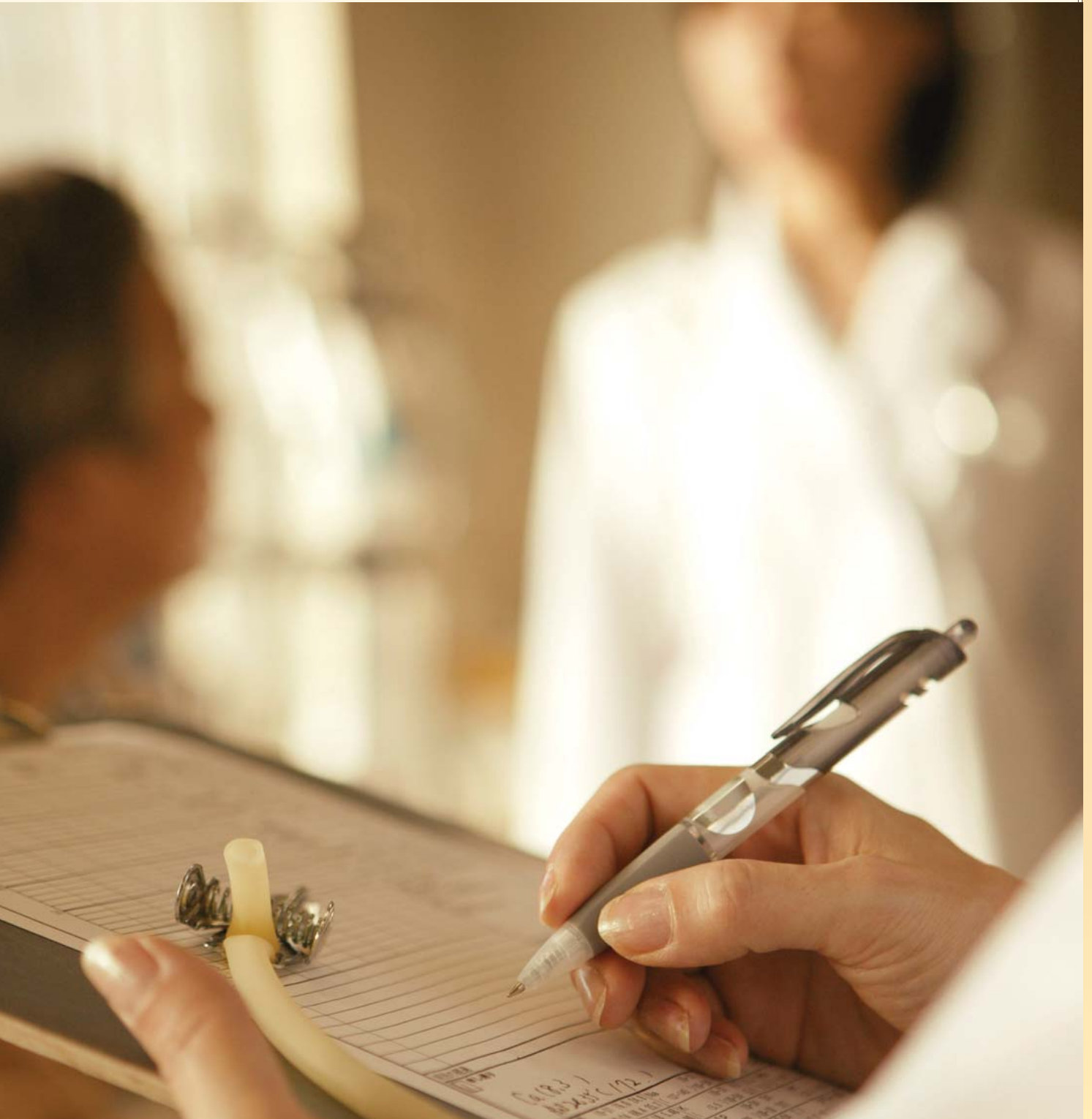


# A Hospital's Tale

Understanding challenges and strategies associated with data reporting is key to effectively communicate performance.



Data reporting, at its core, is about telling a story. Individuals use data to understand what happens within the walls of your facility and what becomes of the patients who receive treatment there. Are patients getting the right kind of care for, say, congestive heart failure? How many nurses are staffed in a certain unit at a given time? How sick are the patients coming through the hospital? The answers to these questions and dozens of others become elements in the narrative that is your hospital's story.

Effectively telling this story can be quite a challenge. For starters, you have to understand who will be receiving the information. Many outside entities—federal and state agencies, health plans, accrediting bodies, and others—will read at least a portion of your story. Each of them will have a different interest in mind, which will help determine which details constitute the final product. However, you and you alone are the author; it's your job to assemble and report the details, and present them in an understandable, coherent format. This process can be expensive, frustrating, and time-consuming. Added to this pressure is that precision, accuracy, and timeliness are of critical importance.

No matter the size of your organization, delivering health care today means processing and analyzing huge volumes of data, and turning those data into usable information. What this information conveys about your hospital is more important than ever, because it will be used as a key source for comparison when evaluating the marketplace and is increasingly important in determining level of payment. Healthcare financial executives need to relay how the organization is performing in patient outcomes, resource utilization, and quality measures so that comparisons between the hospital and its competition are done fairly and participation in quality-based payment programs accurately reflects achievements.

Unlike many stories, this one has no end—it's the ongoing saga of how the organization stacks up. So, although the challenges may be great, it's important to take ownership of your storytelling duties. This is especially true given three current and ongoing developments:

→ Upcoming national and state-specific adoption of the present on admission indicator

- Medicare's anticipated adoption of revisions to the diagnosis-related group system to account for severity-adjusted payment
- Expansion of pay-for-performance and pay-for-reporting initiatives

Data reporting is certain to be among the top issues facing hospitals in 2007. How prepared is your organization for the challenges this task presents? Hospital leaders take note: Get ready to tell your own tale, or else risk having it told for you.

## ■ Present on Admission

In October 2007, the Centers for Medicare and Medicaid Services will begin collecting present on admission data. Secondary as well as principle diagnoses in acute care hospital settings will be reported, and these data will be used to track the development of infections and other complications in patients once they are admitted to the hospital.

Present on admission is defined as existing when the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including during emergency department service delivery, observation, or outpatient surgery, can be considered present on admission. Indication of "present on admission" is based not only on conditions known at the time of admission, but it also includes those conditions that were clearly present but not diagnosed until after the admission took place. There are four reporting definitions for those situations not considered exempt from reporting:

- Y** "Yes," present at the time of inpatient admission
- N** "No," not present at the time of inpatient admission
- U** "Unknown," documentation is insufficient to determine if condition is present on admission
- W** "Clinically undetermined," provider is unable to clinically determine whether the condition was present on admission

Medicare is already working on payment rules for two or more infectious complications that will not be included in the DRG payment calculation. Therefore, it is very important for financial executives to ensure their staff properly record the present on admission indicator in the medical record.

While present on admission reporting requirements are being newly introduced nationwide, their use by some hospitals is not new. The National Committee on Vital and Health Statistics first recommended inclusion of a qualifier for other diagnoses in its 1992 recommendations on proposed revision to the Uniform Hospital Discharge Data Set. New York state was the first to implement POA use, in 1994; California followed suit two years later.<sup>1</sup>

## ■ Severity-Based DRGs

In October 2006, CMS began a three-year phase-in of cost-based relative weights. The agency's intention is to remove systematic variation in hospital markups that distorts the relative weights based on charges. This spring, CMS is expected to announce results of a study of different DRG methodologies, with hopes of beginning a phase-in of a severity-based system for the inpatient prospective payment

system in October 2007. The goal: a DRG-based payment system that more accurately reflects the severity of illness of the patient being treated. Such a system would be designed to adjust payment so the care of a patient with low resource utilization is paid at a lower rate than is the care of a patient with high resource utilization, while also describing conditions that occur during the patient's stay that could reasonably have been prevented through the application of evidence-based guidelines.

Among the severity-adjusted systems the federal government is considering is use of an all patient refined DRG platform. The methodology, developed by 3M, classifies patients into clinically meaningful groups and then divides them into severity-of-illness subclasses within each group. 3M™ APR DRGs describe a complete cross-section of acute care patients and are specifically designed to adjust data for severity of illness (i.e., how sick is the patient?). The

## The Scourge of Infection

Infections acquired within the hospital setting—sometimes known as healthcare associated infections, or HAIs—have vexed both hospital operators and patient advocates for years. It is estimated that up to 10 percent of inpatients acquire one or more infections during their hospitalization. An estimated 2 million hospital-acquired HAIs occur each year in the United States, accounting for an estimated 90,000 deaths and adding up to \$5.7 billion in annual healthcare costs. Experts generally believe that at least 20 percent of such infections are preventable.<sup>2</sup>

A few targeted initiatives have reduced or even eliminated HAIs in certain circumstances, but these infections have proven a persistent problem for the industry overall. Quality improvement initiatives are taking fresh aim; the most recent of these is the Institute

for Healthcare Improvement's 5 Million Lives Campaign, which is seeking to prevent one particularly virulent infection, methicillin-resistant staphylococcus aureus, or MRSA.<sup>3</sup> At the end of 2006, 15 states had enacted legislation requiring HAI reporting,<sup>4</sup> and the National Quality Forum was at work identifying national standards for reporting HAI data.<sup>5</sup>

Although no one doubts the seriousness of HAIs, hospitals do wonder whether it's possible to pinpoint the source of an infection. Present on admission data should address this concern. If a patient demonstrates symptoms of infection upon admission, it should be indicated on the medical record, and picked up on the indicator, to prevent the possibility of the hospital being penalized unfairly for introducing an infection to a patient.

<sup>1</sup> [www.hcup-us.ahrq.gov/reports/2006\\_1.pdf](http://www.hcup-us.ahrq.gov/reports/2006_1.pdf).

<sup>2</sup> [www.qualityforum.org/projects/ongoing/hai/index.asp](http://www.qualityforum.org/projects/ongoing/hai/index.asp).

<sup>3</sup> [www.ihl.org/NR/rdonlyres/7B23AFA5-C460-4970-8BA9-A588FE652F5B/0/5MillionLivesCampaignPressRelease121206.pdf](http://www.ihl.org/NR/rdonlyres/7B23AFA5-C460-4970-8BA9-A588FE652F5B/0/5MillionLivesCampaignPressRelease121206.pdf).

<sup>4</sup> [www.apic.org/Content/NavigationMenu/GovernmentAdvocacy/MandatoryReporting/state\\_legislation/state\\_legislation.htm](http://www.apic.org/Content/NavigationMenu/GovernmentAdvocacy/MandatoryReporting/state_legislation/state_legislation.htm).

<sup>5</sup> [www.qualityforum.org/pdf/projects/HAI.pdf](http://www.qualityforum.org/pdf/projects/HAI.pdf).

fundamental principle of the system is that severity of illness is dependent on the patient's underlying condition. High severity of illness is characterized by multiple serious diseases and the interactions between the disorders.

Many hospitals have been using the severity-adjusted system for internal planning and analysis. The state of Maryland, through its Maryland Health Care Payment System, uses 3M APR DRGs, with data collection beginning there in 2004. (Hospital payment rates in Maryland are set by the state.) The methodology uses up to the fifth digit of the ICD-CM-9 codes, rather than the three-digit base codes.<sup>6</sup>

With CMS continuing to study different methodologies that could be used for reporting severity of illness on a national level, observers anticipate some form of severity-based DRGs to be enacted in 2007 or 2008.

## Pay for Reporting, Pay for Performance

The Medicare Modernization Act, or MMA, is best known as the law that created Medicare Part D, the prescription drug benefit. Little noticed at the time of passage, however, is a provision in the 2003 law that may have a dramatic impact on the future of payment: It calls for a full Medicare update to be granted only to those hospitals that report to CMS the results of certain measures of hospital performance (hospitals in 2007 need to report 21 measures or face a 2 percent penalty). These measures are reported to the public via CMS's Hospital Compare web site, [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

Not surprisingly, nearly all hospitals now report on all of these measures, rather than suffer the financial penalty for failing to report. But this pay-for-reporting initiative is not

## What Is HCAHPS?

With all the measures of hospital performance becoming available, it became apparent to quality improvement professionals that a critical voice was being left out—that of the patient. Hospital CAHPS, or HCAHPS (pronounced “H-caps”), is meant to address this. HCAHPS is the first nationally standardized survey for measuring how patients perceive the care they receive in hospitals.

Hospital surveys of patients' perception of care have been used for many years, but these surveys have been developed by many different entities; because they have not been standardized, they did not provide publicly available, comparable information that could be used by consumers. The HCAHPS survey is different in that it presents a single, standardized method for collecting and scoring this information, which will be publicly reported via Hospital Compare.<sup>7</sup>

Because HCAHPS is standardized, it will allow comparison of care between and among hospitals across the country and over time. The survey asks patients about

their experiences in seven areas of hospital care through 22 questions that address communication with physicians, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quietness of the environment, and discharge information. It also includes five demographic questions (used for patient-mix adjustment and other analytic purposes). To ensure that results are comparable across hospitals, the survey also comes with standard specifications that include sampling, survey administration, and method for how the results are calculated and reported.

HCAHPS was developed by CMS and the federal Agency for Healthcare Research and Quality, cleared through the federal Office of Management and Budget approval process, and publicly vetted through the National Quality Forum's consensus development process. CMS tested the survey in pilot fashion in Arizona, Maryland, and New York, and has been training hospitals on use of the survey. The first public reporting of HCAHPS survey data is anticipated in late 2007.

<sup>6</sup> [multimedia.mmm.com/mws/mediawebserver.dyn?6666660Zjcf6lVs6EVs66S7wwCOrrrQ-](http://multimedia.mmm.com/mws/mediawebserver.dyn?6666660Zjcf6lVs6EVs66S7wwCOrrrQ-)

<sup>7</sup> The survey and additional specifications as approved under the National Quality Forum consensus development process can be found at [www.qualityforum.org/pdf/reports/HCAHPS.pdf](http://www.qualityforum.org/pdf/reports/HCAHPS.pdf).

stopping there. The Hospital Quality Alliance, a coalition of provider, purchaser, consumer, and other groups, is working to expand the number of measures to be publicly reported. These include HCAHPS, a 27-item survey of consumers' perceptions of the care they receive. Hospitals have been testing HCAHPS, and this survey will debut for purposes of public reporting in 2007.

Other measures of care are being added to the HQA framework as well. These include post-discharge mortality rates for heart attack, heart failure, and pneumonia; measures of post-surgery blood clot prevention; measures of processes of care to prevent surgical infections and ventilator-assisted pneumonia; and measures of the rate of infections in hospital intensive care units associated with catheters, intravenous lines, and ventilator use.

A related national initiative is the AQA alliance (formerly the Ambulatory Care Quality Alliance), focusing on measuring areas of physician practice. This effort, similar in structure to the HQA but broader in scope, has approved nearly 50 measures of performance addressing ambulatory care, cardiology, and cardiac surgery. Pilot data collection projects are under way, although no AQA reporting is currently tied to payment.

Finally, there is pay for performance. Integrating clinical and financial performance, these programs award higher reimbursement to providers who score higher than peers on a given set of performance measures. Congress and CMS have been considering ways to enact pay for performance broadly through Medicare, although the debate on how to set up a rewards-and-punishment system and the proper measures of performance has not been settled.

Even so, the concept of pay for performance is gaining wide acceptance, thanks to a variety of experiments. The most prominent of these is the CMS/Premier Hospital Quality Incentive Demonstrative Project, in which approximately 260 hospitals affiliated with Premier Inc. are being evaluated based on 33 measures of performance in five clinical conditions.

## What Should Financial Executives Do?

Broadly speaking, you have three key points to add to your story: indication of present on admission, severity-based DRGs, and the pay-for-reporting and pay-for-performance initiatives. Effectively recording and reporting these measures shouldn't be taken lightly. After all, each of these measures speaks to the quality of your organization. And perception of quality can affect almost every aspect of your business, including community relations, payment, physician relations, recruitment and retention of staff, and even access to capital.

With this in mind, consider the following advice from various industry representatives for improved data reporting:

**Engage in quality at the highest level.** Hospitals serious about data reporting raise it to an officer-level discussion, says Lisa Goldstein, a senior vice president at Moody's. "Many hospitals are now looking at expanding the C-suite to include a chief quality officer," Goldstein says.

In addition, Goldstein recommends hospitals pursue a data collection and reporting strategy that includes regular updates to and engagement with the hospital's board of directors. The Joint Commission on Accreditation of Healthcare Organizations has set forth a set of expectations and responsibilities for hospital boards, and the National Quality Forum in 2004 endorsed a Call to Action encouraging hospital governing boards to become more actively engaged in their hospital quality efforts.<sup>8</sup>

**Focus on education.** One common data-reporting misstep is to focus educational efforts too narrowly. "You have to engage so many parties within a hospital to make these kinds of reporting changes," says Pat Merryweather, a senior vice president with the Illinois Hospital Association. "It's not just the person who does the actual data submission who needs to understand how the reporting process works. There's also the CFO, and anyone who touches the medical record—you need to pull in all those parties so they understand that the information they're reporting will go public, and so much depends on the accuracy of the reporting process."

<sup>8</sup> [www.qualityforum.org/pdf/reports/call\\_to\\_responsibility.pdf](http://www.qualityforum.org/pdf/reports/call_to_responsibility.pdf).

## Major Pay-for-Performance Initiatives

More than 100 pay-for-performance experiments and initiatives are currently in place. Here are a few of the biggest.

**Bridges to Excellence.** This multistate, multiple employer initiative rewards physicians. Charter employers include General Electric, UPS, Procter & Gamble, and Verizon—all of which offer bonus payments to physicians. Participants include the National Business Coalition on Health, National Committee for Quality Assurance, MEDSTAT, and WebMD Health. The NCQA selects which physicians qualify for awards based on evaluating and verifying their data. Rewards vary; for instance, physicians meeting the necessary thresholds will receive a yearly bonus of \$80 for each of their diabetic patients covered by one of the participating employers.

**CMS/Premier Hospital Quality Incentive Demonstration Project.** This three-year project was launched in 2003 to provide financial rewards and public recognition to hospitals that demonstrate high-quality performance in a number of areas of acute care. For each clinical area, hospitals in the top decile receive a 2 percent quality incentive payment on their base Medicare DRG payment for the relevant clinical condition(s); those in the second decile will receive a 1 percent quality incentive payment.

**Integrated Healthcare Association.** Unveiled in 2002, the IHA initiative is a collaborative of six health plans in California that rewards physician groups for clinical achievements, information technology, and patient satisfaction. Common performance measures are used, but each plan uses the results to design its own bonus program.

Kim Streit, vice president of healthcare research and information for the Florida Hospital Association, also stresses the importance of widespread education. “Everyone needs to understand what is being reported, how the data are being used, and how to make sure the information is captured clearly in the medical record,” says Streit. “It’s not only the responsibility of coders, it’s the HIM professionals, and even the physician community.”

Helping stakeholders develop this foundation of knowledge is an easier task now that many definitions and specifications have been standardized. While it is still not easy, the industry has definitely come a long way, according to Denise Remus, PhD, RN, vice president, clinical informatics for Premier Inc. “Different definitions were a real problem,” she recalls of the start of the CMS/Premier pay-for-performance demonstration project. “When we got started, we would direct hospitals with questions to their local Quality Improvement Organization, and we would find that hospitals would get different answers to the same question, which created a lot of confusion. Now communications are centralized and hospitals in the demonstration work with one QIO.”

**Gain confidence in the data.** It goes without saying that accurate coding is essential for meaningful data reporting. When California implemented use of present on admission indicators in 1996, an early study showed problems with the quality of the information being provided. Staff from California’s Office of Statewide Health Planning and Development worked with hospitals to improve their coding. As a result, later years of California data show excellent face validity for present on admission indicators.

New York faced similar challenges during its early years of using present on admission indicators. Researchers largely ignored the state’s efforts at reporting the information because coding inaccuracies were widely recognized. Recently, New York has worked to improve confidence in the data by communicating value of accuracy to hospitals and coders and providing training on proper use.

Also key to gaining confidence in data is to make sure hospital staff verify and validate data once they are submitted.

Data submitted to the Hospital Compare web site is reviewable by hospitals, and it is recommended hospitals take advantage of the opportunity. In Massachusetts, where data have been submitted to the state since 2000, officials learned early that hospitals must be comfortable with the information they provide. “It’s important to make sure that we have a transparency that’s actually transparent,” says Joe Kirkpatrick, vice president of healthcare finance at the Massachusetts Hospital Association. “Hospitals need to have the opportunity to find inaccuracies and then report them and correct them. If it’s difficult for them to retrieve their information and make necessary corrections, then that’s a concern.”

**Get clinicians on board.** Neither California nor New York experienced serious opposition to the collection of present on admission data by their hospitals.<sup>9</sup> Such experience bodes well for implementation of the indicator on a broad scale. However, getting clinical staff to get on board remains a challenge. Goldstein says that clinician “buy-in” is one critical component of evaluating how well a hospital is enacting a quality agenda.

Others agree, improvements truly require team support. “At one time, quality was a one- or two-person department assessing performance and gathering information for accreditation,” Merryweather says. “Now, quality is everything and everyone within a hospital. It’s everyone’s role.”

That includes physicians. “I expect data quality will be tied to physicians’ payment pretty soon,” says Streit with the Florida Hospital Association. “It would be in their best interests to make sure they’re reporting properly.”

**Dedicate resources.** If you haven’t already done so, prepare yourself for a serious information technology investment. “We view IT as a real tool, an enabler to improving processes, data collection, and data mining,” says Moody’s Goldstein.

**Avoid duplication.** Is your state asking for data that also are requested by the Joint Commission? Are your health plans on the same page as Hospital Compare? Given the way specifications and definitions can vary, it’s important to limit your organization’s reporting burden when possible by avoiding duplication of efforts.

Streit recalls how Florida’s recent reporting efforts hit a snag when the National Uniform Billing Committee and the American National Standards Institute developed reporting specifications that were different than those the state had been considering. “It’s so important to have national standards,” she says. “If you have consensus on the measures, it takes away the need for hospitals to define them and make sure that they’re consistent with CMS and Joint Commission definitions.”

Massachusetts faced a similar challenge when the state legislature, the hospitals, and the governor all imposed their own reporting systems, says Kirkpatrick. “There seems to be this feeling amongst many of those in the industry that they want to just jump off and do something quickly, and then talk to people later,” he says. It took multiple meetings among the various parties to avoid costly duplicative efforts. Kirkpatrick’s message: “Get your agenda consistent with the national agenda.”

**Be prepared to shift gears.** Want to see frustration on the face of a quality officer? Just say “ACE-ARB,” and watch the eyes roll. The use of angiotensin-converting enzyme inhibitors as front-line treatment for heart attack and heart failure was commonly accepted, so much so that it became a consensus performance measurement—until new evidence emerged in 2004 that angiotensin receptor blocker drugs (ARBs) would be more appropriate in some instances. It took months for the performance measurement community to catch up.



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<sup>9</sup> www.hcup-us.ahrq.gov/reports/2006\_1.pdf.

Every organization will hit these kinds of roadblocks. How well the organization will respond often comes down to a matter of mindset. "Willingness to stop midstream so you can review against checkpoints is critical," Moody's Goldstein says. Goldstein advises monitoring progress at regular intervals and constantly re-evaluating strategies and tactics rather than taking a "race to the finish line" philosophy.

A willingness to be flexible has served the CMS/Premier pay-for-performance demonstration project administrators well. In the first year of the demonstration, officials decided to suppress one measure: use of internal mammary artery for coronary artery bypass graft. The decision came after examination based on the feedback of participating hospitals revealed that the published measure definition was not completely accurate and was improperly including some patients with a history of a prior CABG, who should have been excluded. Further analysis of results also revealed that the decile method of rewards was effective in driving improvement but created a situation where hospitals made major improvements but would never fall into the top 20 percent. Additionally, with all hospitals improving, the difference between decile thresholds was narrowing and the differentiation among performers in top tiers and those in adjacent deciles was statistically not meaningful.



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**Keep your end goal in sight.** It's easy to feel overwhelmed by all of the complexities and requirements associated with a comprehensive data-reporting process. And with incentive structures in a seemingly constant state of flux, healthcare executives may be tempted to shift priorities toward initiatives with more immediate or tangible payoffs.

However, it's important at these times for leadership to bear in mind the strategic significance of their organization's effectiveness at accurate data recording and reporting. As Roger Goodman, an assistant vice president on the healthcare ratings team at Moody's Investors Service, notes, "If we meet with a hospital's management team and we get a sense that they're doing nothing with quality, and everyone around them is, in the long term that's a real competitive issue."

# 3M

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