Eliminating Hospital-Acquired Conditions

THEY ARE BAD FOR PATIENTS AND, UNDER THE TERMS OF THE MARYLAND MEDICARE WAIVER, BAD FOR THE BOTTOM LINE.

Called to manage inpatients with fever, internist and infectious diseases specialist Khalil Ghanem saw that catheter-associated urinary tract infections (CAUTIs) were being overdiagnosed. That was bad for the patients who were receiving inappropriate antibiotic treatment. And it was bad for Johns Hopkins Bayview Medical Center, because hospital-acquired conditions, such as CAUTIs, are tracked as a quality measure.

CAUTIs are one of 61 conditions composing the Maryland Hospital Acquired Conditions (MHAC) list. Hospitals in the state receive an annual MHAC score that carries with it the possibility of financial penalty or reward.

So Ghanem conducted Grand Rounds about correctly diagnosing CAUTIs. His efforts and those of his colleagues contributed to Johns Hopkins Bayview’s improving its MHAC score by 41 percent from 2013 to 2014. As a result, the hospital will receive a $1.3 million reward from the state.

“We have a spirit here of getting it right for the patient. When people do that, MHACs drop,” says Charles Reuland, Johns Hopkins Bayview’s executive vice president and chief operating officer.

MHACs and the Maryland Medicare Waiver

The MHAC program, instituted in 2009, was revised in 2014 when it was linked with the Maryland Medicare waiver as one of its quality measures. Under the terms of the waiver, Maryland hospitals must show a 7 percent annual reduction in their MHAC scores, for a cumulative five-year reduction of 30 percent. Financial penalties await hospitals that fail to reach those goals. If Maryland hospitals do not meet this performance test, they may be subject to national quality performance standards. Furthermore, if Maryland hospitals

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New Initiative Opens Access

SUSDR, OR SPECIALTY URGENT SAME-DAY RESPONSE, AIMS TO GET PATIENTS IN TO SEE A SPECIALIST BEFORE THEIR CONDITIONS ESCALATE.

When James Ficke joined Johns Hopkins a year and a half ago as director of orthopaedic surgery, patients with orthopaedic issues might have had to wait weeks to get in to see a specialist. Some likely went to other physicians or wound up in the Emergency Department (ED), he says.

Now things have changed. In addition to efforts Ficke has led within the department to open access, the Department of Orthopaedic Surgery is one of the first to have signed on for a new Johns Hopkins program called Specialty Urgent Same-Day Response, or SUSDR. Through this initiative, patients with urgent orthopaedic issues who are enrolled in the Johns Hopkins Medicine Alliance for Patients (JMAP), a Medicare accountable care organization, can be referred to Johns Hopkins orthopaedic surgeons through a dedicated telephone line. Typically, they are then seen within a couple of days, with an appointment in one day the goal.

Department representatives have seen a range of conditions, Ficke says, including sports-related knee injuries, urgent hand injuries, spine issues, and foot and ankle problems. Every physician assistant, nurse practitioner and surgeon on staff now keeps a timestamped open during each clinic for SUSDR referrals at all Johns Hopkins locations.

“We have definitely opened space to be able to see these patients,” he says. “It’s uniformly been positive.” Some 70 percent of issues drive patients to emergency departments are musculoskeletal in nature, Ficke says. “We want to capture that and be able to support our patients here.”

The departments of Ophthalmology and Urology also have been participating in the SUSDR initiative. The divisions of Gastroenterology and Hepatology, and the departments of Surgery, Dermatology, and Otolaryngology—Head and Neck Surgery go live July 1.

Phone calls are triaged by a registered nurse, who confirms the urgent nature of the patient complaint and notifies the specialty department, which then contacts the patient to schedule an appointment. The SUSDR line then follows up with referring physicians to confirm that an urgent appointment has been scheduled, and specialists complete clinical documentation within seven days. For now, the service is primarily for JMAP patients, with some departments accepting additional patients.

The idea, says internist John Flynn, vice president of the Office of Johns Hopkins Physicians and executive director of the Clinical Practice Association, is to refer patients to SUSDR rather than wait until the patient has an emergency that requires an ED visit, driving up medical costs. “We’re working as a health system to provide the right care at the right time and prevent unnecessary escalation.” The fact that the departments are listening and signing on, he says, “is a result of many clinical leaders like Dr. Ficke bringing about a remarkable change in our culture.”

—Karen Blum

do not meet the MHAC and other targets, the Centers for Medicare and Medicaid Services may not extend the waiver past 2018, when its current term expires. The Medicare waiver offers distinct advantages to Marylanders, such as the lowest markup of hospital rates in the U.S.

MHACs are divided into three categories according to their volume and cost. The first tier consists of 20 high-volume, high-cost MHACs, such as CAUTIs, venous thrombosis and septicemia. Less costly and less frequent conditions compose tiers two and three. The Health Services Cost Review Commission, which oversees hospitals in Maryland, understands that a certain number of hospital-acquired conditions are likely and takes this into account when calculating scores. It weights the 20 tier-one conditions more heavily than conditions in tiers two and three.

A hospital’s performance in calendar year 2014 affects its fiscal year 2016 revenue. If all hospitals in the state achieve at least 7 percent improvement in 2014, the highest-performing hospitals earn a reward equal to 0.5 percent of fiscal year 2016 revenue. That is the case with Johns Hopkins Bayview. Its performance in calendar year 2014 will earn it a $1.3 million bonus for fiscal year 2016. If Maryland hospitals in aggregate fail to meet the 8 percent target, no hospital is rewarded, and penalties can be as great as 3 percent.

“It was genius of the state to link hospitals’ performance. Hospitals are incentivized to work together to impact the well-being and health of all patients across the state. We want the highest-quality care in the nation,” says Renee Demski, vice president for quality at Johns Hopkins Medicine.

All Johns Hopkins Medicine hospitals in Maryland exceeded the 7 percent annual target for 2014. The Johns Hopkins Hospital reduced its MHACs by 37 percent, Howard County General Hospital by 35 percent and Suburban Hospital by 27 percent. Johns Hopkins Bayview, however, was the only Johns Hopkins hospital whose score qualified it for a bonus.

Furthing the Effort

Johns Hopkins Medicine will continue to lower its hospitals’ MHAC scores by focusing on documentation, coding and clinical improvement. Carol Ware, quality improvement team leader for The Johns Hopkins Hospital, estimates that about 80 percent of MHAC improvement is due to better documentation of pre-existing conditions and more accurate coding. She is a member of the MHAC task force that Demski formed in mid-2013. It includes coders, clinical documentation experts, colleagues from finance and other quality improvement specialists who meet once a week to review all MHACs.

A similar task force exists at Johns Hopkins Bayview. “We have really approached this from an interdisciplinary perspective and a preventive perspective. We ask, ‘What patterns do I see in the records?’ Then we put processes and systems in place to prevent those things from happening,” says nurse Lisa Grubb, director of quality management for the medical center.

For example, Grubb cites efforts to remove catheters as soon as possible. “I have a list of patients with catheters that I send every day to patient care managers, who assess whether they can come out,” she says. “We know the longer a catheter is in, the more risk of a CAUTI. We’re preventing them from occurring.”

—Christina DuVernay