health Care Delivery. *The New England Journal of Medicine*, 362(9): 772-774.

Summary: The authors of the article evaluate the newly-mandated Center for Medicare and Medicaid Innovation (CMI) and how the entity will facilitate the implementation of key health delivery models. First, the CMI is authorized to run pilot programs rather than demonstration projects, which can be hampered from widespread dissemination by congressional approval. The CMI would also have the authority to decide on which proposals to pursue and can choose to expand pilots that are not budget neutral. The CMI would play an essential role in health care payment reform, especially in the piloting and implementation of new payment approaches.

11. Pham, H. H., Ginsburg, P. B., Lake, T. K., and Maxfield, M. M. (2010) Episode-Based Payments: Charting a Course for Health Care Payment Reform. National Institute for Health Care Reform, Policy Analysis No. 1.

Summary: The authors discuss key design issues related to implementing an episode-based payment system, including defining episodes of care, establishing payment rates, identifying

providers to receive payments, compatibility with other proposed reforms, and staging implementation.

12. Bertko, J. and Effros, R. (2010) Analysis of Bundled Payment. RAND Health COMPARE. Accessed at: <http://www.randcompare.org/analysis-of-options/analysis-of-bundled-payment>.

Summary: The authors measure bundled payment against nine performance dimensions: spending, waste, patient experience, coverage, operational feasibility, consumer financial risk, reliability, health, and capacity. Their information is drawn heavily from results of the Medicare Participating Heart Bypass Center Demonstration and Geisinger's ProvenCare.

13. Ahlstrom, A., Cafarella, N., Dietz, K., and Tumlinson, A. (2010) Piloting Bundled Medicare Payments for Hospital and Post-Hospital Care: A Study of Two Conditions Raises Key Policy Design Considerations. Avalere Health, LLC. Accessed at: http://www.avalerehealth.net/research/docs/20100317_Bundling_Paper.pdf

Summary: Avalere analyzed Medicare claims from 2006 and 2007 for patients with Major Joint Replacement and Chronic Obstructive Pulmonary Disease. The data analysis demonstrated that a 30-day bundle length would capture nearly all of the care provided to joint replacement and COPD patients during an initial hospitalization, first post-hospitalization encounter and any subsequent rehospitalization. However, for a more complex definition of a bundle (defined as all hospital and post-hospital care until there is a break in care) only 79 percent of episodes and 41.5 percent of patient days are completed by the 30th day.

14. Blue Cross Blue Shield of Massachusetts (2010) Blue Cross Blue Shield of Massachusetts: The Alternative QUALITY Contract. Retrieved from: <http://www.qualityaffordability.com/pdf/alternative-quality-contract.pdf>

Summary: This article describes the voluntary global payment system introduced by Blue Cross Blue Shield of Massachusetts for its provider network. The Alternative Quality Contract (AQC) is a bundled payment that has been risk-adjusted for patients' age, sex, and health status and is updated annually for inflation. The system is also tied to performance incentives, which allows providers to receive additional 10 percent reimbursement for meeting a set of ambulatory and hospital measures. The new payment contract ties in with BCBSMA's strategy of "improving the quality and affordability of health care for members, providers, and employers."

15. Hussey, P. S., Sorbero, M. E., Mehrotra, A., Liu, H., and Demberg, C. L. (2009) Episode-Based Performance Measurement and Payment: Making it a Reality. *Health Affairs*, 17(5):1406-1417.

Summary: Using Medicare data, the authors constructed episodes of care using two grouper tools in order to illustrate key design issues associated with defining episodes and attributing accountability to providers. They suggest several areas for future research and demonstration programs that would help move episode-based payment approaches from concept to reality.

16. Hackbarth, G., Reischauer, R., and Mutti, A. (2008) Collective Accountability for Medical Care: Toward Bundled Medicare Payments. *The New England Journal of Medicine*, 359:1.

Summary: Two of the authors on this report are on the Medicare Payment Advisory Commission (MedPAC). The article provides further commentary on MedPAC's recommendation for bundling payments. According to the authors, to ensure "joint accountability for both the volume and the costs of services, payment for physician services as well as hospital and other post-acute services" must be included in a bundle. The authors however highlight that before this payment approach can be implemented, several questions need to be answered, such as whether hospitals and physicians will be able to collaborate and form an entity that can accept and divide a bundled payment.

17. Davis, K. (2007) Paying for Care Episodes and Care Coordination. *The New England Journal of Medicine*, 356:1166-1168.

Summary: In this article, Karen Davis advocates for instituting a global fee for care episodes as a way to reduce variation in payments for acute episodes or for care for patients with chronic conditions. The global fee would cover hospital services, physician services, and other services required for treating acute conditions. A major issue identified by the paper in designing such a system would be how to appropriately assign accountability for care across different settings over time. The author cautions that given the fragmentation of the health system and lack of continuity in patient-physician relations, new payment policies such as bundling payments should be extensively evaluated before being implemented.

18. Kulesher, R. R. and Wilder, M. G. (2006) Prospective Payment and the Provision of Post-Acute Care: How the Provisions of the Balanced Budget Act of 1997 Altered Utilization Patterns for Medicare Providers. *Journal of Health Care Finance*, 33:1-16.

Summary: This study assesses the preliminary impact of extending the prospective payment system to skilled nursing facilities and home health agencies on hospitals, nursing homes, and home health agencies in the mid-Atlantic region and specifically, in Delaware. "In Delaware, hospital-owned nursing homes reduced their Medicare utilization, and proprietary facilities increased their utilization. One-third of the HHAs in Delaware withdrew from Medicare participation."

19. Bryant, L. L., Floersch, N., Richard, A. A. and Schlenker, R. E. (2004) Measuring Healthcare Outcomes to Improve Quality of Care Across Post-Acute Care Provider Settings. *Abstract, Journal of Nursing Care Quality*, 19:368-376.

Summary: This abstract describes a study that reviews existing data sets used in the post-acute setting and examines efforts to create measures for post-acute care and provides future direction for research. The author of the article argues that in order to effectively measure the impact of care on clinical outcomes, "a valid, reliable manner that allows for comparisons to reference or benchmarking data" needs to be developed.

20. Budetti, P. P., Shortell, S. M., Waters, T. M., Alexander, J. A., Burns, L. R., Gilles, R. R., and Zuckerman, H. (2002) Physician and Health System Integration. *Health Affairs*, 21:203-210.

Summary: The primary conclusion of this study is that physicians and health systems are not well-aligned. The authors arrived at this conclusion after studying 14 organized delivery systems and their 11,000 physicians in 69 medical groups and found that health systems paid inadequate attention to issues of importance to physicians.

21. Cotterill, P. G. and Gage, B. J. (2002) Overview: Medicare Post-Acute Care Since the Balanced Budget Act of 1997. *Health Care Financing Review*.

Summary: The authors of this article state that post-acute care providers have historically been highly responsive to payment reform as evidenced by shifts in care settings with the implementation of the SNF and HHA prospective payment system (PPS). The authors further caution that future research would need to focus on "potentially substitutable settings" in response to payment reform in the post-acute setting.

22. Coleman, E. A., Krammer, A. M., Johnson, M., Eilertsen, T. B., and Holthaus, D. (1999) Quality Measurement in Post-Acute Care: The Need for a Unique Set of Measures. *Abstract Book, Association of Health Services Researchers Meeting*, 16:78. Retrieved from: <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102194450.html>.

Summary: According to the authors of this abstract, quality measurement in the post-acute setting has traditionally built on measures in the long-term care setting. However, since post-acute care has shifted from long-term care to acute care, there is now a need to develop a new set of unique measures for post-acute care that span different care settings. The new measures also need to take into consideration the increasing severity and complexity of conditions treated in the post-acute care setting.

23. Welch, P. (1998) Bundled Medicare Payment for Acute and Postacute Care. *Health Affairs*, 17:6.

Summary: The author of this study sought to determine whether bundling payments for acute and post-acute care will result in additional financial risk for hospitals. He points out that "a key issue is how well bundled payments would match the combined costs of acute and post-acute care." Using Medicare's National Claims History Files from 1994 and 1995, the author calculated each hospital's margin under a bundled payment and under the existing system of reimbursement. He found that the standard deviation (financial risk) for episode of care costs were about the same for acute care. However, including post-acute care in the bundle could increase the financial risk to the typical hospital. The author also highlighted some of the other methodological challenges with the bundled payment system, such as unintended consequences, who should receive the payment, its feasibility in rural areas, and how to deal with competition among providers.

Appendix: Summary of Sample Bundled Payment Programs*

Bundled Payment Initiative	Components*						
	Conditions	Providers/Services	Provider Accountability	Payment Timeframe	Administrator Capabilities	Setting Payments	Payment Adjustment
Medicare's Participating Heart Bypass Center Demo	Coronary artery bypass graft surgery	Inpatient and physician services, Medicare hospital pass-throughs, related readmission	Unspecified	Unspecified	Data systems for micro-cost analysis	Bidding by participating hospitals; updated annually per inpatient prospective payment and physician fee schedule	Unspecified
Medicare's Cataract Surgery Alternate Payment Demo	Outpatient cataract surgery	Physician and facility fees, intraocular lens costs, and costs of selected pre- and postoperative tests	Unspecified	Unspecified	Unspecified	Negotiated discounts below usual rates	Unspecified
Geisinger's ProvenCare	Initially, cardiac surgery; expanded to angioplasty, cataract surgery, hip replacement	Facility and physician costs, follow-up care and all complications within 90 days	Adherence to evidence-based clinical measures	30 days before and 90 days after procedure	Integrated health system	Prior fee-for-service costs plus 50% of historical readmission rate	Historical rates
Dr. Johnson and Ingham Medical Center	Knee and shoulder arthroscopic surgery	Surgeon and hospital fees	Two year warranty for procedure	Unspecified	Unspecified	Pre-determined fee	Unspecified
Medicare's Acute Care Episode Demo	Cardiac care (CABG, valves, defibrillators, pacemakers), orthopedic care (hip and knee replacement), etc.	Hospital and physician services	Possible reward for clinicians and hospital staff for meeting quality and efficiency goals	Unspecified	Entities including at least one physician group and at least one hospital	Competitive bidding	Unspecified

Bundled Payment Initiative	Components*						
	Conditions	Providers/Services	Provider Accountability	Payment Timeframe	Administrator Capabilities	Setting Payments	Payment Adjustment
PROMETHEUS Payment, Inc.	Acute myocardial infarction, hip and knee replacement, CABG, coronary revascularization, bariatric surgery, hernias	All providers involved in patient care – inpatient and outpatient	Adherence to clinical guidelines	Acute condition (30 days), hip replacements (180 days), chronic illness (1 year)	Unspecified	Patient-specific payment based on risk factors, fee schedules, and other negotiated rates	Payment based on meeting clinical guidelines
Fairview Health Services	12 “care packages” for chronic conditions (low back pain, diabetes, migraine), specific medical care (prenatal care), and surgical procedures (knee replacement)	Hospital and physician (primary care and specialty) services	Unspecified	Unspecified	Unspecified	Unspecified	Unspecified
BlueCross BlueShield of MA Alternative QUALITY Contract	All conditions	All services and costs – primary, specialty, and hospital care, ancillary, behavioral health, and pharmacy services	Associated performance measures and incentive payment	None	Unspecified	Base rate per-member, per month based on historical regional costs and performance payment of up to 10 percent	Patients’ health status, sex, and age; adjusted annually for inflation

* Chart was developed with publicly-available published data. The components outlined represent the conditions of focus for the particular bundled payment initiative, the providers and services involved in the bundled, strategy for holding providers accountable for care provided, timeframe for the bundled payment, organizational capabilities of the entity receiving the payment, and how payments were determined and adjusted.



American Hospital
Association

Accountable Care ORGANIZATIONS

AHA RESEARCH SYNTHESIS REPORT

JUNE 2010

American Hospital Association
Committee on Research

AHA Research Synthesis Reports are periodic reports that synthesize literature on key issues related to the 2010 to 2012 AHA Research Agenda as part of Hospitals in Pursuit of Excellence. The AHA Committee on Research developed the 2010 to 2012 AHA Research Agenda, which was approved by the AHA Board in November 2009.

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Accountable Care Organizations – AHA Research Synthesis Report

Accountable Care Organizations – AHA Research Synthesis Report

Executive Summary

Introduction

This AHA Research Synthesis Report presents an overview of Accountable Care Organizations (ACOs), including a discussion on the potential impact of ACOs, key questions to consider in developing an ACO, and a review of the key competencies needed to be an effective ACO. This report focuses on the overall concept of ACO yet highlights the specifics of the ACO model proposed in health reform legislation.

What are ACOs?

The term Accountable Care Organization (ACO) describes the development of partnerships between hospitals and physicians to coordinate and deliver efficient care (Fisher, 2006). The ACO concept envisions multiple providers assuming joint accountability for improving health care quality and slowing the growth of health care costs. The concept was also included in national health care reform legislation as one of several demonstration programs to be administered by Medicare (Patient Protection and Affordable Care Act, 2010). However, ACOs described in health reform legislation are operationally different from other ACO models. The role of ACOs in integrating and aligning provider incentives in care delivery requires participating organizations to possess certain key competencies, as identified in the literature:

Required Organizational Competencies for ACOs	Key Literature on ACOs					
	Health Reform (2010)	Shortell/ Casalino (2010)	McClellan/ Fisher (2010)	Miller (2009)	Fisher/ McClellan (2009)	MedPAC (2009)
1. Leadership	x	x	N/A	x	N/A	N/A
2. Organizational culture of teamwork	N/A	x	N/A	x	N/A	x
3. Relationships with other providers	x	x	x	x	x	x
4. IT infrastructure for population management and care coordination	x	x	x	x	x	x
5. Infrastructure for monitoring, managing, and reporting quality	x	x	x	x	x	x
6. Ability to manage financial risk	N/A	x	x	x	x	x
7. Ability to receive and distribute payments or savings	x	x	x	x	x	x
8. Resources for patient education and support	x	x	N/A	x	N/A	N/A

Information on the impact of ACOs is limited and points to key questions that still need to be answered as both the federal and private sectors prepare for widespread implementation of the model.

Key Questions to Consider

The following are key questions to consider in the development and implementation of ACOs.

1. What are the key competencies required of ACOs?
2. How will ACOs address physician barriers to integration?
3. What are the legal and regulatory barriers to effective ACO implementation?
4. How can ACOs maintain patient satisfaction and engagement?
5. How will quality benchmarks be established?
6. How will savings be shared among ACOs?

Introduction

Under the charge of the AHA Committee on Research, the AHA Research Synthesis Reports seek to answer parts of the AHA's top research questions. This AHA Research Synthesis Report addresses the following question from the AHA Research Agenda:

What is the role of the hospital in a new community environment that provides more efficient and effective health care (e.g., what are the redesigned structures and models, the role and implementation of accountable care organizations, the structures and processes needed to implement new payment models such as bundled payments, and how do organizations transition to this new role)?

This report is the second in the series and presents an overview of Accountable Care Organizations (ACOs), including a discussion regarding the potential impact of ACOs, key questions to consider in developing an ACO, and a specific review of the key competencies needed to be an effective ACO.

What are Accountable Care Organizations?

The term Accountable Care Organization (ACO) was formalized by Dr. Elliott Fisher in a 2006 *Health Affairs* article to describe the development of partnerships between hospitals and physicians to coordinate and deliver efficient care (Fisher, 2006). The ACO concept, which had been in existence before the Elliot Fisher article, seeks to remove existing barriers to improving the value of care, including a payment system that rewards the volume and intensity of provided services instead of quality and cost performance and widely held assumptions that more medical care is equivalent to higher quality care (Fisher et al., 2009).

The ACO concept envisions the development of legal agreements between hospitals, primary care providers, specialists, and other providers to align the incentives of these providers to improve health care quality and slow the growth of health care costs. ACOs would reach these goals by promoting more efficient use of treatments, care settings, and providers (Miller, 2009).

The success of the ACO model in fostering clinical excellence and continual improvement while effectively managing costs hinges on its ability to incentivize hospitals, physicians, post-acute care facilities, and other providers involved to form linkages that facilitate coordination of care delivery throughout different settings and collection and analysis of data on costs and outcomes (Nelson, 2009). This predicates that the ACO will need to have organizational capacity to establish an administrative body to manage patient care, ensure high quality care, receive and distribute payments to the entity, and manage financial risks incurred by the entity.

The ACO model was included in national health care reform legislation as one of several demonstration programs to be administered by the Centers for Medicare and Medicaid Services (CMS), along with bundled payment and other key care delivery approaches. ACOs participating in the CMS program would assume accountability for improving the quality and cost of care for a defined patient population of Medicare beneficiaries. As proposed, ACOs would receive part of any savings generated from care coordination as long as benchmarks for the quality of care are also maintained. Health care reform provides a definition for the ACO model included in the demonstration programs. However, many details have yet to be defined.

Many experts believe ACOs in general will include certain core characteristics, including the participation of a diverse group of providers—including primary care physicians, specialists, and a hospital—and the ability to administer payments, determine benchmarks, measure performance indicators, and distribute shared savings (Deloitte, 2010). However, they could vary in their structure and payment model. For example, the ACO program proposed in health reform legislation limits provider exposure to financial risks, as it does not deviate from the current fee-for-service payment system and includes no payment penalties. On the other hand, ACOs that are being paid a fixed price are responsible for financial gain or loss.

This report focuses on the overall concept of the ACO and will attempt to highlight specifics of the ACO model proposed in health reform legislation where differences appear in existing literature.

Distinguishing Between ACOs and Earlier Care Delivery Initiatives

Health maintenance organizations (HMOs) and patient-centered medical homes (PCMHs) share commonalities with the ACO concept as large-scale attempts to improve health care delivery and payment. Even though the ACO model builds upon these previous attempts at health care delivery reform, there are variations between the ACO model and HMOs and PCMHs.

ACOs and PCMHs

The PCMH model, which emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care, can be viewed as being complementary to the ACO model (Devers and Berenson, 2009). Both models promote the utilization of enhanced resources—including electronic health records, patient registries, and increased patient education—to achieve the goal of improved care (Miller, 2009). However, unlike the ACO model, the PCMH does not offer explicit incentives for providers to work collaboratively to reduce costs and improve quality. Also, the PCMH model calls specifically for primary care providers to take responsibility for coordinating care, which could prove challenging if these providers do not have resources or established relationships with other providers to undertake these tasks.

The ACO model is expected to address some of the limitations in the PCMH model. For instance, the ACO model fosters accountability for care and costs by offering a joint payment to all providers involved in the provision of care. Also, the ACO model does not specify any type of provider to take the role as administrator of the ACO, but rather, offers characteristics for the types of organizations/providers that could assume the role of administrator. Also, unlike the PCMH model, a variety of payment models have been proposed for the ACO model, ranging from traditional fee-for-service payment to full capitation. Despite these key differences in the PCMH and ACO models, it is important to note that, far from being competing models, the PCMH structure could aid providers in taking on the additional accountability and administrative activities necessary to become an ACO.

ACOs and HMOs

The key difference between the ACO concept and HMOs lies in the payment structure and level of provider risk involved. While HMOs have typically been arranged around capitation, ACOs

recognize variation in regional health care markets and the ability of providers to accept new payment models (Devers and Berenson, 2009). One proposed payment approach for public and private-sector ACO programs is the “shared savings” approach, used in the Brookings-Dartmouth and Medicare ACO program, where providers receive regular fee-for-service payment but qualify to share in any savings resulting from cost reduction and meeting predetermined performance and/or utilization targets. Other payment methods proposed in current literature for ACOs include a bundled payment, negotiated by the providers and payers, for an episode of care or capitation, similar to HMOs. It is important to note that the type of payment approach adopted is closely related to the level of financial risk that the providers are expected to assume. The primary criticism of the HMO model is that by making cost reduction its primary goal it sometimes sacrificed the quality of care. Providers participating in HMOs have also complained about the inadequate payment rates and high level of financial risk involved in the HMO model. Policymakers believe the ACO model incorporates some of these lessons learned from the HMO model.

ACOs and Health Care Reform

The Patient Protection and Affordable Care Act calls for the creation of an ACO program administered by CMS by January 1, 2012. Qualifying providers, including hospitals, physician group practices, networks of individual practices, and partnerships between hospitals and other health care professionals will be eligible to form ACOs. ACOs will “be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it” and will also be expected to meet specific organizational and quality performance standards—which are still to be determined by CMS—in order to be eligible to receive payments for shared savings. The legislation does not provide specifics on how ACOs will be held financially accountable, as they will not be subject to financial risks in the form of payment penalties if they do not achieve their savings targets (CMS, 2010). Some of the additional stipulations for ACOs include:

- ACOs must have a formal legal structure to receive and distribute shared savings to participating providers.
- Each ACO must employ enough primary care professionals to treat their beneficiary population (minimum of 5,000 beneficiaries) as deemed sufficient by CMS.
- Each ACO must agree to at least three years of participation in the program.
- Each ACO will have to develop sufficient information about their participating health care professionals to support beneficiary assignment and for the determination of payments for shared savings.
- ACOs will be expected to include a leadership and management structure that includes clinical and administrative systems.
- Each ACO will be expected to have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- ACOs will also be required to produce reports demonstrating the adoption of patient-centered care.

CMS expects to release additional information about the ACO program this fall in a Notice of Proposed Rulemaking (CMS, 2010).

Potential Impacts of ACOs

Given the recent emergence of ACOs, providers considering participation in the CMS program do not have a long history of research on practicing ACOs to review. A limited amount of research exists on payment and delivery initiatives similar to ACOs that have been tested since as early as 1998 (shown in Box 1). These models include a combination of federal, regional, state, and local initiatives. These efforts offer some evidence on the potential impact of ACOs to reduce costs, improve coordination, and better align incentives of providers, payers, and patients. These efforts also share some of the critical characteristics of the ACO concept, including care coordination, evidence-based practice, and the sharing of savings based on improvements in quality and reductions in cost.

Box 1 – Precursors of ACOs

Community Care of North Carolina

Since 1998, the state of North Carolina has operated Community Care of North Carolina, an enhanced medical home supported by the state's Medicaid program. The program builds community health networks organized collaboratively by hospitals, physicians, health departments, and social service organizations to manage care. Each enrollee is assigned to a specific primary care provider, while network case managers work with physicians and hospitals to identify and manage care for high-cost patients. A study by the University of North Carolina found that the program saved roughly \$3.3 million in the treatment of asthma patients and \$2.1 million in the treatment of diabetes patients between 2000 and 2002, while reducing hospitalizations for both patient groups. In 2006, the program saved the state roughly \$150 to \$170 million (Kaiser Commission, 2009).

Physician Group Practice Demonstration

In 2005, Medicare developed the Physician Group Practice Demonstration, a group of ten provider organizations and physician networks to test shared savings. Providers are incentivized to coordinate care delivered to Medicare patients. Physician groups receive cost and quality performance payments if they achieve Medicare savings of more than two percent and additional bonuses beyond the two percent threshold. Performance payments are designed to reward both cost efficiency and performance on 32 quality measures phased in through the life of the demonstration. Through year three of the program, all ten participating sites achieved success on most quality measures, and five collectively received over \$25 million in bonuses as a share of \$32 million in Medicare cost reductions (McClellan et al., 2010).

Pathways to Health, Battle Creek, Michigan

In 2006 Integrated Health Partners participated in a chronic disease initiative with Blue Cross Blue Shield of Michigan (BCBSM). The initiative was later restructured into Pathways to Health, a framework that includes several local health care stakeholders such as insurers, consumers, and employers interested in reducing hospitalization and improving chronic care delivery in their area. Pathways to Health features key ACO concepts such as a patient-centered medical home, value-based purchasing, and community buy-in. The collaborative is currently developing a new payment structure and improving its patient data collection efforts. BCBSM reports that hospitalizations for conditions that can be prevented via better ambulatory care have dropped 40 percent over the three-year life of the program (Simmons, 2009).

Even though the models in Box 1 include some characteristics of ACOs and could provide some insight in the impact of ACOs, federal and private sector ACO programs (Box 2) that are currently underway or planned for the future could provide better lessons for providers and payers interested in participating in ACOs.

Box 2 – Sample ACO Pilots

Brookings/Dartmouth Accountable Care Collaborative

The Brookings Institution and the Dartmouth Institute for Health Policy are currently collaborating on the development of an ACO model focusing on local accountability, shared savings, and enhanced performance measurement. Roanoke, Virginia-based Carilion Clinic, a multi-specialty group practice with more than 500 physicians and seven hospitals, has been selected by the Brookings/Dartmouth collaborative as a pilot site for ACO adoption, along with Norton Health System in Louisville and Tucson Medical Center in Arizona.

Baylor Health System

Dallas-based Baylor Health System, a 13-hospital system with 4,500 physicians, is currently developing an ACO model with a bundled payment system to control costs and improve care coordination. Baylor is directly marketing the ACO concept to employers, offering lower costs in exchange for participation in specific health insurance plans (Deloitte, 2010).

Robert Wood Johnson Foundation Medical School

A pilot ACO program at Robert Wood Johnson Foundation Medical School in New Jersey will engage 100-500 physicians, several specialties, and six hospitals (Deloitte, 2010). The ACO's payment structure is still to be determined, but system leaders envision that the effort will link up the Robert Wood Johnson Medical Group—the state's largest multi-specialty network—with the 30 to 40 percent of primary care practices that have existing relationships with the school (Nelson, 2009).

Premier ACO Collaboratives

In May 2010, the Premier health care alliance announced plans to launch a two-track system for its member hospitals to participate in an ACO. The first effort, the ACO Implementation Collaborative, will consist of members who already possess the critical characteristics and relationships needed for successful ACO participation. The second effort, the ACO Readiness Collaborative, is designed to prepare hospitals by helping them to develop the skills and operational capacity necessary to implement in the future. To date, 70 hospitals and 5,000 physicians in 15 states have signed up for the two collaboratives.

Key Questions to Consider

Hospitals and other providers interested in participating in private sector and CMS ACO programs need to consider their preparedness in the face of the limited information available and identify steps to undertake to facilitate participation in the emerging ACO programs. To aid hospitals, physician groups, and other organizations in making this assessment, we identify the following key questions in Box 3 that still need to be addressed and attempt to answer them with information available from the literature.

Box 3 – Key Questions on ACOs

1. What are the key competencies required of ACOs?
2. How will ACOs address physician barriers to integration?
3. What are the legal and regulatory barriers to effective ACO implementation?
4. How can ACOs maintain patient satisfaction and engagement?
5. How will quality benchmarks be established?
6. How will savings be shared among ACOs?

1. What are the key competencies required of ACOs?

In order to qualify for the CMS program, participating ACOs will have to formalize a management structure to coordinate operations between participating providers and create a system for distributing shared payment. In general, the tasks and goals of ACOs will require both the ACO administrator and participating providers to possess certain core competencies. The competencies outlined in Table 1 below are identified in recent key literature on ACOs.

Table 1: Required competencies for ACOs as determined by key ACO literature

Required Organizational Competencies for ACOs	Key Literature on ACOs					
	Health Reform (2010)	Shortell/Casalino (2010)	McClellan/Fisher (2010)	Miller (2009)	Fisher/McClellan (2009)	MedPAC (2009)
1. Leadership	x	x	N/A	x	N/A	N/A
2. Organizational culture of teamwork	N/A	x	N/A	x	N/A	x
3. Relationships with other providers	x	x	x	x	x	x
4. IT infrastructure for population management and care coordination	x	x	x	x	x	x
5. Infrastructure for monitoring, managing, and reporting quality	x	x	x	x	x	x
6. Ability to manage financial risk	N/A	x	x	x	x	x
7. Ability to receive and distribute payments or savings	x	x	x	x	x	x
8. Resources for patient education and support	x	x	N/A	x	N/A	N/A

Legend:

- N/A – indicates that the authors do not explicitly discuss the competency in their literature.
- X – Even though the indicated authors discuss the key competencies, there may be differences in how they perceive the importance and application of the competencies in ACOs.

The structure of some care delivery organizations, such as Integrated Delivery Systems (IDSs) may facilitate the formation of an ACO because they may already possess the competencies identified in the literature. IDSs typically already assume some accountability for cost and quality, and often possess the population health data needed to effectively administer an ACO

(Miller, 2009). IDs with high-functioning leadership structures to handle the legal and clinical requirements of the ACO model may be best prepared to qualify for an ACO at present (Hastings, 2009). Other care delivery organizations such as Multispecialty Group Practice (MSGP), Physician-Hospital Organization (PHO) and Independent Physician Association (IPA) may possess a partial list of the competencies and need to work on developing others. However, free-standing hospitals, post-acute care providers such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs), and small physician practices, can also position themselves to successfully participate in an ACO with appropriate technical assistance and/or practice redesign.

In addition to the core competencies identified in the literature above, there are other important competencies cited by thought leaders that could help organizations participating in an ACO acclimate to the novel care delivery and payment structure:

- **Spread** – ability to aggressively identify and disseminate best practices that promote efficiency of care delivery, improved quality of care, and reduced cost within an organization. This competency is important both at the individual institution level as well as the ACO level.
- **Reach** – established linkages between ACOs (or participating organizations) and public health/community resources in their catchment area to facilitate the transition of patients from the care delivery setting back into the community.
- **Regional Health Information Exchange** – participation in a multi-stakeholder health information exchange to share health care information with the goal of improving health and care in the community.

2. How will ACOs address physician barriers to integration?

Overcoming physician attitudes favoring autonomy and individual accountability over coordination will pose a major challenge to hospitals pursuing an ACO model, especially if they do not currently enjoy strong affiliations with physician groups who have admitting privileges (Fisher et al., 2006). Physician groups who are already part of integrated health systems may have an early edge in comparison to independent practice associations preparing to join an ACO. Physician groups will also have to be convinced that a strong business case exists for ACO development, and some groups may resist capitation and potential penalties for physicians related to quality performance, as have been proposed for some ACO models (Deloitte, 2010).

Other challenges may include deciding on the appropriate reimbursement model that is attractive to physicians and that falls within the existing legal requirements. Organizations participating in an ACO will also need to navigate differences in what they consider to be the appropriate use of potential shared savings. While hospitals may choose to use savings to offset any expenditures related to the ACO implementation or decrease in revenue stream resulting from reduction in volume, primary care physicians may choose to use the savings to pay for care management and information technology infrastructure (Miller, 2009).

3. What are the legal and regulatory barriers to effective ACO implementation?

The actualization of the ACO concept will prove challenging in the current legal environment. Sharing financial incentives across providers and incentivizing the use of evidence-based protocols can place participating providers at risk of violating federal laws that govern physician

self-referral for Medicare patients and laws that protect patients and federal health care programs from fraud and abuse.

Hospitals preparing to join both federal and private-sector ACO programs may need to assess and potentially revise their existing contracts with other providers also taking part in the ACO. Implementing the ACO concept, which may require hospitals and physicians and other providers to accept one payment for all services and share financial incentives, could be in violation of previous interpretations of the Anti-Kickback Statute and Civil Monetary Penalty Law (Fader, 2010). Uncertainty about the antitrust consequences will deter precompetitive, innovative arrangements. Nonprofit hospitals would need to determine whether their involvement with participating, for-profit physician practices as part of an ACO complies with IRS guidelines for nonprofit institutions (Fader, 2010).

The health care reform bill does not create safe harbors or exceptions that address the operation of ACOs under current laws. However, the bill does permit the Secretary of Health and Human Services (HHS) to waive the requirements of the Anti-kickback, Stark, and Civil Monetary Penalty laws as necessary to administer ACOs (Bass, Berry, and Sims, 2010).

4. How can ACOs maintain patient satisfaction and engagement?

Medicare beneficiaries participating in the ACO program may not necessarily be aware of their assignment within an ACO and will be able to continue to choose their providers, including those who are not participating in their assigned ACO (CMS, 2010). However, adequate patient education will still be necessary to ensure that patients do not regard the ACO model unfavorably. Patients will need to understand how ACOs will impact the care they receive in the form of better quality, efficient care, and improved health outcomes resulting from coordinated care.

Since health outcomes are largely dependent on patients' participation in care, providers will need to actively engage consumers in the care that they receive and ensure that patients have a basic understanding of health care costs and the importance of efficient care delivery (Miller, 2009). Lastly, ACOs could maintain accountability to patients by measuring and reporting on patients' experience of care, in addition to reporting on costs and health outcomes (Miller, 2009).

5. How will quality benchmarks be established?

A critical component of the administration of ACOs that has not been determined in federal health reform and other key literature pertains to the quality benchmarks to which providers will be held accountable. Health reform legislation leaves the final decision of measure selection for ACOs to federal health officials, and the available literature does not provide guidance on how to choose appropriate measures.

As the CMS program and other private ACO initiatives are established, it is important to ensure that the quality benchmarks established and how they are interpreted and reported are standardized nationwide. The measures will also have to be applicable to different care providers and span care settings to accommodate the set of providers included in an ACO.

Lastly, the benchmarks will need to include a combination of process, outcome, and patient experience measures in order to accurately evaluate all aspects of care provided.

6. How will savings be shared among ACOs?

Payment reform is an important component of ACOs, since it is the main vehicle for holding providers accountable for the quality and cost of care that they provide. Experts have proposed several payment approaches for ACOs, which correlate with the level of risk that providers are expected to assume. Shortell and Casalino propose a three-tiered approach for risk-reward payment. In the first tier, which involves no risk, providers will receive shared savings and bonuses for meeting defined quality measures and staying under the expected costs of delivering care to patients. In the second tier, providers will receive shared savings for managing costs and hitting quality benchmarks, and will be liable for care that exceeds spending targets. In the third tier, providers assume greater risk and are paid through full or partial capitation. They could also qualify for substantial bonuses for meeting quality and patient experience targets (Shortell and Casalino, 2010).

The proposed payment model in health reform is a combination of the first and second tier of the Shortell/Casalino model. However, the specifics of it are yet to be defined by federal health officials. The model of payment for any ACO, as well as associated bonuses and penalties, will have to be substantial enough to generate change in the way care is delivered.

Conclusions

While some parallels exist between ACOs and existing efforts to coordinate care and integrate provider activities, substantial gaps exist in how an ACO will be structured and the impact that it will actually have on care delivery, quality, and costs. The early consensus emerging from ACO researchers appears to be that the model shows some promise as a driver of both quality improvement and cost control via care coordination (Devers and Berenson, 2009).

Hospitals and health systems considering ACO participation should assess their capabilities in several key core competencies that will likely be necessary for successful ACO implementation, including IT infrastructure, resources for patient education, team-building capabilities, strong relationships with physicians and other providers, and the ability to monitor and report quality data. Providers should be prepared to make major investments in these areas where necessary (Shortell and Casalino, 2010). ACOs whose members already possess many of these characteristics are expected to be most successful at implementation in the short run (Deloitte, 2010). However, even providers who already possess key organizational, technical and clinical competencies may find that adjusting to an ACO will still require the sustained development and strengthening of those capacities in order to be successful (Devers and Berenson, 2010).

Appendix – Medicare ACO Q & A Document

Medicare “Accountable Care Organizations” Shared Savings Program – New Section 1899 of Title XVIII

Preliminary Questions & Answers

CMS/Office of Legislation

The Affordable Care Act (ACA) improves the health care delivery system through incentives to enhance quality, improve beneficiary outcomes and increase value of care. One of these key delivery system reforms is the encouragement of Accountable Care Organizations (ACOs). ACOs facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. This document provides an overview of ACOs and the Medicare Shared Savings Program.

Q: What is an “Accountable Care Organization”?

A: An Accountable Care Organization, also called an “ACO” for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

For ACO purposes, “assigned” means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

Q: What forms of organizations may become an ACO?

A: The statute specifies the following:

- 1) Physicians and other professionals in group practices
- 2) Physicians and other professionals in networks of practices
- 3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
- 4) Hospitals employing physicians/professionals
- 5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q: What are the types of requirements that such an organization will have to meet to participate?

A: The statute specifies the following:

- 1) Have a formal legal structure to receive and distribute shared savings
- 2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
- 3) Agree to participate in the program for not less than a 3-year period
- 4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.

- 5) Have a leadership and management structure that includes clinical and administrative systems
- 6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
- 7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish this fall.

Q: How would such an organization qualify for shared savings?

A: For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.

Q: What are the quality performance standards?

A: While the specifics will be determined by the HHS Secretary and will be promulgated with the program's regulations, they will include measures in such categories as clinical processes and outcomes of care, patient experience, and utilization (amounts and rates) of services.

Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?

A: No. Medicare beneficiaries will continue to be able to choose their health care professionals and other providers.

Q: Will participating ACOs be subject to payment penalties if their savings targets are not achieved?

A: No. An ACO will share in savings if program criteria are met but will not incur a payment penalty if savings targets are not achieved.

Q: When will this program begin?

A: We plan to establish the program by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

Source: <https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>

Key References

Proposals:

1. Fisher, E.S., Staiger, D.O., Bynum, J. and Gottlieb, D.J. (2006) Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs* (26: w44-w57).

Summary: The article introduces the concept of accountable care organizations and explores the concept of the “extended hospital medical staff,” defined as a hospital-associated multi-specialty group practice tightly aligned to a specific hospital through direct or indirect referrals. The article assesses a group of hospitals and their extended medical staffs on their performance with heart attacks, colon cancer, and hip fractures, finding that hospitals and extended medical staffs who performed high on quality measures tended to have tighter affiliations with each other. The authors conclude that the extended medical staff model can bolster performance measurement, foster local accountability for capacity decisions, and improve quality and lower costs. The article also outlines some of the barriers to change, including the fee-for service payment system, the cultural importance U.S. physicians traditionally place on autonomy and the difficulty less tightly aligned hospitals and physician groups will have in adjusting to a new model.

<http://content.healthaffairs.org/cgi/content/abstract/26/1/w44>

2. Fisher, E., McClellan, M., Bertko, J., Lieberman, S., Lee, J., Lewis, J. and Skinner, J. (2009) Fostering Accountable Health Care: Moving Forward in Medicare. *Health Affairs* (Web exclusive).

Summary: The authors survey the variation in health care costs and outcomes in the United States, and propose the ACO model as part of a major realignment of payment incentives to support providers in improving care. The article advocates for increased accountability for providers to improve quality and manage costs, a shift away from practices that reward providers based on the volume and intensity of services and the use of transparent, meaningful performance measures to evaluate results. The article calls for ACOs to create formal legal structures, assume responsibility for a defined population of Medicare beneficiaries, and participate in public reporting of performance measures. In exchange, ACOs would receive shared savings for meeting quality standards while keeping costs below defined benchmarks.

<http://content.healthaffairs.org/cgi/reprint/28/2/w219>

3. Shortell, S. and Casalino, L. (2010) Implementing Qualifications Criteria and Technical Assistance for Accountable Care Organizations. *Journal of the American Medical Association*, 303 (17): 1747-1748.

Summary: The authors suggest a three-tiered system of ACO qualification, with each level representing graduated levels of assumed risk and payment incentives. In this model, Level I ACOs would assume no financial risk but would be eligible for shared savings for meeting quality and spending targets. Level II ACOs would receive greater proportions of shared savings but would assume some risk for not meeting agreed-upon targets. Level III ACOs would be

paid through full or partial capitation. The article also explores the implementation hurdles that prospective ACOs must pass, including practice redesign, process improvement, EHR implementation and leadership development.

4. Miller, H. (2009) How to Create Accountable Care Organizations. *Center for Healthcare Quality and Payment Reform*.

Summary: This comprehensive assessment surveys the potential of the ACO model for improving quality and controlling costs, and examines the ways ACOs will impact primary care physicians, hospitals and consumers. The article notes several potential areas of improvement for hospitals participating in ACOs, including improved efficiency of patient care, the use of less costly treatment avenues, reductions in health care-acquired conditions and reductions in preventable admissions. The author concludes that ACOs will not adhere to a single formula, and asserts that while long-term improvements are possible, providers should prepare both organizationally and financially for an extended transition period.

<http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf>

5. MedPAC (2009) *Report to the Congress: Improving Incentives in the Medicare Program*. Chapter 2.

Summary: The report explores different potential models for ACOs administered by CMS, including a voluntary program with bonuses for meeting quality and spending targets and a mandatory model with physicians assigned to hospitals based on Medicare claims. The article concludes that ACOs could slowly incentivize change, emphasizing the importance ACOs will need to place on coordination, system thinking and constant refinement.

http://www.medpac.gov/chapters/Jun09_Ch02.pdf

6. Devers, K. and Berenson, R. (2009) Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries? *Robert Wood Johnson Foundation*.

Summary: The authors survey the potential of ACOs for managing patients' continuum of care across different institutional settings, better allocation of resources and serving as a framework for improved performance measurement of patient populations. The article concludes that ACOs have the potential to improve quality and reduce costs, but will require years of practice and refinement to reach those goals.

<http://www.rwjf.org/qualityequality/product.jsp?id=50609>

Evaluation of demonstration projects:

7. Simmons, J. (2010) The Medical Home as Community Effort. *Health Leaders*. (April 2010, pp. 50-51).

Summary: The author looks at the three-year-old Pathways to Health collaborative in Battle Creek, Michigan, an effort that brought together Integrated Health Partners, Battle Creek Health

System and local health plans to create a framework including a patient-centered medical home, value-based purchasing and community buy-in. The article focuses on the development of the ACO, as providers, consumers and health plans met and ultimately formed a leadership team. The article details efforts to retain accurate patient data and implement Plan-Do-Study-Act ideals, while creating a new bundled payment structure. So far, Blue Cross Blue Shield of Michigan reports that hospitalizations “for those conditions that better ambulatory care can prevent” have dropped forty percent.

<http://www.healthleadersmedia.com/content/MAG-249300/Quality-The-Medical-Home-as-Community-Effort>

8. Kaiser Commission on Medicaid and the Uninsured. (2009) *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*.

Summary: This article assesses North Carolina’s Community Care of North Carolina program, an enhanced medical home model operated by the state’s Medicaid program. The program relies on nonprofit community networks of hospitals, physicians, health departments and social service organizations to manage care, and notes that the program saved roughly \$3.3 million in the treatment of asthma patients and \$2.1 million in the treatment of diabetes patients between 2000 and 2002, while reducing hospitalizations for both patient groups. In 2006, the program saved the state roughly \$150 to \$170 million. The article concludes that the practices developed by CCNC show promise as tools to implement health reform national and provide “coordinated, cost effective care to low-income individuals with significant health needs.”

<http://www.kff.org/medicaid/upload/7899.pdf>

9. Nelson, Bryn. (2009) Quality over Quantity. *The Hospitalist*.

Summary: The article considers the role integrated systems have played in inspiring ACOs, and surveys a handful of ACO pilots, including Carilion Clinic in Virginia and Robert Wood Johnson Medical School in New Jersey. The article explores possible ACO frameworks, noting that successful models will include the key concepts of local accountability, shared savings and enhanced performance measurements.

http://www.the-hospitalist.org/details/article/477391/Quality_over_Quantity.html

Other Published Literature

10. CMS Office of Legislation (2010) *Medicare Accountable Care Organizations Shared Savings Program: Preliminary Questions And Answers*.

Summary: The document provides an overview of the ACO Shared Savings Program as established in the 2010 Patient Protection and Affordable Care Act, and explores some of the questions emerging from providers regarding ACO participation, including eligibility for shared savings, quality performance standards and the release of future information from CMS concerning the ACO program.

<https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>

11. McClellan, M., McKethan, A.N, Lewis, J.L., Roski, J., and Fisher, E.S. (2010) A National Strategy to Put Accountable Care Into Practice. *Health Affairs*. (29, No. 5: 982-990).

Summary: The authors analyze ACOs in the context of recent health care reform legislation, suggesting that ACOs should have flexibility in terms of design but should broadly be provider-led organizations centered on primary care, with payments linked to quality improvement and cost reduction, and increasingly sophisticated performance measurement. The article discusses the structures of a variety of potential payment models, including partial capitation models integrating flat payments with bonuses and penalties related to performance and cost benchmarks, and “symmetric” payment models that offer providers proportionately larger bonuses as they assume greater accountability for costs. The authors conclude that ACOs may have a modest impact on the transformation of payment models in the short-term, but have the potential to drive clinical and financial transformation in the long run.

<http://content.healthaffairs.org/cgi/content/abstract/29/5/982>

12. Davis, G. and Rich, J. (2010) Health Care Reform: ACOs and Developments in Coordinated Care Delivery, Shared Savings and Bundled Payments. *McDermott Newsletters*.

Summary: The authors compare ACOs to Physician Hospital Organizations (PHOs), arguing that while PHOs were organized mainly to facilitate managed care contracting, while ACOs aim to better coordinate care as a means to both improve quality and control costs. The article also notes some of the key elements of an effective ACO—including medical homes, networks of specialists, care integration and reimbursement models that reward cost-effective high-value-care, and summarizes the provisions of recent health care reform legislation related to ACOs and bundled payment.

http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/6699b22c-127a-4cf0-a80b-bab7a75767de.cfm

13. Burke, T. and Rosenbaum, S. (2010) Accountable Care Organizations: Implications for Antitrust Policy. *Robert Wood Johnson Foundation*.

Summary: The authors detail the relationship between ACOs and federal antitrust policy. Specifically, the article outlines the emphasis the judiciary system has placed on clinical and financial integration as a prerequisite to joint efforts between providers, and notes that arrangements that do not meet financial integration standards are susceptible to violating antitrust statute. The article summarizes several recent antitrust cases brought by the Federal Trade Commission in the context of clinical integration, with examples of both sustained partnerships and those rejected by the legal system. The article concludes that taken together, the decisions support the enforcement agencies’ position that in order to justify anti-competitive practices, partnerships between providers must demonstrate collective effort to improve quality and control costs beyond what would have been achieved independently.

<http://www.rwjf.org/qualityequality/product.jsp?id=57509>

14. Fader, Henry C. (2010) Are Accountable Care Organizations in Your Vocabulary? *Pepper Hamilton, LLP*.

Summary: The author details the legal framework for structuring an ACO, arguing that the entity will require a separate administrative staff that is separate from both the hospital and

physicians. That staff would be charged with monitoring and providing care both within the hospital and outside the hospital. The article also emphasizes the importance of clinicians in an ACO model, and assesses the hurdles ACOs will have to overcome to comply with antitrust and anti-kickback statutes.

http://www.pepperlaw.com/publications_update.aspx?ArticleKey=1757

15. Deloitte. (2010) *Accountable Care Organizations: A New Model for Sustainable Innovation*.

Summary: The article outlines the promise of the ACO model for improving care delivery, summarizing the structural guidelines of ACOs included in recent health reform legislation and discussing emerging ACO pilots in Massachusetts, Vermont and Colorado. The article argues that the degree of integration within current physician models may be a predictor of early success in creating an ACO. The authors assert that successful ACOs will be defined by strong leadership, governance and operational clinical management capabilities, and outlines the challenges of physician buy-in, consumer response, the structure of payments and managing risk before concluding that ACOs will need to carefully structure provider relationships, accept that results may be slow in materializing and commit themselves to continual improvement as clinical conditions change over time.

http://www.deloitte.com/view/en_US/us/Industries/US-federal-government/center-for-health-solutions/research/bc087956da618210VgnVCM100000ba42f00aRCRD.htm

16. Hastings, D.A. (2009) Accountable care organizations and bundled payments in Health Reform. *Health Law Reporter*.

Summary: The author surveys the landscape of proposed health reform legislation, and notes several legal challenges to ACO development, including the revision of contracts between providers participating in ACOs, compliance with anti-kickback and antitrust statutes, new compliance responsibilities related to adherence to ACO regulations and public reporting, the increased responsibilities of leadership and board management and the integration of bundled payments with ACOs. The article concludes that ACOs and bundled payments both show promise as drivers of health care quality improvement.

http://www.ebglaw.com/files/37716_BNA%20Article%20-%20Accountable%20Care%20Organizations%20and%20Bundled%20Payments%20in%20Health%20Reform.pdf

17. Bass, Berry, and Sims (2010) *The ABCs of ACOs*.

Summary: The article analyzes the legal requirements and hurdles providers will face as they prepare for ACO implementation. Specifically, the article explores ACO compliance with the Anti-Kickback Statute, the Stark Law, antitrust laws and the Civil Monetary Penalty Law, noting that while health care reform legislation did not create safe harbors or exceptions to these statutes in connection to the development of ACOs, the Secretary of HHS has been authorized to waive requirements of these statutes as necessary.

<http://www.bassberry.com/files/Publication/f55dbab0-b844-4a1f-bf0a-0e34ebab8d7d/Presentation/PublicationAttachment/a98eb254-ce4f-48f3-924b-0e91896128f7/HealthReformImpact29April2010.pdf>



Signature Leadership Series

Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project

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EXECUTIVE SUMMARY

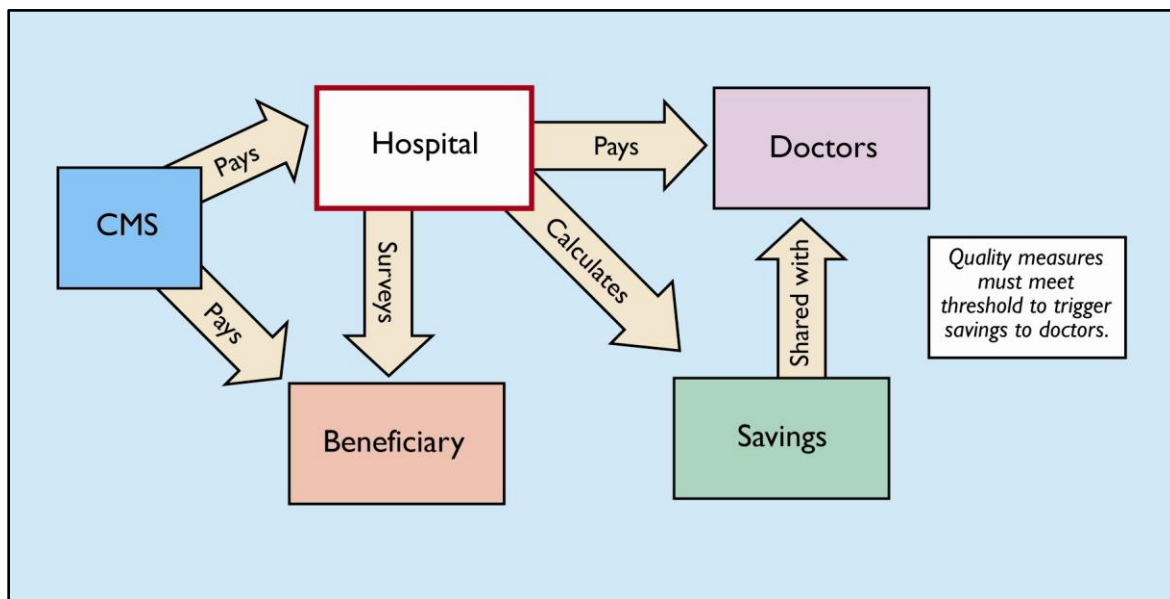
Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project aims to explain the Acute Care Episode Demonstration or ACE Demo from the Centers for Medicare & Medicaid Services (CMS). Although it is a small demo (five test hospitals), the implications of the success of the program are far-reaching. From CMS' perspective, the goals of the project are to:

1. Improve coordination and quality of care
2. Align incentives between hospitals and physicians using bundled payment and other incentives
3. Designate *Value Based Care Centers*
4. Provide financial incentive for Medicare beneficiaries

Beneficiaries must be both Medicare Part A and Part B fee for service participants with conditions that fall under a variety of either cardiac or orthopedic MS-DRGs. The eligible MS-DRGs can be found in the appendix of this guide.

One of the five test sites, Hillcrest Medical Center, is the focus of this report. This Tulsa, Oklahoma hospital started the process of the ACE Demo first, so they are the farthest along in the three-year demonstration. Also of note is that Hillcrest Medical Center (and the adjoining Oklahoma Heart Institute) is a test site for both cardiac and orthopedic MS-DRGs.

The diagram below gives a quick overview of how the ACE Demo works at Hillcrest. The program is governed by a board of managers who direct the project. This board meets quarterly and consists of three committees (quality, financial, and gain sharing). The committees work with continual clinical oversight. While the hospital is required to lower costs, Hillcrest has done so without reducing reimbursement to its physicians. In fact, the doctors may participate in provider incentive payments if they share in implementing efficiency and quality improvements.



Throughout the early stages of the ACE Demo, Hillcrest has reported the following lessons learned. These lessons are expounded upon throughout the guide as Hillcrest’s journey is examined.

1) Constructing a framework before beginning is helpful. This framework includes quality improvement initiatives, cost-accounting systems, and a robust data warehouse.
2) Getting more patient volume isn’t as important as getting market share with supply vendors through renegotiation of contracts.
3) Bringing physicians on board early in the process to drive cost-cutting measures, quality metrics, and negotiations with suppliers is vital.
4) It is important to understand that the monetary incentive does not drive patients to choose a hospital.
5) Hiring a full-time case manager is necessary to track all patients in the program from admission to post-discharge.
6) Having prior health plan experience is a plus.

Questions still remain to be answered in the early stages of the ACE Demo, mostly due to the fact that the situations where they will be posed haven’t actually occurred yet. However, the following are a list of questions that need to be answered as the process moves forward.

- 1) How can the ACE Demo be expanded into a post-hospital setting? What would a post-acute payment bundle that goes 30–60 days post discharge look like?
- 2) What will the provider incentives look like as the project enters future years of the demo, especially if it is harder to find savings as the “low-hanging fruit” is all picked.
- 3) How does the project work if there are multiple, competitive hospitals doing the same thing in the same market? Granted, the money doesn’t seem to be an incentive to drive patient volume. But, how do vendors react if all hospitals in one market are working in this type of program?
- 4) How can this be expanded to non-surgical MS-DRGs? The benefit of the currently selected MS-DRGs is that there are very few outliers. Would this program work well for cancer patients, for example?
- 5) How do you create better beneficiary incentives? Are the incentives even worthwhile as the demo expands?
- 6) What quality measures do you use for other MS-DRGs? There are not easily measurable quality measures for everything.

INTRODUCTION

The Acute Care Episode Demonstration, or ACE Demo, is a demonstration project by the Centers for Medicare & Medicaid Services (CMS). The demonstration project works under the following three assumptions:

1. That the beneficiaries have to be both Part A *and* Part B Medicare fee for service
2. That the program utilizes a bundled payment system from admit to discharge, to include all related inpatient services.
3. That the program focuses on either orthopedic MS-DRGs or cardiac MS-DRGs (or both). The appendix lists the MS-DRGs for both areas of focus.

The five participant hospitals in the ACE Demo had to go through a selective RFP process. Two of these locations, Hillcrest Medical Center in Tulsa, Oklahoma, and Lovelace Health System in Albuquerque, New Mexico, are a part of Ardent Health Services. There is a twofold reason as to why Hillcrest Medical Center became the focus of this guide on the early learnings from the ACE Demo. For one, Hillcrest would be demonstrating on both the cardiovascular and orthopedic aspects of the project. The second reason is that Hillcrest was the first out of the gate and because of this they not only are the farthest along but they have also begun to serve as a mentor hospital for other organizations that are not as far along in the process.

Hillcrest Medical Center is a 691-bed facility that adjoins the newly opened (March 2009) Oklahoma Heart Institute. By virtue of participating in the ACE Demo, they've been designated a Value Based Care Center by CMS. This designation is one of four of CMS' goals for the ACE Demo. The goals are

1. Improve care coordination to improve quality of care.
2. Align incentives between hospitals and physicians through bundled payment and cost-saving incentives.
3. Designate selected facilities as Value Based Care Centers.
4. Provide financial incentives for Medicare beneficiaries.

The last goal is what makes the ACE Demo a somewhat unprecedented affair. Medicare beneficiaries who meet the Part A and Part B requirements and whose care falls under one of the eligible MS-DRGs will receive an incentive payment from Medicare. The incentive payment is 50% CMS' savings created by the program, which are not to exceed the typical annual Part B premium and carry a maximum rate of \$1,157. Not all beneficiaries receive an incentive payment this high. The joint replacement MS-DRGs, have an average payment of \$350.

What could possibly be the impact and the importance of such a small demonstration program on the current state of health affairs and health reform? How could the actions of a small group of hospitals in the middle of the county affect the wider health care community? The answer to this question is elegantly addressed by Atul Gawande in an example from a different field (agriculture) and a different time (early 20th Century). In the example provided by Gawande, demonstration farm projects engaged one farmer in a local community, this farmer, following all the suggestions of the USDA invariably ended up outperforming the other local farmers which then led to the spread of the new farming best practices across the local community. Farmers may not have trusted an outsider from the USDA to teach them new techniques to increase crop yields, lower prices, increase quality, and increase profit. But, if there was just one local farmer who could show these ideas in practice then the farmers would try them

themselves.¹ That is the power of the demonstration project. If Hillcrest Medical Center and the other participants of the ACE Demo can show the success of bundled payments and other cost-saving incentives then hospitals everywhere might take up the same practices.

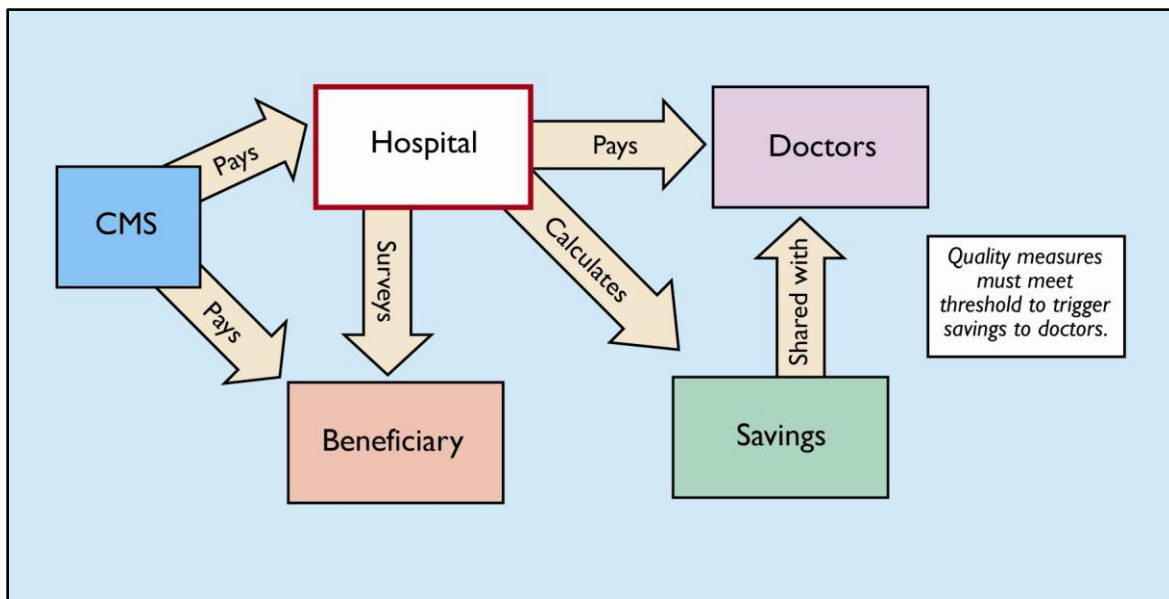
The purpose of this guide then is to share early learnings from the ACE Demo at Hillcrest Medical Center. If it accelerates the uptake of such practices, all the better. However, the main purpose of the guide is to share what is going on in the field and to allow others to form their own opinions as to whether the CMS “testing of new model opportunities” are something they are interested in engaging with and piloting.

PART I: ACE in Action

Hillcrest is the farthest hospital along in the ACE Demo process. The process has been entirely engrained in the lifecycle of the two service lines (cardiology and orthopedics—hip and knee replacements). All patients that are eligible are included in the program. There is no choice.

The ACE Demo impacts all Hillcrest teams’ work from clinical departments to billing and marketing. And it has done so with the addition of a limited amount of funds to the bottom line. In fact, Hillcrest has only hired one full-time employee (FTE) as a case manager. Other than that, direct costs have been mostly towards marketing the program. Hillcrest has cut costs and increased efficiency all while saving the money on supply chain issues and not cutting payment to their physicians.

The diagram gives a quick overview of how the ACE Demo works at Hillcrest. Following the diagram is a detailed description of ACE in action at Hillcrest.



¹ Gawande, A. “Testing, Testing,” *The New Yorker*. December 14, 2009. Accessed online at: http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande_on_June_16, 2010.

The program is governed by a board of managers that direct the project. This board meets quarterly and consists of three committees that carry out much of the work to support the project. The three committees are:

- 1) Finance committee: monitors the cost savings needed to be successful in the ACE demo
- 2) Quality committee: monitors the quality data that is used in order to trigger payment to the doctors. The quality metrics used are national.
- 3) Gain sharing committee: this committee includes a patient advocate for the community. It ensures gain sharing program requirements are met prior to distributing provider incentive payments to physicians.

The committees must go through the proper clinical channels when making any care-related decisions. However, these committees also enjoy a degree of autonomy that allows them to make decisions regarding aspects of the program like what can be addressed to save further funds, quality thresholds to trigger financial incentives, and then the actual savings distribution.

While part of the program requires that hospitals provide savings for CMS through competitive bidding. Hillcrest has not cut costs by lowering payment to their physicians. In fact, the physicians have the opportunity to receive additional compensation through the gain sharing program. As the diagram shows, provider incentive payments are not automatic. Instead, they are triggered by the physicians meeting a certain threshold of nationally benchmarked quality measures.

Physicians also benefit from this program by a possible increase in number of patients. It is hard to say with any certainty, however, whether the ACE Demo is driving any new business to Hillcrest. There has been a 28% increase in volume for the cardiologists. However, the recent opening of the highly advertised high-tech Oklahoma Heart Institute may cloud this data. There has also been a 31% increase in the orthopedic product line.

The main areas where Hillcrest Medical Center has beneficial lessons to share with the wider hospital community are in the following areas, which will be covered, along with lessons learned, throughout the following section.

Beneficiary outreach and marketing
Incentives
Case management
Materials management

Beneficiary Outreach and Marketing

In order to drive more potential patients to Hillcrest, the marketing team advertised using traditional forms of media. They stressed the fact to the public that there was an incentive payback for coming in for care at Hillcrest. These forms included newspaper, radio, and television as well as public relations outreach to local newspapers and community organizations. Advertisements included a facility contact number for patients to call with questions and additional information requests.

Direct outreach to beneficiaries went along less traditional advertisement lines as well. A proactive orthopedist agreed to hold symptom-based seminars. Seminars that focused on chronic knee or back pain drew large crowds of locals and the orthopedic staff followed up each individual with a phone call. Outreach was also needed for community physicians, physicians within the Hillcrest family, and Hillcrest staffers. Education and training sessions explained the ins and outs of who was eligible and the goals and benefits of the program.

Lessons Learned: Beneficiary Outreach and Marketing

- Advertisements can drive up volume on the orthopedic side.
- Symptom-based seminars also drive up volume—10%–25% of attendees came in for an appointment.
- Advertisement and outreach isn't as successful on the cardiac side.
- Since many of the cardiac MS-DRGs utilized by this demo were of an emergent nature, patients typically went to the facility where they had an established relationship with their physician or brand recognition of the facility.
- The best way to reach the patients with the cardiac MS-DRGs was through their cardiologists and physicians.

Incentives for Patients, Providers, and the Hospital

Financial provider incentives vary between the cardiac and the orthopedic settings at Hillcrest under the ACE Demo. The orthopedic physicians are an independent group so they are each eligible to receive a share of the savings out of the gain sharing plan. The cardiologists are employed by the Oklahoma Heart Institute and therefore do not receive direct payment. However, they benefit from the gain sharing through money being put aside for cardiac-related initiatives. Physicians also benefit from the higher volumes that may be the result of the ACE Demo and may also result in the increase attention paid to them by the marketing group and the interested media and public in general.

Incentives for the hospital include working closely with CMS and benefiting from being early adopters if bundled payment becomes an imminent reality. It has also forced the hospital to analyze their way of doing things. As a result of participating in the ACE Demo already high quality metrics improved and many lean processes have been enacted. Since no reduction in reimbursement was passed along to the physicians, Hillcrest continues to be forced to reexamine their processes and to find other ways to foster further cost reductions (see materials management section).

Quite plainly, the most obvious incentive for patients is the maximum patient incentive payment of \$1,157.00. This incentive comes directly from Medicare and not from Hillcrest. Other incentives for patients are improved quality of care and outcomes because of the increased collaboration between staff and physicians on these issues. Patients also benefit from the enhanced care coordination that comes with a bundled payment program. Individual instances of care are no longer considered; instead the entire stay at the hospital for one of these MS-DRGs is one unit. The physicians, nurses, and other clinicians all work tightly together to create the same high quality outcomes of care consistently from patient to patient. The hospital is reimbursed the same per patient per DRG and does not receive case related outlier payments; outlier amounts were considered in the competitive bid.

Lessons Learned: Incentives

- By not lowering the reimbursement levels of physicians, there will be physician support
- The Lean processes and focus on outcomes has lead to a better patient experience
- Patients do not list the financial incentive as the reason for choosing the hospital
- Patients seem more interested in the fact that the hospital has been validated as a good place to have treatment by CMS (by an outsider)
- Conversely there may be a possible problem with the CMS term “value based” providing the perception to some that the services are slightly less than the highest quality

Case Management

A dedicated case manager is the only new FTE hired for ACE Demo at Hillcrest. The case manager may be the most important person in the entire process as he or she sets the process in motion by identifying qualified patients eligible for the program. Most of this reconnaissance work by the case manager is done with the cardiac patients. Based on their scheduled procedure, orthopedic patients are easier to identify on admission. Most of the eligible orthopedic MS-DRGs are primarily elective in nature.

Many of the eligible cardiac MS-DRGs come in through the emergency department or are direct admits and unplanned. Often times, it is easier to work through the cath lab to catch the cardiac patients because the emergency departments do not have the direct knowledge of what will happen to a cardiac patient upon being admitted. However, by the time the cath lab becomes a part of the patient’s care, it is more certain as to the specific MS-DRG.

Once the case manager identifies the patient is eligible it is vital that the patient is flagged for the ACE Demo as early as possible. The role of the case manager in the ACE Demo is as follows:

- 1) Find all eligible patients and feed them into program
- 2) Follow traditional RN case management model by giving quality service to patient
- 3) Facilitate and coordinate staff to better serve the patient
- 4) Communicate to patient expectations of the program
- 5) Explain that the program will not impact future Medicare benefits
- 6) Communicate post-hospitalization

Lessons Learned: Case Management

- Case managers must be proactive in identifying eligible cases.
- It is imperative that eligible cases are found early in the process so they get into the demonstration as soon as possible.
- Patients will often believe that they should receive full financial benefit when in fact case managers need to explain \$1,157 is maximum benefit. Many of the cardiac MS-DRGs have lower levels of patient incentive payment.
- Post-hospital communication is a key to continuing patient understanding of the project. It also may be helpful in reducing readmissions.

Materials Management

In the cardiac and orthopedic MS-DRGs there are many supplies used that can be considered physician preference items (PPIs). These PPIs are often implants and other supplies common in these sorts of procedures. The main source of savings for Hillcrest Medical Center in the ACE Demo has come from reconstructing the system for selecting these supplies.

Physician choice has not been taken away. However, the materials management team has approached the physicians of both disciplines with reports of how much their supplies cost. Since there is physician interest in lowering cost so they can increase the potential gain-sharing they may receive, the physicians have looked closely at the price of their supplies. They see that if they are willing to select one or two supplies instead of a multitude of PPIs they are able to get a better deal from vendors.

The materials management team has approached the vendors with the idea that they can obtain market share within Hillcrest Medical Center if they come up with the right price. This has led to reduced costs and to the physicians assisting with contract negotiations. Instead of the materials management team telling physicians to change supplies to cut costs, the physicians are telling the materials management people that they are willing to cycle between a variety of different vendors and brands in order to save money.

Lessons Learned: Materials Management

- Physicians will steer the ship towards lower cost when they see the cost of the supplies
- Physician brand loyalty is replaced by financial and clinical consideration
- ACE is a bargaining tool because vendors know they can move market share
- It is more useful to look at supplies through the lines of MS-DRG instead of product line

PART II: ADVICE TO THE FIELD

The following advice is culled from the lessons learned at Hillcrest Medical Center throughout the CMS ACE Demo. Some of the following advice is expounded upon in the lessons learned sections above while other advice is listed here solely.

Constructing a framework before beginning is helpful.

Certain systems need to be in place and running well before an endeavor along the lines of the ACE Demo is attempted. These systems include a robust data warehouse, a cost accounting system, and a quality accounting system. The investment in quality at Hillcrest came through tracking CMS core measures, hospital-acquired conditions, never events, and readmissions.

Getting more patient volume isn't as important as getting market share with the vendors.

Hillcrest learned that by far its greatest level of savings came not from a higher volume of patients drawn to the facility because of the incentives provided because of participation in the ACE Demo. Instead, the great savings came from creating opportunities for vendors to get market share for supplies related to the eligible MS-DRGs.

Bringing physicians on board early in the process is vital.

Physicians are concerned about hospitals controlling the revenue stream, even though at Hillcrest reimbursement to physicians was not reduced so there was no financial downside to their participation. Physicians should be given influence over supply selection and materials management issues as well as other cost saving measures. By doing this they have a hand in creating their own gain-sharing in the savings.

Understanding that money is not a driving incentive for patients is important.

Although volume did go up for both the orthopedic departments and the cardiac departments at Hillcrest, there were a variety of mitigating elements that could have caused the increase. When surveyed, patients often did not list the patient incentive as the main reason for going to Hillcrest. Increased volume is not the key incentive therefore for hospitals. Instead, it is saving money, becoming more efficient, and increasing quality.

Hiring a full time case manager is necessary.

A case manager is needed first to shepherd all the eligible patients into the program, especially for the cardiac MS-DRGs since they are often unplanned admissions.

Having prior health plan experience is a plus.

From a financial perspective, during the ACE Demo Hillcrest effectively became an insurance plan for the eligible procedures.

PART III: QUESTIONS TO BE ANSWERED

The good work of Hillcrest Medical Center has been in the face of a great deal of risk and the strides they have made in the short months of their participation in the ACE Demo are remarkable. However, by their own account, they've gone after "low-hanging fruit" when reducing costs and increasing efficiencies and quality. What are the other areas that can be addressed in order to continue to increase efficiencies? Many other questions are also unanswered simply because the nature of the ACE Demo has not brought them to the forefront—yet.

- 7) How can the ACE Demo be expanded into a post-hospital setting? What would a post-acute payment bundle that goes 30–60 days post discharge look like?
- 8) What will the provider incentives look like as the project enters future years of the demo, especially if it is harder to find savings as the "low-hanging fruit" is all picked.
- 9) How does the project work if there are multiple, competitive hospitals doing the same thing in the same market? Granted, the money doesn't seem to be an incentive to drive patient volume. But, how do vendors react if all hospitals in one market are working in this type of program?
- 10) How can this be expanded to non-surgical MS-DRGs? The benefit of the currently selected MS-DRGs is that there are very few outliers. Would this program work well for cancer patients, for example?
- 11) How do you create better beneficiary incentives? Are the incentives even worthwhile as the demo expands?
- 12) What quality measures do you use for other MS-DRGs? There are not easily measurable quality measures for everything.

As the conversation continues around this demonstration project and others put forward by CMS, it is imperative that hospitals take the same risks as Hillcrest and the other participants have and stride forward. For those that aren't the demonstration sites, it is equally vital that they engage in conversation about the demonstrations and then be ready to implement the successful strategies in the same way farmers once embraced new methods of planting and raising their crops.

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APPENDIX: ELIGIBLE MS-DRGs IN THE ACE DEMO

Orthopedic MS-DRGs

MS-DRG	Description
461	Bilateral or multiple major joint procedures of lower extremity w/MCC
462	Bilateral or multiple major joint procedures of lower extremity w/o MCC
466	Revision of hip or knee replacement w/MCC
467	Revision of hip or knee replacement w/CC
468	Revision of hip or knee replacement w/o CC/MCC
469	Major joint replacement (hip)
470	Major joint replacement (knee)
488	Knee procedures w/o primary diagnosis of infection w/ CC/MCC
489	Knee procedures w/o primary diagnosis of infection w/o CC/MCC

Cardiac MS-DRGs

MS-DRG	Description
216	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/MCC
217	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/CC
218	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/o CC/MCC
219	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/MCC
220	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/CC
221	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/o CC/MCC
226	Cardiac defib implant w/o cardiac cath w/MCC
227	Cardiac defib implant w/o cardiac cath w/o MCC
231	Coronary bypass w/PTCA w/MCC
232	Coronary bypass w/PTCA w/o MCC
233	Coronary bypass w/cardiac cath w/MCC
234	Coronary bypass w/cardiac cath w/o MCC
235	Coronary bypass w/o cardiac cath w/MCC
236	Coronary bypass w/o cardiac cath w/o MCC
242	Permanent cardiac pace implant w/MCC
243	Permanent cardiac pace implant w/CC
244	Permanent cardiac pace implant w/o CC/MCC
246	Percutaneous cardiovascular procedure w/drug-eluting stent w/MCC or 4+ vessels/stents
247	Percutaneous cardiovascular procedure w/drug-eluting stent w/MCC
248	Percutaneous cardiovascular procedure w/ non drug-eluting stent w/MCC or 4+ vessels/stents
249	Percutaneous cardiovascular procedure w/ non drug-eluting stent w/MCC
250	Percutaneous cardiovascular procedure w/o coronary artery stent or AMI w/MCC
251	Percutaneous cardiovascular procedure w/o coronary artery stent or AMI w/o MCC
258	Cardiac pacemaker device replacement w/MCC
259	Cardiac pacemaker device replacement w/o MCC
260	Cardiac pacemaker revision ex. device replacement w/MCC
261	Cardiac pacemaker revision ex. device replacement w/CC
262	Cardiac pacemaker revision ex. device replacement w/o CC/MCC

HEALTH CARE REFORM



Moving Forward

Implementation Timeline

May 2010



American Hospital
Association

www.aha.org

Background

In March, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA) and the *Health Care and Education Reconciliation Act* (HCERA), which made modifications to the PPACA. Together, this historic legislation constitutes the largest change to America's health care system since the creation of Medicare and Medicaid.

To help hospitals understand the numerous provisions, programs, pilots and deadlines associated with implementing the health care reform legislation, the AHA developed this detailed timeline exclusively for our members. It graphically depicts key milestones in three-month increments from 2010 until 2020 and organizes the legislation into the following sections.

Consumers and Purchasers: The new law expands coverage to 32 million people through a combination of public program and private-sector health insurance expansions. Key insurance reforms include a mandate for individuals to have insurance; employer responsibility to provide or contribute to health insurance; low-income subsidies to help individuals purchase insurance; an expansion of Medicaid eligibility; and the creation of state-based health insurance "exchanges."

Payment and Revenue: The law takes a number of steps to reduce the rate of increase in Medicare and Medicaid spending through reduced payment updates, decreases in disproportionate share hospital payments, and financial penalties. The new law is financed by taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries.

Delivery System Reform and Quality: The law adopts several key delivery system reforms to better align provider incentives to improve care coordination and quality and reduce costs. These reforms include value-based purchasing; pilot projects to test bundled Medicare payments; voluntary pilot programs where qualifying providers – including hospitals – can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with "excessive" readmissions.

Wellness and Workforce: The law provides grants and loans to enhance workforce education and training, to support and strengthen the existing workforce, and to help ease health care workforce shortages. It requires public and private insurers to cover recommended preventive services, immunizations and other screenings with zero enrollee cost sharing. It also initiates policies to encourage wellness in schools, workplaces and communities, and takes steps to modernize the public health care system.

Other: The law includes provisions to reduce waste, fraud and abuse in the Medicare and Medicaid programs and new reporting requirements are imposed on tax-exempt hospitals. In addition, the law also incorporates several oversight programs including new requirements for physician-owned hospitals.

HEALTH CARE REFORM MOVING FORWARD

This timeline provides only a brief description and not every provision is depicted. (We recommend printing the timeline in color.) For a detailed summary of the health care reform legislation, refer to the AHA's April 19 *Legislative Advisory*. It is available at www.aha.org under "Health Care Reform Moving Forward." This section of our website features numerous resources and tools to help hospital leaders understand health care reform and inform their board, employees and community about the implications for the hospital.

Assumptions/Notes

- When changes are permanent, they are listed only once in the timeline, followed by “thereafter.”
- Some provisions did not include a specific date within a year. If only a year was listed, it was included in 1st Quarter of the listed year.
- Few provisions did not include any reference to a due date. Those provisions are listed in Appendix A.
- A number of provisions extended previous legislative due dates. The assumed start date for those extensions is the date of enactment. Only the expiration date will be reflected in the timeline.
- If a provision began prior to the date of enactment or was a retrospective adjustment, it was included in 2010: 1st Quarter.
- Many items in the timeline have the PPACA and HCERA section numbers listed in parentheses. We encourage you to use these section numbers as a crosswalk to the April 19 AHA *Legislative Advisory* and the PPACA and HCERA. Assume the section number refers to the PPACA unless noted as HCERA.

Acronyms

ACO: Accountable Care Organization
AGI: Adjusted Gross Income
ASC: Ambulatory Surgical Center
CAH: Critical Access Hospital
CDC: Centers for Disease Control & Prevention
CHIP: Children’s Health Insurance Program
CLASS: Community Living Assistance Services and Supports Act
CMI: Center for Medicare & Medicaid Innovation
CMP: Civil Monetary Penalty
CMS: Centers for Medicare & Medicaid Services
CPI: Consumer Price Index
CY: Calendar Year
DGME: Direct Graduate Medical Education
DME: Durable Medical Equipment
DOL: Department of Labor
DRG: Diagnosis-Related Group
DSH: Disproportionate Share Hospital
EFT: Electronic Funds Transfer

FICA: Federal Insurance Contribution Act
FMAP: Federal Medical Assistance Percentage
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
FTE: Full-Time Employee
FY: Fiscal Year
GAO: Government Accountability Office
GME: Graduate Medical Education
HAC: Hospital-Acquired Condition
HCERA: Health Care and Education Reconciliation Act of 2010
HCFAC: Health Care Fraud and Abuse Control
HHA: Home Health Agency
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HIT: Health Information Technology
HPSA: Health Professional Shortage Area
HRSA: Health Resources and Services Administration
HVBP: Hospital Value-Based Purchasing

IME: Indirect Medical Education
IPAB: Independent Payment Advisory Board
IPF: Inpatient Psychiatric Hospital
IPPS: Inpatient Prospective Payment System
IRC: Insurance Research Council
IRF: Inpatient Rehabilitation Facility
LTCH: Long-Term Care Hospital
MA: Medicare Advantage
MAC: Medicare Administrative Contractor
MACPAC: Medicaid and CHIP Payment Access Commission
MB: Market Basket
MEDPAC: Medicare Payment Advisory Commission
MIP: Medicare Program Integrity
MMSEA: Medicare, Medicaid, and S-CHIP Extension Act of 2007
MUA: Medically Underserved Area
NAIC: National Association of Insurance Commissioners
NF: Nursing Facility
NPI: National Provider Identifier

OPM: Office of Personnel Management
OPPS: Outpatient Prospective Payment System
PFS: Physician Fee Schedule (Medicare)
PI: Program Integrity
PPACA: Patient Protection and Affordable Care Act
PQRI: Physician Quality Reporting Initiative
PSO: Patient Safety Organization
PSTF: Prevention Services Task Force
RAC: Recovery Audit Contractor
ROI: Return on Investment
RRC: Rural Referral Center
RTC: Report to Congress
RY: Rate Year
SCH: Sole Community Hospital
SECA: Self-Employment Contribution Act
SNF: Skilled Nursing Facility
VBP: Value-Based Purchasing
USPSTF: U. S. Preventive Services Task Force



Health Care Reform Implementation Timeline

ENACTMENT (MARCH 23, 2010)
2010

CONSUMERS & PURCHASERS	Nonprofit hospitals are required to conduct a community needs assessment; adopt financial assistance policy; limit charges to charity care patients to the amount billed to insured patients (10903)	Publication of certain information on <i>Nursing Home Compare</i> (6103)	States required to maintain CHIP through Sept 30, 2019 (2101)
	Requires hospitals to publicize an annual updated list of their standard charges, including DRGs beginning in plan years after March 23, 2010 (1001)	Establish medical reimbursement data centers to collect, and publish publicly, reimbursement data from health insurers (10101)	
PAYMENT & REVENUE	Extends (from Oct 1, 2009 through Sept 30, 2010) Section 508 Medicare hospital payment protections	Creates IPAB (3403)	
DELIVERY SYSTEM REFORM & QUALITY	Extends the gainsharing demonstration's completion date (3027)	Establishes a nationwide program for national and state background checks on direct care providers in long-term care facilities (6701-6703)	Establishes the patient-centered outcomes research institute to set a national research agenda and conduct comparative clinical effectiveness research (6301, 10602)
	Creates 3-year demonstration program for up to 15 urban/rural hospices		
WELLNESS & WORKFORCE	Establishes grants for teaching health center GME programs (5508)	Establishes an Office for Women's Health in the Office of the HHS Secretary and several HHS agencies	Provides grants and contracts to support and develop a primary care training program (5201-5202)
Directs negotiated rulemaking, with stakeholders, to establish a methodology and criteria for designating medically underserved populations and HPSAs (5602)	Extends the National Health Service Corps Scholarship and Loan Repayment Program for 2011-2015 (5207, 10503)	Establishes a Prevention and Public Health Investment Fund to improve health and restrain cost growth (4002)	Requires better coordination between the USPSTF and Community PSTF (4003)
			Implements a national public-private partnership for a prevention and health promotion outreach and education campaign (4004)
			Establishes grants, through FY 2014, to support "school-based health centers" (4101)
			Retroactively establishes (Oct 1, 2009) grant programs (FY 2010-2014) through CDC to community-based organizations to reduce chronic disease, address health disparities, and promote evidence-based community preventive health activities; not less than 20% of grants must be awarded to rural and frontier areas
			Retroactively establishes (Oct 1, 2009) community-based prevention programs for Medicare beneficiaries and others (4202)
			Allows for redistribution of residency positions from a hospital closed on or after March 23, 2008 (5506)
OTHER	Prohibits physician-owned hospitals from converting to ASCs	MAC authority to perform additional PI reviews (1302 of HCERA)	Authority to suspend Medicare and Medicaid payments to a provider/supplier pending an investigation of fraud
Expands of existing PI programs, data sources, and data sharing across Federal agencies (6402)	Requires any person with knowledge of an overpayment to return it	Provides \$10 million each year, for 10 years, to the HCFAC program	Requires Medicare and Medicaid administrative contractors to submit performance statistics on fraud referrals, overpayments, and ROI
Authority to impose administrative penalties if a beneficiary knowingly participates in a Federal health care offense	Violation of claims processing statutes constitutes false or fraudulent claims; amends CMP and anti-kickback statutes (6403)	Authorizes annual CPI adjustment to HCFAC and MIP funding	Requires that all Medicare claims be submitted within 1 year after the date of service (previously allowed 3 years), beginning with services rendered after Jan 1, 2010 (6404)
			Requires SNFs and NFs to implement compliance and ethics programs
			Establishes additional requirements for Section 501(c)(3) charitable hospital organizations (pertains to conducting community needs assessments in 2012)
			Establishes Health Reform Implementation Fund within HHS to implement the PPACA legislation with a \$1 billion appropriation (1005)
			Modification to SNF cost reporting (staff wages and benefits) by staff type

FIRST QUARTER
2010

CONSUMERS & PURCHASERS

Retroactively provides small business tax credit of up to 35% of premiums for the purchase of coverage for employees (1421, 10105) **(Jan 1)**

Extends Medicaid drug rebate program to drugs dispensed through managed care plans (2501) **(Jan 1)**

Retroactively establishes the Federal Coordinated Health Care Office within CMS to coordinate coverage and payment for dually eligible beneficiaries (2602) **(March 1)**

Requires drug manufacturers to pay rebates for beneficiaries in managed care plans (2501-2503) **(Jan 1)**

Provides \$250 rebate for Medicare Part D beneficiaries who have reached prescription drug "donut hole" (3301) **(Jan 1)**

PAYMENT & REVENUE

Retroactively requires MB - 0.25% for OPPIs **(Jan 1)**

Retroactively extends MMSEA LTCH provisions and therapy caps through Dec 31, 2012 **(Jan 1)**

Authorizes \$11 million for MAC-PAC (2802) **(Jan 1)**

Retroactively extends 340B expansion to children's hospitals, free standing cancer hospitals, CAHs, RRCs and SCHs that meet certain outpatient criteria; orphan drugs excluded **(Jan 1)**

Extends and revises the Medicare Rural Hospital Flexibility Program through FY 2012 (3129) **(Jan 1)**

Retroactively increases PFS payment rate for psychiatric services by 5% for 1 year; through Dec 31, 2010 (3107) **(Jan 1)**

Retroactively extends payment for the technical component for certain lab services; through Dec 31, 2010 **(Jan 1)**

Retroactively extends Rural Community Hospital Demonstration Program; through Dec 31, 2014 **(Jan 1)**

Retroactively modifies how power wheel chairs are reimbursed (3109) **(Jan 1)**

Reinstates Medicare Dependent Hospital Program through Sept 30, 2012 **(Jan 1)**

Extends the 1.0 floor for the geographic index for physician work through 2010 **(Jan 1)**

Requires a medical loss ratio of 85% or higher in order for non-profit Blue Cross Blue Shield organizations to take advantage of their special tax benefits (9016) **(Jan 1)**

DELIVERY SYSTEM REFORM & QUALITY

Retroactively establishes the Medicaid global payment demonstration in 5 states (2705) **(Oct 1)**

WELLNESS & WORKFORCE

Retroactively authorizes modification of certain preventive services covered by Medicare; prohibits payment for preventive services that have been graded A, B, C, or I by the USPSTF (4105) **(Jan 1)**

OTHER

No provision to be implemented

SECOND QUARTER
2010

CONSUMERS & PURCHASERS

Allows state Medicaid option to cover parents and childless adults up to 133% FPL and receive current law FMAP (2001) **(April 1)**

Establishes temporary national high risk pools for adults with pre-existing conditions and who have been uninsured for 6 months through Jan 1, 2014 (1101) **(June 21)**

Establishes a temporary national reinsurance pool for early retirees (55-64) and their families through Jan 1, 2014 (1102) **(June 21)**

PAYMENT & REVENUE

MB - 0.25% for IPPS hospitals, IRFs, and LTCHs **(April 1)**

Reinstates 3% add-on payment for rural home health providers through 2015 (3131, 10315)

DELIVERY SYSTEM REFORM & QUALITY

Medication management in the treatment of chronic diseases program begins (3503) **(May 1)**

WELLNESS & WORKFORCE

No provision to be implemented

OTHER

Publication on HHS website of a list of all authorities provided under PPACA **(April 23)**

THIRD QUARTER
2010

CONSUMERS & PURCHASERS

Requires the Secretary to establish a website for the public to access information on affordable and comprehensive options (1103) **(July 1)**

Requires insurance coverage for dependent children up to age 26 (1001-1105) **(Sept 23)**

Requires insurance ban on rescission, pre-existing condition exclusions for children, no lifetime coverage limits (1001-1105) **(Sept 23)**

Requires new health plans to cover preventive services and immunizations with no cost sharing (1001) **(Sept 23)**

Prohibits discrimination by group health plans in favor of highly compensated individual plans (1001) **(Sept 23)**

Requires plans to allow enrollees to select participating pediatrician as primary care provider for a child and other patient protections related to the choice of health care professionals and access to OB/GYN services (1001) **(Sept 23)**

Requires HRSA to establish a 10-State, 3-year, demonstration for the uninsured to reduce fees for comprehensive health services (10504) **(Sept 23)**

Plans required to have an effective internal appeals process for coverage determinations and claims denials (1001) **(Sept 23)**

Hospitals must begin reporting annually to HHS and the public its standard charges for items and services (2818) **(Sept 23)**

PAYMENT & REVENUE

MB – 0.25% for IPF **(July 1)**

Excise tax on indoor tanning services begins (9017) **(July 1)**

Retroactively extends outpatient hold-harmless, ambulance add-on, physician pathology services through Dec 31, 2010 **(July 1)**

Reinstates reasonable cost reimbursement for laboratory services in small rural hospitals through June 30, 2011 **(July 1)**

DELIVERY SYSTEM REFORM & QUALITY

Development of standards and protocols, in consultation with the HIT Policy and Standards Committees, to promote interoperability of enrollment in Federal and State programs (3021) **(Sept 19)**

WELLNESS & WORKFORCE

Modifies rules for counting resident time in non-provider outpatient settings for purposes of DGME and IME payments if the hospital incurs the cost of resident stipends and benefits (5504) **(July 1)**

Establishes a National Health Care Workforce Commission to review and project workforce needs. GAO appoints the board of governors (5101, 10501) **(Sept 30)**

Interim final rule for designating MUA and HPSA through negotiated rulemaking (9017) **(July 1)**

OTHER

Development of a mechanism for voluntary disclosure of information on actual and potential violations of the physician self-referral law (6409) **(Sept 23)**

FOURTH QUARTER
2010

DELIVERY SYSTEM REFORM & QUALITY

\$75 million authorized for the Medicaid emergency psychiatric demonstration project; funds available through Sept 30, 2015 (2707) **(Oct 1)**

Funding available for demonstration on alternative approaches to tort reform (10607) **(Oct 1)**

WELLNESS & WORKFORCE

Funding available for healthy living grants to states to conduct community-based prevention and wellness program for the pre-Medicare (ages 55-64) population (4202) **(Oct 1)**

Establishes grants (5-years) for small businesses (less than 100 employees) to provide access to comprehensive workplace wellness programs (10408) **(Oct 1)**

Establishes grants (FY 2011 – 2015) for community-based collaborative care networks; Hospitals must meet certain low-income utilization; all FQHCs located in the community must participate (10333) **(Oct 1)**

Funding available to build new and expand existing community health centers (3502)

OTHER

Eliminates the physician-owned hospital exception under Stark Law if no provider agreement prior to Dec 31, 2010; Grandfathers providers with existing agreements (6001, 10601, 1106) **(Dec 31)**

Expands Medicare RAC program to Medicare Parts C and D and Medicaid (6411) **(Dec 31)**

CONSUMERS & PURCHASERS

Secretary and NAIC shall develop a uniform explanation of coverage documents and standard definitions for all health plans (1001) **(Dec 31)**

NAIC to establish standard methodology for calculating minimum medical loss ratios (1001, 10101) **(Dec 31)**

PAYMENT & REVENUE

MB – 0.25% for IPPS and IRF **(Oct 1)**

Implementation of SNF concurrent therapy change and changes to the “look-back” period (10325) **(Oct 1)**

MB – 0.5% for LTCH **(Oct 1)**

MB – 0.3% for hospice **(Oct 1)**

Application of wage index floor of 1.0 for frontier states annually thereafter (10324) **(Oct 1)**

Application of budget neutrality nationwide for the calculation of the wage index floor annually thereafter (3137, 3141, 10317) **(Oct 1)**

Year 1 geographic variation Medicare payments made to hospitals in low-cost counties (1109 of HCERA)

CONSUMERS & PURCHASERS

Freezes income thresholds at 2010 levels for income-related Part B premium through Dec 31, 2019 (3402) **(Jan 1)**

Creation of a voluntary long-term care insurance program for adults (CLASS), financed by payroll deductions (8002) **(Jan 1)**

Federal grant money available to states to establish or expand health insurance consumer assistance and ombudsman programs (1001) **(March 23)**

Requires HHS Secretary to establish a basic health program for individuals below 200% FPL and not eligible for state Medicaid programs (1331)

Requires employers to disclose the cost of employer-sponsored health insurance coverage on employee's annual W-2 form for taxable year after Dec 31, 2010 (9004) **(Jan 1)**

Requires insurance company annual reporting on the share of premium dollars spent on medical care and where appropriate, includes medical loss ratio requirements as determinants by minimum medical loss ratios (1003, 10101) **(Jan 1)**

Federal assistance must be available to states to start health insurance exchanges; funds available through Jan 1, 2015 (1311) **(March 23)**

Deadline for proposed regulation on nutritional labeling of menu items at chain restaurants (4205) **(March 23)**

PAYMENT & REVENUE

MB - 0.25% for OPPIs **(Jan 1)**

Annual fee for branded prescription pharmaceuticals begins **(Jan 1)**

Special FMAP adjustment for states recovering from major disasters (LA hurricane relief) (2006) **(Jan 1)**

Study on whether costs incurred under OPPIs by cancer hospitals exceed costs incurred by other hospitals (3138) **(Jan 1)**

MA payments frozen at 2010 level **(Jan 1)**

MB - productivity for ASCs, Certain DME, Ambulance **(Jan 1)**

Additional 10% Medicare payment bonus to primary care practitioners and general surgeons through 2015 **(Jan 1)**

Increases reimbursement for certified nurse-midwife services from 65% to 100% of PFS rate (3114) **(Jan 1)**

Exclusion of over-the-counter medicines, unless prescribed by a physician, for health reimbursement arrangements, health flexible spending accounts and Archer medical savings accounts (9003) **(Jan 1)**

Increases the medical expense tax from 10% to 20% for early withdrawal from health savings accounts for those under age 65 (9004) **(Jan 1)**

MB - 1.0% for HHAs **(Jan 1)**

Establishes minimum floors for the IPPS, OPPIs, and PFS in certain states where at least 50% of counties are frontier (less than 6 people/square mile)

Payment cuts for imaging services based on equipment utilization factors begin (3135) **(Jan 1)**

Requires an annual flat fee on the pharmaceutical manufacturing sector for branded prescription drugs (9008) **(Jan 1)**

MB - (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

Provider-specific HHA outlier cap of 10%; annually thereafter **(Jan 1)**

DELIVERY SYSTEM REFORM & QUALITY

Secretary shall publish for comment, a recommended core set of adult health quality measures for Medicaid eligible adults (2701) **(Jan 1)**

Extends voluntary Medicare PQRI Program through 2014; Maintenance of Certification may serve as a substitute for submission of quality measures in PQRI; PQRI informal appeals process begins; 0.5% bonus for PQRI **(Jan 1)**

Establishes the CMI to test 20 possible models of payment reform and provides \$1 billion/year for 10 years (3021) **(Jan 1)**

Development of a *Physician Compare* website due (10331) **(Jan 1)**

Phase down of Part D co-insurance to 25% (3301) **(Jan 1)**

Awards for state planning grants for the Medicaid health home program for enrollees with chronic conditions begin (2703) **(Jan 1)**

Five year community-based care transitions program to reduce readmissions in PPS hospitals begins (3026) **(Jan 1)**

Permits physician assistants to order SNF services (3108) **(Jan 1)**

Manufacturers provide 50% discount on drugs to participate in Part D (3301) **(Jan 1)**

WELLNESS & WORKFORCE

Expands coverage for an annual Medicare wellness visit during which personalized prevention plan is provided (4103) **(Jan 1)**

Eliminates cost sharing requirements for certain Medicare covered preventive and screening services (initial physician exam and personalized prevention services and colorectal screening) (4104, 10406) **(Jan 1)**

Provides grants (5-years) to states to implement incentives to Medicaid beneficiaries who successfully participate in programs for healthy lifestyles (4108) **(Jan 1)**

Secretary to submit to Congress an implementation plan for VBP in ASCs (3306, 10301) **(Jan 1)**

OTHER

ICD-9-CM crosswalk to ICD-10 due **(Jan 1)**

Deadline for all Medicare and Medicaid providers and suppliers to include national provider identifier on claims and enrollment applications (6402) **(Jan 1)**

SECOND QUARTER
2011

CONSUMERS & PURCHASERS	No provision to be implemented
PAYMENT & REVENUE	Deadline for congressional committees of jurisdiction to report legislation with targeted level of savings (3403) (April 1)
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
OTHER	No provision to be implemented

THIRD QUARTER

CONSUMERS & PURCHASERS	<p>Establishes the Community First Choice Medicaid Benefit option for community-based services provided to Medicaid beneficiaries with disabilities (2401)</p> <p>Medicaid FMAP to Puerto Rico and territories increased by 5% (2005) (July 1)</p>
PAYMENT & REVENUE	<p>MB – 0.25% for IPF (July 1)</p> <p>Demonstration project altering payment for laboratory services rendered in an inpatient setting begins (3113) (July 1)</p> <p>Requires a 10% tax paid by individuals for indoor tanning services (10907) (July 1)</p>
DELIVERY SYSTEM REFORM & QUALITY	<p>Regulations prohibiting federal Medicaid payment for health care-acquired conditions due (2702) (July 1)</p> <p>Establishes and announces performance standards for HVBP (3001) (Aug 1)</p> <p>Gainsharing demonstration extension ends (3027) (Sept 30)</p>
WELLNESS & WORKFORCE	<p>Final rule on MUAs and HPSAs due (5602) (July 1)</p> <p>Redistribution of unused residency position for DGME and IME cost reporting periods beginning after July 1, 2011 (5503) (July 1)</p>
OTHER	<p>Secretary shall adopt operating rules for electronic eligibility determinations for health plans and health claim status transactions (10109) (July 1)</p> <p>Establishes physician ownership policies for Stark compliance audits (6001) (Sept 23)</p>

FOURTH QUARTER

CONSUMERS & PURCHASERS	Establishes new state option with enhanced FMAP for Community First Choice Medicaid Benefit to provide home and community-based services to Medicaid beneficiaries (2401) (Oct 1)
PAYMENT & REVENUE	<p>MB – (0.1% + productivity) for IPPS, LTCH and IRF (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>Expands temporary Medicare payment adjustment to certain low-volume hospitals through 2012 (Oct 1)</p> <p>MB – (0.3% + productivity) for hospice</p> <p>Delays for 1 year the implementation of certain “RUGs-IV” Medicare payment changes</p> <p>CMS plan for Medicare wage index reform plan due (3137, 3141, 10317) (Dec 31)</p>
DELIVERY SYSTEM REFORM & QUALITY	<p>Publication of Medicare quality measures; annually thereafter (3011 – 3015) (Dec 1)</p> <p>Initial performance period begins for HVBP (3001) (Oct 1)</p>
WELLNESS & WORKFORCE	Provides grants (FY 2011-2015) for training GME residents in preventive medicine specialties (10501) (Oct 1)
OTHER	No provision to be implemented

CONSUMERS & PURCHASERS

Requires regulatory standards to be issued by the Architectural and Transportation Barriers Compliance Board for medical diagnostic equipment based in hospitals, emergency rooms, clinics and physician offices to be accessible to individuals with disabilities (4203) **(March 23)**

Health plans will be required to provide information about the plans' benefits and coverage to applicants and enrollees; failure to provide information results in \$1,000 fine/failure for each enrollee (1001) **(March 23)**

Deadline for proposed regulation on providing break time for nursing mothers (4207) **(March 23)**

PAYMENT & REVENUE

MB – (0.1% + productivity) for OPSS **(Jan 1)**

MB – 1.0% for HHAs **(Jan 1)**

Revision of practice expense geographic adjustment factor under the PFS due (3102; 1108 of HCERA) **(Jan 1)**

Requires businesses that pay any amount over \$600 per year to corporate providers of property and services to file an information report with each provider and with the IRS (9006) **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

MA plan payment cut phase-in begins (3201-3210) **(Jan 1)**

DELIVERY SYSTEM REFORM & QUALITY

Final recommended core set of adult health quality measures for Medicaid enrollees published (2701) **(Jan 1)**

Plan for integrating PQRI physician data with Meaningful Use due; 0.5% PQRI bonus through 2014 (3002, 10327) **(Jan 1)**

Medicare shared savings ACO program begins (3022) **(Jan 1)**

Performance quality measurement data made available to qualified entities (10331) **(Jan 1)**

HHS Secretary shall develop health plan quality reporting requirements including care coordination and prevention of hospital readmissions (1001) **(March 23)**

State Medicaid health home demonstration begins and continues through Dec 31, 2015 (2703) **(Jan 1)**

Episode grouper and physician resource use reports due (3003) **(Jan 1)**

8-State Medicaid bundled payment pilot begins and continues through Dec 31, 2016 (2704) **(Jan 1)**

Secretary shall recommend to Congress options to expand Medicare's hospital-acquired conditions payment policy to other settings of care, including LTCH, IRE, IPF and OPSS (3008) **(Jan 1)**

PSO program to support quality improvement efforts to reduce IPPS readmissions begins (3025) **(March 23)**

Pediatric ACO demonstration with states and pediatric providers begins and continues through Dec 31, 2016 (2706) **(Jan 1)**

Publication of specific physician value-based modifier measures for implementation and identification of the performance period due (3007) **(Jan 1)**

Independence at home Medicaid demonstration begins (3024) **(Jan 1)**

CAH and hospitals with "small numbers" HVBP demonstrations begin (3001) **(March 23)**

WELLNESS & WORKFORCE

Establishes a 5-year national public education campaign focused on oral health care prevention and education (4102) **(March 23)**

Requires all federally funded programs to collect data on race, ethnicity, primary language and other factors (4302) **(March 23)**

Secretary to implement approaches to collect health disparities data in Medicaid and CHIP (4302) **(March 23)**

OTHER

Deadline for HHS regulations on the process that grandfathered physician-owned hospitals must comply with in order to expand (6001) **(Jan 1)**

Deadline for implementation of the process that grandfathered physician-owned hospitals must comply with in order to expand (6001) **(Feb 1)**

Mandates screening of all providers and suppliers enrolled in Medicare, Medicaid and CHIP before granting billing privileges (6401) **(March 23)**

Annual treasury RTC on levels of charity care, bad debt, unreimbursed costs and costs of community benefit activities (9007)

Community needs assessment requirement for hospitals (9007)

SECOND QUARTER
2012

CONSUMERS & PURCHASERS	No provision to be implemented
PAYMENT & REVENUE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
OTHER	Deadline for the HHS audit process that ensures compliance with the regulations for physician-owned hospital expansion (May 1)

THIRD QUARTER

CONSUMERS & PURCHASERS	HHS Secretary shall establish federal guidance on the initial enrollment process for state exchanges (1311) (July 1)
PAYMENT & REVENUE	MB – (0.1% + productivity) for IPF (July 1)
DELIVERY SYSTEM REFORM & QUALITY	CMS to Inform each hospital of the HVBP adjustments to payments (3001) (Aug 1) Medicaid global payment demonstration ends (2705) (Sept 30)
WELLNESS & WORKFORCE	No provision to be implemented
OTHER	Secretary shall adopt operating rules for electronic funds transfers and health care payment and remittance advice (July 1)

FOURTH QUARTER

CONSUMERS & PURCHASERS	Secretary shall promulgate regulations concerning the standards for a CLASS independence benefit plan (8002) (Oct 1)
PAYMENT & REVENUE	MB – (0.1% + productivity) for IPPS, IRF, LTCH (Oct 1) MB – productivity for SNF (Oct 1) MB – (0.3% + productivity) for hospice through FY 2019 (depending upon number of insured individuals nationwide) (10391) (Oct 1) Year 2 geographic variation payments to hospitals in low-cost counties (1109 of HCERA)
DELIVERY SYSTEM REFORM & QUALITY	HVBP Medicare program begins; 1.0% of IPPS MB tied to HVBP; Risk adjustment of HVBP quality outcome measures due; (3001) (Oct 1) Maximum reduction to IPPS MB update under readmissions policy is 1% Selection and publication of LTCH, IRF, IPF, PPS-exempt cancer hospital, and hospice quality measures due (3004, 3005, 10322) (Oct 1) Appropriation of Medicare Trust funds to the Patient-Centered Outcomes Research Trust Fund (6301) (Oct 1)
WELLNESS & WORKFORCE	No provision to be implemented
OTHER	Effective date for unique health plan identifier (1104) (Oct 1)

CONSUMERS & PURCHASERS

HHS Secretary certifies state-based exchanges will be operational by Jan 1, 2014 and HHS will establish a federally operated exchange in any state failing certification (1321, 1322) **(Jan 1)**

New tax on insured and self-insured health plans; levied to fund the Patient-Centered Outcomes Research Institute (6301) **(Jan 1)**

Secretary will determine whether a state will have a qualified exchange operational by Jan 1, 2014 (1321) **(Jan 1)**

Drug manufacturers shall provide a 50% discount on prescriptions when a beneficiary is in the "donut hole" (3301-3315; 1101 of HCERA) **(Jan 1)**

Employers must notify employees of the availability of state exchanges and potential eligibility for federal subsidies for insurance purchased through the exchange (1512) **(March 1)**

HIT rules become operational that allow use of a machine-readable insurance identification card (1104, 10109) **(Jan 1)**

PAYMENT & REVENUE

MB – (0.1% + productivity) for OPPS **(Jan 1)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance **(Jan 1)**

MB – 1.0% for HHAs **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

Requires states to pay Medicare rates to primary care physicians serving Medicaid enrollees. Fully funds (100% FMAP) additional state costs; through Dec 31, 2014 (1202) **(Jan 1)**

\$2,500 cap on annual tax-free contribution to a flex spending account begins for tax years after Dec 31, 2012 (1403) **(Jan 1)**

Requires an annual tax on the sale of taxable medical devices by a manufacturer, producer or importer equal to 2.3% of the sales price (1405 of HCERA) **(Jan 1)**

Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5% to 10% for tax years after Dec 31, 2012 (9013) **(Jan 1)**

Imposes a new \$500,000 limit on the amount that can be deducted from executive compensation for insurance providers if at least 25% of the insurance provider's gross premium income from health business is derived from health insurance plans (9014) **(Jan 1)**

Increases Medicare hospital payroll tax by 0.9 percentage points on wages in excess of \$200,000 (\$250,000 for married couples filing jointly). Increases unearned income Medicare contribution of individuals, estates, and trusts 3.8% for taxable year starting with 2013 (9015) **(Jan 1)**

DELIVERY SYSTEM REFORM & QUALITY

Secretary issues standard format for reporting adult quality measures (2701) **(Jan 1)**

Public reporting of physician performance information on *Physician Compare* begins (10331) **(Jan 1)**

Deadline for establishing the national voluntary (5-year) Medicare bundled payment pilot for hospitals, physicians and post-acute care providers through Dec 31, 2018 – may be extended nationwide by the Secretary (3023, 10308) **(Jan 1)**

WELLNESS & WORKFORCE

Amends Medicaid state option to include any clinical preventive service assigned grade A, B, C, or I by the USPSTF. Provides 1% FMAP increase when states cover these clinical preventive services with no cost sharing. Approves vaccines and certain services for adults. (4106) **(Jan 1)**

OTHER

Drug, device, and supply manufacturers that pay or transfer items of value to a physician or teaching hospital must submit information to the Secretary; annually thereafter **(March 31)**

Eliminates the deduction subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees (9012) **(Jan 1)**

SECOND QUARTER
2013

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

PAYMENT & REVENUE

No provision to be implemented

CONSUMERS & PURCHASERS

No provision to be implemented

THIRD QUARTER

OTHER

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

MB penalty (2%) for failure to report IPF quality measures (10322) **(July 1)**

IPAB must submit first annual draft report to MedPAC and HHS with a proposal to reduce Medicare spending by targeted amounts (3403) 10320) **(Sept 1)**

PAYMENT & REVENUE

MB – (0.1% + productivity) for IPF **(July 1)**

Complex laboratory tests payment demonstration ends (3113)

CONSUMERS & PURCHASERS

Consumer Operated and Oriented Plan (CO-OP) Program established (1322) **(July 1)**

Health Care Choice Compact (2 or more states agree to offer one or more plans in both or all states) regulations due (1333) **(July 1)**

FOURTH QUARTER

OTHER

Requires health plans to file a statement with HHS certifying that their data and information systems are in compliance with federal applicable HIPAA standards and associated operating rules for electronic fund transfers, eligibility, health claim status, health care payment, and remittance advice **(Dec 31)**

WELLNESS & WORKFORCE

No provision to be implemented

DELIVERY SYSTEM REFORM & QUALITY

Inclusion of efficiency measures in HVBP and 1.25% of IPPS MB tied to HVBP (3001) **(Oct 1)**

Mandatory quality reporting program begins for PPS-exempt cancer hospitals (3004, 10322) **(Oct 1)**

MB penalty (2%) for LTCHs, IRFs and Hospices that fail to report quality measures (3004 and 3005) **(Oct 1)**

Maximum reduction to IPPS MB update under readmissions policy is 2%

1.25% of IPPS MB update withheld for HVBP redistribution.

PAYMENT & REVENUE

MB – (0.3% + productivity) for IPPS, IRF, LTCH, Hospice **(Oct 1)**

MB – productivity for SNF **(Oct 1)**

\$500 million reduction to funds available for Medicaid DSH (2551) **(Oct 1)**

Medicare DSH payment reductions begin; annually thereafter **(Oct 1)**

Increased federal match of 23 percentage points up to 100% for CHIP-covered items and services begins (2101) **(Oct 1)**

Requires an annual flat fee of \$6.7 billion on the health insurance sector (9010) **(Oct 1)**

CONSUMERS & PURCHASERS

No provision to be implemented

FIRST QUARTER
2014

CONSUMERS & PURCHASERS

Prohibits health insurers and health plans from pre-existing condition exclusions for adults, prohibits annual limits, requires guaranteed issue and renewability of coverage, and limits premium rating (1201) **(Jan 1)**

Prohibits all health plans from applying excessive waiting periods exceeding 90 days (1201) **(Jan 1)**

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) is set at 100% through FY 2017 (2001) **(Jan 1)**

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 50% (2001) **(Jan 1)**

Health insurance exchanges open in each state to individual and small group markets (1311) **(Jan 1)**

OPM enters into contracts with health insurers to offer at least 2 multi-state qualified health plans in each state (1334) **(Jan 1)**

Creates transitional re-insurance program to cover costs for high-risk individuals in the individual and group markets for 2014 – 2016 (1341) **(Jan 1)**

Tax credits and cost-sharing subsidies available through the state exchanges for individuals and families between 100-400% of FPL (1401) **(Jan 1)**

Tax credits for small employers begin with full tax credit available for those with 10 or fewer employees (1421) **(Jan 1)**

Imposes individual mandate on purchase of acceptable health insurance subject to penalties for non-compliance for taxable years after Dec 31, 2013 (1501) **(Jan 1)**

Employers with 200 or more employees must automatically enroll employees in their health plans (1511) **(Jan 1)**

“Free Rider” employer assessment is imposed on employers with 50 or more employees that either do not offer coverage or have employees that purchase coverage through the exchange with federal subsidies (1512) **(Jan 1)**

Medicaid program expansion to 133 percent of FPL for parents, children and childless adults (2001) **(Jan 1)**

Requires states to offer premium assistance and wrap around benefits to Medicaid beneficiaries offered employer-sponsored insurance if it is cost effective (2003) **(Jan 1)**

Permits Medicaid-participating hospitals and eligible providers to make presumptive eligibility determinations (2202) **(Jan 1)**

Free choice vouchers available for workers who qualify for an affordability exemption (10108) **(Jan 1)**

Requires plans to cover routine patient care costs of qualified individuals participating in certain clinical trials (10103) **(Jan 1)**

Secretary of Labor to report to Congress annually on self-insured plans (1253, 10103) **(Jan 1)**

PAYMENT & REVENUE

MB – (0.3% + productivity) for OPPS **(Jan 1)**

MB – (1.75% + productivity) for Clinical Laboratories **(Jan 1)**

Rebasing of HHA payments begins; 4-year phase-in period

Secretary must submit proposed to Congress and the President if IPAB fails to submit a proposal (3403) **(Jan 25)**

MB – productivity for ASCs, Dialysis, Certain DME, Ambulance **(Jan 1)**

Requires health plans participating in an exchange to pay FQHCs at Medicaid rates or higher (1302) **(Jan 1)**

IPAB must present proposals to the President to reduce cost growth and improve quality and it must be transmitted to Congress within 2 calendar days. Exempts IPPS hospitals (3403) **(Jan 15)**

DELIVERY SYSTEM REFORM & QUALITY

Interim report on state Medicaid health home program participants due (2703) **(Jan 1)**

WELLNESS & WORKFORCE

Employer-sponsored health plans can offer financial rewards in the form of discounts or rebates on premiums or cost-sharing waivers (subject to certain requirements) for participation in wellness programs (1201) **(Jan 1)**

Establishes non-discrimination requirements for employer-provided health promotion or disease prevention (wellness) programs (1201) **(Jan 1)**

OTHER

HIT rules become operational that allow for EFT and health care payment and readmittance advice (1104, 10109) **(Jan 1)**

SECOND QUARTER

2014

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	Deadline for congressional committees of jurisdiction to report legislation with targeted level of savings. If unable to report, IPAB proposals move forward. (3403) (April 1)
CONSUMERS & PURCHASERS	No provision to be implemented

THIRD QUARTER

OTHER	IPAB proposals are implemented automatically if Congress fails to act on a package without the required level of Medicare savings (3403) (Aug 15)
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	Medicaid adult quality reporting program begins (2701) (Sept 30)
PAYMENT & REVENUE	<p>IPAB proposals are implemented automatically if Congress fails to act on a package without the required level of Medicare savings (3403) (Aug 15)</p> <p>Due date for IPAB's first annual public report (3403) (July 1)</p> <p>MB – (0.3% + productivity) for IPF (July 1)</p>
CONSUMERS & PURCHASERS	No provision to be implemented

FOURTH QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	<p>Maximum reduction to IPPS MB update under readmissions policy is 3%. Four additional conditions from the June 2007 MedPac RTC will be added (3025) (Oct 1)</p> <p>1.0% IPPS MB penalty applied for hospitals with HAC rates in the top 25% nationally, annually thereafter (3008) (Oct 1)</p> <p>1.5% of IPPS MB withheld for HVBP redistribution (3001) (Oct 1)</p>
PAYMENT & REVENUE	<p>New prospective payment system for FQHCs begins (10501) (Oct 1)</p> <p>\$600 million reduction to funds available for Medicaid DSH (2551) (Oct 1)</p> <p>MB – (0.3% + productivity) for Hospice; Potential for "give back" (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>MB – (0.2% + productivity) for IPPS, IRF, LTCH (Oct 1)</p>
CONSUMERS & PURCHASERS	No provision to be implemented

2015

FIRST QUARTER

OTHER				CONSUMERS & PURCHASERS	<p>Medigap plans C & F shall require nominal cost sharing to encourage the appropriate use of physician services (3210) (Jan 1)</p> <p>State-based exchanges shall be financially self-sustaining (1311) (Jan 1)</p> <p>States shall begin annual reporting on the number and characteristics of Medicaid enrollees, including estimates of the number of newly enrolled individuals (2001, 10201) (Jan 1)</p>
WELLNESS & WORKFORCE					<p>Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 60% (2001) (Jan 1)</p> <p>Qualified health plans in state-based exchanges can no longer contract with hospitals with more than 50 beds unless the hospital participates in a PSO and implements a mechanism for a comprehensive program for hospital discharges (1311) (Jan 1)</p>
DELIVERY SYSTEM REFORM & QUALITY	<p>Regulations updating the Medicaid adult quality measures program due and annually thereafter (2701) (Jan 1)</p> <p>1.5% penalty applied to PFS update for physicians who fail to submit PQRI measures successfully (3002, 10327) (Jan 1)</p>	<p>Implements a budget neutral value-based payment adjustment to vary physician payments based on quality of care relative to costs (3007) (Jan 1)</p> <p>CAH and hospitals with "small numbers" demonstrations on HVBP ends (3001) (March 23)</p>			<p>MB – (1.75% + productivity) for Clinical Laboratories (Jan 1)</p> <p>MB – productivity for ASCs, Dialysis, Certain DME, Ambulance and HHAs (Jan 1)</p>
PAYMENT & REVENUE					<p>MB – (0.2% + productivity) for OPPS (Jan 1)</p> <p>IPAB to submit recommendation to Congress and the President on slowing growth in national health expenditures (3403) (Jan 15)</p>
OTHER					<p>No provision to be implemented</p> <p>No provision to be implemented</p>

SECOND QUARTER

OTHER				CONSUMERS & PURCHASERS	<p>No provision to be implemented</p>
WELLNESS & WORKFORCE					<p>No provision to be implemented</p>
DELIVERY SYSTEM REFORM & QUALITY					<p>No provision to be implemented</p>
PAYMENT & REVENUE					<p>No provision to be implemented</p>
OTHER					<p>No provision to be implemented</p>

THIRD QUARTER

OTHER				CONSUMERS & PURCHASERS	<p>No provision to be implemented</p>
WELLNESS & WORKFORCE					<p>No provision to be implemented</p>
DELIVERY SYSTEM REFORM & QUALITY					<p>No provision to be implemented</p>
PAYMENT & REVENUE					<p>MB – (0.2% + productivity) for IPF (July 1)</p>
OTHER					<p>No provision to be implemented</p>

FOURTH QUARTER

OTHER				CONSUMERS & PURCHASERS	<p>Increases FMAP for each state for CHIP through FY 2019 (2101, 10203) (Oct 1)</p>
WELLNESS & WORKFORCE					<p>No provision to be implemented</p>
DELIVERY SYSTEM REFORM & QUALITY	<p>1.75% of IPPS MB withheld for HVBP redistribution (3001) (Oct 1)</p> <p>Community-based care transitions of care program targeting readmissions ends (3026) (Dec 31)</p>				<p>MB – (0.2% + productivity) for IPPS, IRE, LTCH (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>MB – (0.3% + productivity) for Hospice; Potential for "give back" (Oct 1)</p> <p>\$600 million cut to funds available for Medicaid DSH (2551) (Oct 1)</p>
PAYMENT & REVENUE					
OTHER					<p>No provision to be implemented</p>

2016

FIRST QUARTER

OTHER	Claims and encounter information operating rules enforced (Jan 1)
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	<p>2.0% penalty applied to PFS update for physicians who fail to submit PQRI measures successfully; annually thereafter (3002, 10327) (Jan 1)</p> <p>Secretary must initiate separate programs to test VBP for LTCHs, IRFs, IPFs, PPS-exempt cancer hospitals and hospices (10326) (Jan 1)</p> <p>Secretary may expand scope and duration of the national Medicare voluntary bundling pilot (3023, 10308) (Jan 1)</p> <p>Extends Medicaid "Money Follows the Person" rebalancing demonstration (2403) (Jan 1)</p>
PAYMENT & REVENUE	<p>MB – (0.2% + productivity) for OPPIs (Jan 1)</p> <p>MB – productivity for ASC, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)</p>
CONSUMERS & PURCHASERS	<p>Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 70% (2001) (Jan 1)</p> <p>States can enter into health care choice compacts to allow health benefits to be sold across state lines (1333) (Jan 1)</p>

SECOND QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	No provision to be implemented
CONSUMERS & PURCHASERS	No provision to be implemented

THIRD QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	MB – (0.2% + productivity) for IPF (July 1)
CONSUMERS	No provision to be implemented

FOURTH QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	<p>2.0% of IPPIs MB tied to HVBP; annually thereafter (3001) (Oct 1)</p> <p>State Medicaid health home demonstration ends (2703) (Dec 31)</p> <p>Medicaid bundled payment demonstration ends (2704) (Dec 31)</p> <p>Pediatric ACO demonstration ends (2706) (Dec 31)</p>
PAYMENT & REVENUE	<p>MB – (0.75% + productivity) for IPPIs, IRF, LTCH (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>MB – (0.3% + productivity) for Hospice; Potential for "give back" (Oct 1)</p> <p>\$1.8 billion cut to funds available for Medicaid DSH (2551) (Oct 1)</p>
CONSUMERS & PURCHASERS	States may enroll CHIP eligible children in exchange based qualified health plans if the children are denied CHIP coverage due to enrollment caps (2101) (Oct 1)

2017

FIRST QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	Value-based payment modifier applied to PFS update with respect to all physicians, physician groups and eligible professionals (3007) (Jan 1)
PAYMENT & REVENUE	<p>MB – (0.75% + productivity) for OPPS (Jan 1)</p> <p>MB - productivity for ASC, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)</p>
CONSUMERS & PURCHASERS	<p>Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 95% (2001) (Jan 1)</p> <p>Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 80% (2001) (Jan 1)</p> <p>States may allow for large groups to obtain coverage in the exchanges (1312) (Jan 1)</p> <p>Permits states to apply to HHS for a 5-year waiver of requirements, such as individual mandate, qualified health plans and exchanges health insurance (alternative coverage programs) (1332) (Jan 1)</p>

SECOND QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	No provision to be implemented
CONSUMERS & PURCHASERS	No provision to be implemented

THIRD QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	MB – (0.75% + productivity) for IPF (July 1)
CONSUMERS & PURCHASERS	No provision to be implemented

FOURTH QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	<p>MB – (0.75% + productivity) for IPPS, IRF, LTCH (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>MB – (0.3% + productivity) for Hospice; Potential for “give back” (Oct 1)</p> <p>\$5 billion cut to funds available for Medicaid DSH (2551) (Oct 1)</p>
CONSUMERS & PURCHASERS	No provision to be implemented

2018

FIRST QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	Decision due on whether to expand SNF, HHA, and ASC VBP pilot programs (10326) (Jan 1)
PAYMENT & REVENUE	<p>Imposes an excise tax on insurers that offer high cost plans ("Cadillac" tax); Subject to threshold of \$10,200 for individuals and \$27,500 for families; Exempts separate vision and dental coverage policies from premium amounts (9001) (Jan 1)</p> <p>MB – productivity for ASCs, Dialysis, Certain DME, Ambulance, HHAs and Clinical Laboratories (Jan 1)</p> <p>MB – (0.75% + productivity) for OPPS (Jan 1)</p>
CONSUMERS & PURCHASERS	<p>Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 94% (2001) (Jan 1)</p> <p>Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 90% (2001) (Jan 1)</p>

SECOND QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	No provision to be implemented
CONSUMERS & PURCHASERS	No provision to be implemented

THIRD QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	No provision to be implemented
PAYMENT & REVENUE	MB – (0.75% + productivity) for IPF (July 1)
CONSUMERS & PURCHASERS	No provision to be implemented

FOURTH QUARTER

OTHER	No provision to be implemented
WELLNESS & WORKFORCE	No provision to be implemented
DELIVERY SYSTEM REFORM & QUALITY	National Medicare voluntary bundled payment pilot ends (3023, 10308) (Dec 31)
PAYMENT & REVENUE	<p>\$5.6 billion cut to funds available for Medicaid DSH (2551) (Oct 1)</p> <p>MB – (0.3% + productivity) for Hospice; Potential for "give back" (Oct 1)</p> <p>MB – productivity for SNF (Oct 1)</p> <p>MB – (0.75% + productivity) for IPPS, IRF, LTCH (Oct 1)</p>
CONSUMERS & PURCHASERS	No provision to be implemented

2019

CONSUMERS & PURCHASERS

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 93% (2001) **(Jan 1)**

Medicaid FMAP for childless adults in early expansion states (AZ, DE, DC, HI, ME, MA, MN, NY, PA, VT, WA and WI) increases to 100% thereafter (2001) **(Jan 1)**

PAYMENT & REVENUE

MB – (0.75% + productivity) for OPPS **(Jan 1)**

MB – productivity for IPPS, IRF, LTCH, SNF; annually thereafter **(Oct 1)**

MB – productivity for ASC, Dialysis, Certain DME, Ambulance, HHA and Clinical Laboratories **(Jan 1)**

MB – (0.3% + productivity) for Hospice; Potential for “give back” **(Oct 1)**

MB – (0.75% + productivity) for IPF **(July 1)**

\$4 billion cut to national state allotments for Medicaid DSH (2551) **(Oct 1)**

First year IPAB proposal to reduce Medicare spending can include recommendations to reduce hospital or hospice payments (3403) **(Sept 1)**

DELIVERY SYSTEM REFORM & QUALITY

Allows Secretary to establish a demonstration to provide financial incentives to beneficiaries who receive services from high-quality physicians (10331) **(Jan 1)**

WELLNESS & WORKFORCE

No provision to be implemented

OTHER

No provision to be implemented

2020

CONSUMERS & PURCHASERS

Medicaid FMAP for newly eligible enrollees (children, childless adults and parents) decreases to 90% (2001) **(Jan 1)**

PAYMENT & REVENUE

MB – productivity for OPPS, ASC, HHA, Dialysis, Certain DME, Ambulance and Clinical Laboratories and annually thereafter **(Jan 1)**

MB – productivity for IPF; annually thereafter **(July 1)**

MB – productivity for Hospice; annually thereafter **(Oct 1)**

DELIVERY SYSTEM REFORM & QUALITY

No provision to be implemented

WELLNESS & WORKFORCE

No provision to be implemented

OTHER

No provision to be implemented

Health Care Reform Appendix

Appendix A

PROVISIONS THAT DID NOT INCLUDE A DUE DATE

No Date

- Requirements and definitions for qualified health plans and essential health benefits will be determined by HHS Secretary with opportunities for public comment (1301 and 1302)
- Improvements to the demonstration project on community health integration models in certain rural counties (3126)
- Health care delivery system research; quality improvement technical assistance (3501)
- Establishing community health teams to support the patient-centered medical home (3502)
- Program to establish shared decision making (3506)
- Patient navigator program (3510)
- Community-based collaborative care networks (10333)
- Community college and career training grant program (1501)
- CDC study and evaluation of the best employer-based wellness practices; Educational campaign to promote benefits of workplace wellness programs to employers (4303)

Appendix B

REPORT DUE DATES

2010

- Report on the National Prevention, Health Promotion and Public Health Council due to the President and Congress and annually at the beginning of the CY thereafter **July 1**
- Biosimilar disposal user fee RTC due (7001-7003) **Oct 1**
- HHS study due on additional payment for urban MDHs (3142) **Dec 23**
- Plan to modernize CMS data systems due (10330) **Dec 23**
- Inter-agency quality working group RTC due (3011 – 3015) **Dec 31**

2011

- National quality strategy RTC and internet website due; annually thereafter (3011 – 3015) **Jan 1**
- HHS study due on cancer hospitals (3138) **Jan 1**
- National Prevention, Health Promotion and Public Health Council RTC due; annually thereafter through 2015 **Jan 1**
- Efforts with states and Medicaid enrollees to reduce obesity RTC due; every 3-years through 2017 thereafter (4004) **Jan 1**
- RTC for SNF, HHA, and ASC VBP programs due (10301) **Jan 1**
- MEDPAC RTC on Medicare payment accuracy for rural health care providers due (3125, 10314) **Jan 1**
- HHS RTC on providing HHA in low-income or medically underserved areas due (3131) **March 1**
- MACPAC first annual RTC **March 15**
- RTC on prescription drug labeling due (3507) **March 23**
- RTC on the effects of insurance reforms on large group markets and self-insured group plans (10103) **March 23**
- GAO study on the cost, affordability, and rates of denial for plans offered in the exchanges **March 23**
- GAO study on oral drugs in the treatments of end-stage renal disease due (10336) **March 23**
- National Health Care Workforce Commission high priority area RTC due; every year thereafter (5105, 10501) **April 1**
- National Health Care Workforce Commission general RTC due; every year thereafter (5105, 10501) **Oct 1**
- RTC for SNF, HHA, and ASC VBP programs due (3006) **Oct 1**
- GAO study on improving the 340B program due **Oct 1**
- Secretary of Labor RTC on self-insured health plans due (10103)

2012

- Adjusting the FPL for different geographic regions RTC due **Jan 1**
- HAC RTC due (3008) **Jan 1**
- Multi-stakeholder group quality measure input due; annually thereafter (3011 – 3015) **Feb 1**
- HHS assessment of National Quality Strategy due; at least once every three years thereafter (3011 – 3015) **March 1**
- Health professional patient safety training RTC due; annually thereafter (3508) **March 23**
- CMI RTC due; once every other year thereafter (3021) **Dec 31**

2013

- Gainssharing demonstration RTC due (3027) **March 31**
- RTC with recommended legislation and administrative actions to promote healthy lifestyles and chronic-disease self-management for Medicare beneficiaries due (4202) **Sept 30**
- RTC on pre-Medicare population (55-64) wellness pilot due (4202) **Sept 30**
- Medicaid global payment demonstration RTC due (2705) **Oct 1**
- Emergency psychiatric demonstration RTC and recommendations for expansion due (2707) **Dec 31**

2014

- GAO RTC on competition and market concentration in the reformed health insurance market due every other year thereafter (1322) **Dec 31**
- Medicaid adult quality measure program RTC due; every 3 years thereafter (2701) **Jan 1**
- Medicaid healthier lifestyles grant program RTC due (4108) **Jan 1**
- Interim preventive care and obesity-related services available via Medicaid RTC due (4004) **Jan 1**
- IPAB RTC; annually thereafter **Jan 15**
- Effectiveness of vaccine grant program RTC due (4204) **March 23**
- RTC with recommendations on improving and identifying health care disparities among Medicaid and CHIP beneficiaries due (4302) **March 23**

2015

- Physician Compare RTC due (10330) **Jan 1**
- MEDPAC HHA payment RTC due (3131) **Jan 1**
- GAO IPAB RTC due July 1
- GAO interim HVBP RTC due (3001) **Oct 1**

2016

- HHS HVBP RTC due (3001) **Jan 1**
- RTC on Medicaid healthier lifestyles due (4108) **Jan 1**
- Final preventive care and obesity-related services available via Medicaid RTC due (4004) **Jan 1**
- HVBP CAH and hospitals with “small numbers” demonstration RTCs due (3001) **Sept 23**
- MEDPAC and MACPAC tort reform alternative payment RTCs due **Dec 23**

2017

- State health home program RTC due (2703) **Jan 1**
- GAO final HVBP RTC due (3001) **Oct 1**
- Nurse in-hospital training program RTC due (5509) **Oct 17**
- Medicaid bundled payment demonstration RTC due (2407) **Dec 31**

Appendix C

ADVISORY BOARDS, COMMISSIONS, COUNCILS AND COMMITTEES

- Advisory Boards for State Cooperatives (1322)
 - Appointments made no later than **June 23, 2010**
 - Terminates by **Dec 31, 2015**
- Independent Payment Advisory Board (IPAB) (3403)
 - IPAB Consumer Advisory Council
- Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (4001)
- Interagency Pain Research Coordinating Committee (4305)
 - Appointments made no later than **March 23, 2011**
- National Health Care Workforce Commission (5101)
 - Appointments made no later than **Sept 30, 2010**
- Commission on Key National Indicators (5605)
 - Appointments made no later than **April 22, 2010**
- Patient-Centered Outcomes Research Institute (6301)
 - Appointments made no later than **Sept 23, 2010**
 - Clinical Trials Advisory Panel
 - Rare Disease Advisory Panel
 - Standing Methodology Committee for the Institute
- Advisory Board on Elder Abuse, Neglect and Exploitation (6703)
- CLASS Independence Advisory Council (8002)
- Personal Care Attendant’s Workforce Advisory Panel (8002)
 - Appointments made no later than **June 21, 2010**
- Cures Acceleration Network Review Board (10409)
- Advisory Committee for Young Women’s Breast Health Awareness Education Campaign (10413)
 - Appointments made no later than **May 22, 2010**



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