

A \$330 Million Risk: What Boards Should Know About New Medicare Penalties for Hospital Errors

by Rodney F. Hochman, MD

Hundreds of hospitals are likely to be hit with new Medicare penalties for patient injuries under the Hospital-Acquired Condition (HAC) Reduction Program, according to a preliminary assessment released by the Centers for Medicare & Medicaid Services (CMS) earlier this year.

Starting in October, hospitals with the highest rates of certain complications will face sanctions estimated to total \$330 million in fiscal year (FY) 2015 under the new program. The preliminary assessment suggests that on average, each penalized hospital stands to lose nearly \$434,000 in Medicare reimbursements. However, large hospital systems and those with a high volume of Medicare payments could face much greater losses if they provide unsafe care.

In this environment, governing boards need to understand how the new penalty program works as well as the drivers of quality, safety and costs in their organizations. Only with such knowledge can trustees play a meaningful role in helping their hospitals make a successful transition from volume-based to value-based care, while reducing the risk of incurring severe financial penalties.

Which Hospitals Are in the Penalty Zone?

In the preliminary assessment, Medicare identified 761 hospitals at risk for reimbursement cuts in FY 2015, based on an important new metric of safety and quality of care trustees need to understand: their facility's HAC score.

Scores are calculated on a scale of one to 10, according to each hospital's rates of infections and eight other serious complications, including accidental puncture and collapse of a patient's lung (iatrogenic pneumothorax) during medical treatment, and central venous catheterization, a procedure performed more than 5 million times a year in U.S. hospitals. (For more information on the safety and quality measures used in penalty assessments, see "At a Glance: Medicare's New HAC Reduction Program" on page 4.)

In CMS's preliminary assessment, hospitals with a HAC score above seven will be docked one percent of their Medicare reimbursements across all diagnosis-related groups in FY 2015. However, some facilities may avoid sanctions after an additional year of performance data is factored into the final assessments to be released later this year. (To download a spreadsheet of the 761 hospitals at risk for sanctions, visit <http://www.kaiserhealthnews.org/Stories/2014/June/23/patient-injuries-hospitals-most-likely-to-be-penalized.aspx>.)

Certain types of hospitals are at particularly high risk for incurring penalties, Harvard School of Public Health researchers reported in an analysis of CMS's preliminary penalty assessments prepared for *Kaiser Health News*. Among the most startling disparities in hospitals' relative risk for sanctions are the following identified by the research team:

- Compared to non-teaching hospitals, major teaching hospitals are nearly three times more likely to be penalized.
- Large hospitals have more than double the penalty risk of small facilities.
- Urban hospitals are nearly twice as likely to be penalized as their rural counterparts.
- Hospitals serving the highest proportion of low-income patients have a 50 percent higher risk of being penalized, compared to hospitals with the lowest proportion.
- Public hospitals are 40 percent more likely to be sanctioned than for-profit facilities

(More findings from the Harvard analysis of penalty risk appear in the chart on page 2, "Some Types of Hospitals Hit Harder.")

Eliminating Million-Dollar Mistakes

While the prevailing belief in medicine has long been that a certain level of errors is unavoidable, the new penalty program challenges hospitals and their boards to make health care as safe as Qantas Airlines, which hasn't had a fatal crash since 1951, or the U.S. Navy's nuclear submarine fleet, which has never had

a reactor accident. "We want [hospitals] laser-focused on eliminating patient harm," said Dr. Patrick Conway, Chief Medical Officer of CMS.

If eliminating HACs sounds impossible, consider the following example: In a randomized study of 900 critical care patients, real-time ultrasound-guided central venous catheterization (CVC) of the internal jugular vein reduced rates of pneumothorax to zero, compared to a rate of 2.4 percent when traditional "blind" techniques based on anatomical landmarks were employed.

The study also reported the following outcomes:

- A 100 percent success rate with ultrasound-guided CVC placement, compared to 94.4 percent in the landmark group.
- A 0.6 percent rate of hematoma with ultrasound, versus 8.4 percent without it.
- A 1.1 percent rate of accidental carotid artery puncture with ultrasound, versus 10.6 percent when landmark methods were used.
- Significantly reduced blood-vessel access time and rates of CVC-associated bloodstream infection and increased first-pass success with ultrasound guidance.

Indeed, evidence of ultrasound guidance's safety benefits from multiple studies is so robust that many leading hospitals now mandate it for all CVCs, based on related guidelines from medical societies, including the American Board of Internal Medicine, American Society of Anesthesiologists, American College of Chest Physicians, National Institute of Health and Clinical Excellence and many others.

Ultrasound visualization also can help hospitals avoid financial risks. A 2011 study published in *Health Affairs* found that of all the medical errors studied, collapsed lung is one of the most expensive, costing the U.S. health care system \$580 million in 2008. This potentially life-threatening complication can add four to seven days to the patient's

hospital stay and increase costs by up to \$45,000, according to a study by the Agency for Healthcare Research and Quality (AHRQ).

The cost of CVC-associated injuries can soar far higher if the patient sues, however. An analysis of closed malpractice claims found that these HACs "had a higher severity of injury, with an increased proportion of death (47 percent)," compared to other types of claims for patient injuries (29 percent). Payments for all CVC claims—such as blood vessel injuries, pulmonary artery rupture, air embolism and collapsed lung—ranged as high as \$6.9 million, the researchers reported.

Understanding the impact of CVC-related injuries played a key role in one system's efforts to improve patient outcomes and lower costs—with leadership and support from its governing board.

A Success Story of Board Involvement in Safety Improvements

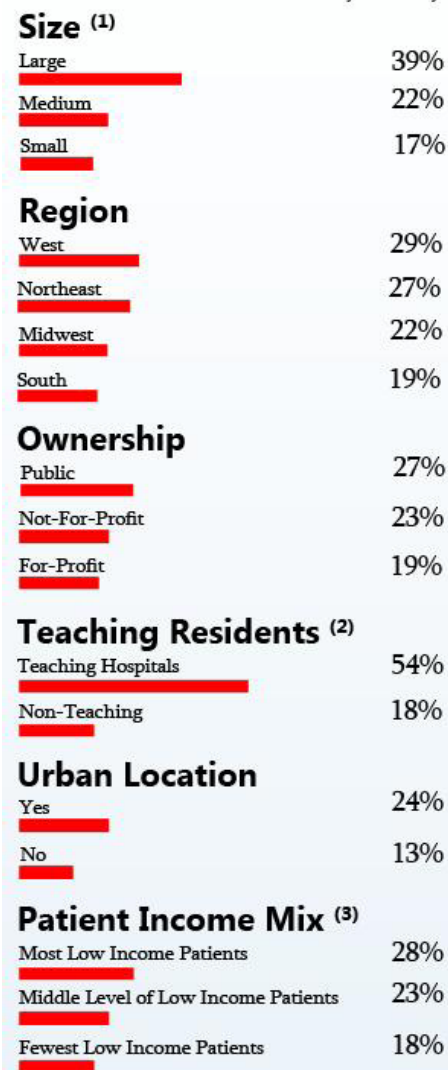
Memorial Hermann Healthcare System comprises 12 hospitals that collectively treat more than 138,000 inpatients and provide emergency department (ED) care to more than 411,000 patients annually. After the system adopted ultrasound-guided CVC as its standard of care as part of its "High Reliability: Journey from Board to Bedside Initiative," several of its hospitals and EDs achieved an unprecedented rate of zero pneumothorax for one year or longer.

As the name of this safety initiative suggests, it began with support and involvement of Memorial Hermann's governing board, said the health care system's chief medical officer, M. Michael Shabot, MD. "Our board members are learning along with us," he said, adding that trustees attend safety and quality conferences and take courses on how to improve patient safety.

The Board to Bedside Initiative began when its leadership realized the improvement was essential. "To be honest, the high-reliability program grew out of a series of adverse events

Some Types Of Hospitals Hit Harder

Percent of Hospitals With Preliminary Penalty



Footnotes:

(1) Small hospitals <100 beds; medium hospitals between 100 and 399 beds; large hospitals ≥ 400 beds.

(2) Teaching hospitals are members of the Council of Teaching Hospitals and Health Systems (COTH) of the Association of American Medical Colleges. Non-COTH hospitals with medical school affiliations were omitted from the analysis.

(3) Based on a Medicare index that reflects the prevalence of admitted patients who qualify for Medicaid or Medicare Supplemental Security Income. Hospitals were divided into the top and bottom quartiles and middle 50 percent.

Source: Dr. Ashish K. Jha and Jie Zheng
Harvard School of Public Health

Andrew Villegas/Kaiser Health News

Chart provided by Kaiser Health News.

that occurred in 2006," Dr. Shabot explained in a paper published in *Infection Control & Clinical Quality*. "There was a need to totally change the approach

to safety and quality in the health care system,” with measures that included:

- Making patient safety the system’s sole core value.
- Retraining all employees in how to perform their jobs safely, using lessons from leaders in high-reliability industries, such as airline pilots and nuclear engineers.
- Employing root cause analysis of medical errors, using the “Five Whys” technique developed by Sakichi Toyota, founder of Toyota Industries, to expose system problems. The technique involves asking, “Why?” at least five times to delve into underlying causes of an error.
- Rewarding success with awards presented to hospitals that have gone 12 or more months without such adverse events as pneumothorax, falls with injuries and bloodstream infections.
- Using safety checklists and best practices bundles to guard against HACs.

Best Safety Practices to Prevent Bloodstream Infections

Using a bundle of best practices has helped 353-bed White Memorial Hospital, part of the Adventist Health System in Los Angeles, eliminate two of the serious complications used to determine penalties under Medicare’s HAC Reduction Program: pneumothorax and central line-associated bloodstream infections (CLABSIs). Both conditions are now included on AHRQ’s list of patient safety indicators.

On any given day, about one in 25 hospitalized patients in the U.S. are battling at least one hospital-acquired infection (HAI)—and each year, about 75,000 of these patients die during their hospital stay, according to a recent report by the Centers for Disease Control (CDC). Device-associated and surgical-site infections account for nearly half of all HAIs, with infections stemming from CVCs (also known as central lines) causing death rates ranging from 12 to 25 percent.

practices that collectively result in better outcomes, ranging from hand hygiene to maximum barrier precautions upon central line insertion and daily review of the continued need for CVC.

Now there’s a growing movement to add ultrasound-guided central-line placement as a sixth component of the bundle. Hospitals that have adopted the approach, including Cedars-Sinai Medical Center in Los Angeles, have seen striking reductions in CLABSIs. White Memorial was able to achieve a rate of zero between January 2010 and August 2011.

The lesson learned is that with a true commitment to excellence that includes proven safety practices, the right technology and the involvement of the entire hospital—including its board, leadership and physicians—it really is possible for medical providers to do no harm.

Editor’s Note: For additional resources on HAC prevention see the circle to the left. For actions boards can take to address the impact of HACs and other patient safety issues see “Six Ways for Hospital Boards to Improve Safety” on page 4.

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HAC Prevention Resources

The government, medical organizations and some manufacturers have developed evidence-based toolkits, safety bundles and other protocols to help prevent hospital errors, including these:

- The CDC’s toolkit of CAUTI prevention tactics is online at http://www.cdc.gov/HAI/pdfs/toolkits/CAUTIToolkit_3_10.pdf.
- CMS downloadable report on evidence-based protocols to prevent falls, pressure ulcers and nine other HACs is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/Evidence-Based-Guidelines.pdf>.
- For details on implementing the Institute for Healthcare Improvement’s central line bundle, as well as improvement stories, case studies and whitepapers, visit <http://www.ihl.org/resources/Pages/Changes/ImplementtheCentralLineBundle.aspx>.
- The SonoSite Solution for Safer Central Venous Catheter Insertion provides consensus and evidence papers, practice guidelines, training videos, a downloadable iBook and more. Visit <http://www.sonositesolutions.com>.

CLABSIs are both expensive—increasing length of hospital stay by a mean of seven days with excess costs estimated to be up to \$29,000 per bloodstream infection—and dangerous, with mortality rates reported between 12 and 25 percent. However, a 2014 study published in the *New England Journal of Medicine* reports impressive success in preventing CLABSIs.

For example, the Institute for Healthcare Improvement has designed an evidence-based bundle of five safety

At a Glance: Medicare's New HAC Reduction Program

For FY 2015, Medicare is assessing hospitals' performance in two domains, based on three measures used to calculate HAC scores on a scale of one to 10, according to a hospital's national percentile ranking. A score of one indicates the best performance and 10, the worst. In FY 2016 and 2017, Medicare will add more measures to this list:

Domain 1: AHRQ (Agency for Healthcare Quality and Research) Patient Safety Indicators.

This composite measure is based on rates of these major, but potentially preventable complications from in-patient hospital care or medical procedures:

- Pressure ulcers (bed sores)
- Collapsed lung resulting from medical treatment (iatrogenic pneumothorax)

- Broken hip from a fall after surgery
- Blood clot in the lung (pulmonary embolism) or a deep vein (deep vein thrombosis) after surgery
- Bloodstream infection after surgery (postoperative sepsis)
- A wound that splits open after surgery
- Central line-associated bloodstream infection
- Accidental punctures or lacerations.

Domain 2: CDC Prevention National Healthcare Safety Network (PHSN) Measures.

This domain consists of rates of two types of dangerous infections that can significantly increase both length of stay and hospital cost, compiled by the CDC through the PHSN:

- Central Line-associated Bloodstream Infections (CLABSI)
- Catheter-Associated Urinary Tract Infections (CAUTIs).

How penalties are determined: A hospital's HAC score is ranked with those of other hospitals to identify the lowest performing 25 percent, which will be penalized with a one percent cut in Medicare reimbursements in FY 2015. HAC penalty adjustments are made after payment cuts (if any) have been calculated and made under Medicare's other two penalty programs: the Value-based Purchasing and Readmission Reduction Programs.

For more information on the HAC Reduction Program, visit http://www.stratishealth.org/documents/HAC_fact_sheet.pdf.

Six Ways for Hospital Boards to Improve Safety

Almost every governing board already has made a commitment to improving the quality and safety of care, but these key governance and leadership activities can play an important role in achieving measurable results and better patient outcomes:

1. **Find out your facility or system's HAC score.** How does it compare to other hospitals in your city, state and nationally? If your system has incurred a penalty for patient injuries, which HACs account for its poor performance?
2. **Collect data and listen to stories.** To put a human face on medical harm, the full board should consider talking to patients, or families of patients, who have recently suffered serious HACs, such as a pneumothorax or central-line associated bloodstream infection. As the first agenda item at each board meeting, review HAC rates and how they compare to prior periods.
3. **Set big-picture goals to reduce harm.** Memorial Hermann Healthcare System's boards and leadership decided their mission was to "make every day a safe day for patients" by aiming to reduce rates of serious adverse events to zero.
4. **Identify and monitor system-wide safety measures.** Are all of the hospitals and departments in the system using the same safety practices? It's essential to have one standard of excellent care whether the patient is treated in the emergency department, the operating room or the intensive care unit at any of the hospitals in the system.
5. **Learn from mistakes . . . and successes.** To improve outcomes, it's crucial to establish and maintain an environment in which physicians and staff can disclose errors soon after they occur and discuss as a group steps to avoid adverse outcomes in the future. Boards should ask executives and physician leaders: "If rates of a certain error have dropped, what measures explain the improvement and how can they be reinforced to sustain progress?"
6. **Ask tough questions and get answers.** Trustees shouldn't accept facile explanations, such as "It's normal for some patients to get central-line associated bloodstream infections in the critical care unit because these are the sickest people in the hospital." Use this article as a springboard for discussion about what can be done to get such rates to zero.

The Shared Governance Imperative

by Pam Knecht

Just as the health industry continues to shift care delivery from a volume- to a value-based model, so too must the health care board evolve beyond its traditional fiduciary and core governance responsibilities to encompass a more strategic and global view. The success of this evolving model depends on shared governance—a stronger alignment and engagement among the board, physician leadership and management.

Health system leaders and their boards must determine how to best move from fragmented to coordinated care, going beyond treating individual patients to providing care for patient populations, and shifting from payer-driven managed care to provider-driven accountable care. In other words, they must chart a course for becoming clinically and fiscally accountable for the entire continuum of care that their patient population may need.

None of these new goals replaces the board's fundamental responsibilities, however, which include: ensuring competent management, as well as clinical quality, service and safety; advocating for those served and the organization; perpetuating effective governance; protecting the financial health of the organization; and setting strategic direction—all of which must tie back to the hospital's core mission, which the board is further charged with developing, overseeing and maintaining.

In addition to understanding and carrying out their basic oversight duties, boards need to maintain clarity around the distinction between their roles and those of the C-suite. While it is the responsibility of governance to set organizational goals, make major policy and strategy decisions and oversee their implementation, management's job is to deliver results by implementing those policies and strategies, as well as managing operations and reporting on performance.

Nevertheless, a fundamental shift is occurring within that dynamic. As part of the board's "new" work, trustees, management and physicians must collaborate more closely to discover and solve the most important issues facing the organization, while still maintaining the governance/management distinction. This is the essence of shared governance, particularly in the environment of fundamental change now facing health care organizations.

Creating New Relationship Definitions

As a foundation for this new model, the board must ensure that physicians are adequately prepared for participating in shared governance at the board level and for other organizational leadership roles (e.g., educating physicians about the difference between management and governance). In addition, the CEO and board (including the physician board members) must envision and define their desired relationship. This process could evolve as follows:

- The board and CEO agree on a governance "philosophy," or the desired interaction between the board and the CEO.
- They reach agreement on the board's overall roles and responsibilities and then create an "authority matrix."
- Agreements are recorded in formal board policies and procedures.
- The board and the CEO jointly develop written job descriptions for themselves and communicate regularly about mutual expectations and how they are being fulfilled.
- The board continues to evaluate the CEO's performance at least annually and sets goals for the CEO's and the organization's performance.
- The board requires a written succession plan for the CEO and his/her direct reports.

- The board continues to hold the CEO accountable for performance.

These elements suggest an evolving model of the board providing leadership, *along with* management and physicians. Within this model, there are three modes of governance—fiduciary, strategic and generative—each with its own distinctive traits.

The fiduciary governance mode comprises the traditional trustee roles of maintaining stewardship of the organization's tangible assets and faithfulness to the organization's mission, as well as performance accountability and compliance with relevant laws and regulations. The board's role in this context might be seen as one of policing, or making good faith efforts to ensure the organization does not engage in wrongdoing. The strategic governance mode moves past policing to planning, in which the board helps set the organization's course and priorities and deploys resources accordingly, working in strategic partnership with management. Finally, the evolving generative governance mode involves envisioning, becoming a source of broader thought leadership for the organization. In this mode, the board discerns and frames problems and works to make sense of them, in effect helping to determine what questions the organization should ask of itself to prepare for the future.

Although the board's strategic mode may still seem fairly traditional, trustees must now have a significantly more thorough understanding of the current situation, proposed organizational strategies and the potential impact of those plans on performance in key areas, such as finance and quality. The board's first task in this more prominent role should be to undertake an assessment of the political, economic, social and technological challenges and opportunities within the current health care landscape. The assessment should result in

continued on page 6

leadership declaring its “point of view” regarding what the external environment will (and will not) look like (e.g., will all hospitals have risk-based contracts). The board should also have candid discussions about stakeholder perceptions, patient satisfaction and its financial and quality performance. Physicians and community board members can often provide valuable insight into such areas as current market share, potential competitors and increased payer (e.g., employer) demands.

At the end of the strategic process, the board, physician leaders and senior management should agree on the unique, critical strategic issues facing their organization over the next three to five years. Strategic (versus operational) concerns can be defined as those that require significant resources and a longer-term decision-making timeframe, and that have a wide-ranging impact on key stakeholders and/or the organization’s viability. Current examples of strategic issues might include participating in insurance exchanges, matching financial performance with Medicare reimbursement levels and overseeing physician-led care redesign, among others.

The Next Wave: Generative Governance

Boards cannot attain the next evolutionary level of generative governance without first understanding and implement-

Practicing Strategic and Generative Governance

- **Set clear principles and expectations.** This should include an agreement that the board, physician leaders and management will act as partners and engage in out-of-the-box, generative thinking in their interactions.
- **Calendar rigorously.** Ensure that there is a strategic/generative topic for each board meeting as part of the annual board meeting schedule.
- **Develop carefully crafted agendas and targeted materials.** Insist on governance-level preparation materials and create “framing questions” for each agenda topic.
- **Dedicate discussion time.** Each time the board meets (e.g., monthly meetings, education sessions and annual retreats), a significant amount of time should be devoted to discussion rather than presentation.
- **Align board and committee composition.** Envision, design and structure complementary competencies, skills and perspectives.
- **Prioritize continuous education.** Provide complete initial orientation and active mentoring, as well as establishing annual board and committee education plans.
- **Ensure prepared board leadership.** These activities ensure the perpetuity of the strategic and generative shared governance model through: developing board leaders and thinking through succession planning; creating clear leadership position descriptions, including competencies and qualifications; identifying, developing, nominating and selecting organizational leaders; providing individualized leader orientation, education and evaluation.
- **Conduct consistent board evaluation and goal-setting.** This should be done at each meeting as well as annually, at both the board and committee levels.

ing enhanced strategic governance. The board and the organization’s executive and physician leaders should work together to define the future state and determine what priority actions will allow them to attain that desired state. From these conversations, the board can move to a more generative governance mode by asking such global questions as, “What problems are we solving?” In other words, the board, managers and physician leaders should transition from asking a question such as, “How do we increase our focus on patient care?” to discussing, “What is our core purpose (e.g., patient care or population health)?” This takes governance from a

performance mindset to a more expansive one, envisioning its place in the future of health care.

Once understood, strategic and generative governance go hand in hand, and can be pursued concurrently. The board might proceed as outlined in the box to the left.

The ultimate aim of the shared governance model is to create a culture of engagement in which trustees, physician leaders and the C-suite trust and challenge one another, engaging directly on the big-picture issues that matter most to the organization’s current and future success. To create that trust and meet the challenge, board members must commit themselves to a full understanding of the ongoing, accelerating changes occurring in the health care industry. Like health care

itself, governance must be a nimble, adaptable, living organism, aligning its purpose with its organization’s role in the rapidly evolving health care landscape.

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Editor’s Note: AHA’s Great Boards would like to welcome Pam Knecht as a regular contributor to the Great Boards newsletter.