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4 Strategies to Encourage Evidence-Based Medicine in Hospitals

By Sabrina Rodak

Evidence-based medicine is a key component in reaching healthcare reform's goals of higher quality and lower costs. CMS' proposed rules for accountable care organizations, for example, include a requirement to set up a process for promoting evidence-based medicine. However, it has been widely reported that only approximately 15 percent of medicine is based on evidence. Jeffrey S. Rose, MD, vice president of clinical excellence and informatics at St. Louis-based Ascension

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The Valued Partner: Q&A With Catholic Health Initiatives CMO Dr. Stephen Moore

By Molly Gamble

The country's increased focus on high-quality but cost-effective care is setting off a sea change in the healthcare industry. Pushed to be more conscious of prices and efficiency, more physicians are adopting team-based approaches to care and seeking business degrees. The traditional relationship between hospital CEOs and CMOs is also evolving, as the two work more closely to trim costs without interfering with quality of care.

continued on page 5

Study: Medical Homes Only Bring Modest Improvements in Quality, Satisfaction

By Jaimie Oh

Researchers have suggested that the transformation of primary care clinics into medical homes may yield only modest improvements in healthcare quality and patient experience, according to a study published in the *Annals of Family Medicine*.

For their study, the researchers assessed quality and patient experience outcomes among 21 Minnesota primary care clinics that are attempting to achieve level III recognition as medical homes by the National Committee for Quality Assurance. These clinics have been collecting data on these metrics for an undisclosed number of years. Researchers used this data to compare this group of primary care clinics to other groups in the community.

The results of their analysis showed that the 21 primary care clinics achieved a modest 1-3 percent increase each year in patient satisfaction. The clinics also experienced a 2-7 percent increase per year for performance on quality measures for diabetes, coronary artery disease, preventive services and generic medication use. When compared to other primary care groups in the community, rates for quality improvement were similar for both groups, though the 21 primary groups achieved a greater increase in patient satisfaction.

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4 Strategies to Encourage Evidence-Based Medicine in Hospitals
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Health, discusses four ways hospitals can encourage the use of evidence-based medicine to increase the quality of care, patient safety and savings.

Where's the evidence?

Evidence of effective medicine comes in two forms, Dr. Rose says: One is scientific evidence, either from double-blind randomized clinical trials or literature research reviews; the second is experiential evidence, practices that physicians have judged effective through their treatment of patients. "To practice current, good, informed care, you need to access both those sources of evidence," Dr. Rose says.

There are several reasons for the low rate of adherence to evidence-based medicine, one of which is unawareness of the evidence for or against a certain practice. "One of the biggest myths is that doctors can keep up [with the evidence], even if they're in a narrow field of practice," Dr. Rose says. For example, Dr. Rose says it has been routine to put patients with hypertension on a low-salt diet, but recently people have revisited the literature and found there is little evidence for the effectiveness of the practice. He attributes this inability to stay current with the literature to the "explosion of information" and the difficulty of gauging the quality of the information being published.

Other examples of common practices that are not based on evidence include routine ankle X-rays for ankle trauma, chest X-rays prior to anesthesia, antibiotics for upper respiratory viral infections, MRI studies for low back pain and a host of other questionable procedures both in the acute and ambulatory settings, according to Dr. Rose.

On the other hand, many providers may be aware of evolving knowledge but maintain their practices out of habit or because the evidence has not been presented in an effective way. "[When a practice has attained] mythical status, everybody believes what should be done. If you make evidence to the contrary available, at least there is a consideration at the time of treatment rather than 'This is how I always did it,'" Dr. Rose says. Reimbursement also plays a role in the use of evidence-based medicine. "I don't think greed is a factor," Dr. Rose says. "But certainly if you're getting paid for a study that's of no value, you're less likely stop doing it." Conversely, providing evidence and guidance that improve care practices, efficiency or reimbursement is more likely to succeed.

Now, the government is beginning to incentivize evidence-based medicine through healthcare reform measures, and providers may have to change how they practice medicine. "We really are going to have to shift in this new world to be more fluid with our habits and more reliant on what's changing and current and of demonstrable value," Dr. Rose says. Despite incentives, Dr. Rose says there is "resistance to change." Hospital leaders can break down this resistance by presenting solid, relevant evidence in a compassionate and accessible way to change the hospital culture. "Meeting resistance head on with intelligence and compassion and understanding and measuring outcomes is the way you gradually create culture change," Dr. Rose says.

Strategies

1. Present solid evidence. Hospital leaders need to present believable evidence that is relevant to the clinician's practice, Dr. Rose says. "When they [see] one or two pieces of information that are relevant and make a difference, they start to trust the system more." The evidence should be provided by a respected colleague from the group being addressed and tailored to the particular challenges facing that audience. "Direct, accurate peer group-related practice and outcome data speak loudly," he says.

2. Adopt a compassionate approach. Providing scientific evidence alone is not enough to change physicians' behavior; hospital leaders need to adopt a compassionate approach that respects physicians' skills and beliefs. "Unless [physicians] are compassionately presented with evidence contrary to their customs, they are very resistant to change," Dr. Rose says. Instead of singling out physicians for practicing "bad" medicine, leaders should have a conversation with physicians to understand their perspective and reasoning for their current practices, benchmarked against relative peers. In this approach, "People feel part of the system rather than being evaluated by 'Big Brother' for being a bad apple," Dr. Rose says.

Encouraging physicians to practice evidence-based medicine should also focus on patient safety, according to Dr. Rose. "In general clinicians don't respond when the approach is framed as 'a cost issue.' They respond much better to data addressing safety or quality issues, and safer, higher quality practices have been repeatedly shown to improve costs, especially in the evolving reimbursement environment."

3. Include links to information in EHR systems. The hospital's electronic health records should include links to the most current evidence or practice standards so physicians can easily access evidence-based medicine. "The way to make practice better is to present evidence at the point of care while patients are being treated," Dr. Rose says. "This is the best way to provide ongoing, current continuing medical education for your caregivers."

4. Use clinical decision support. Automated clinical decision support is another tool that can help physicians practice evidence-based medicine. This support would produce relevant alerts or reminders when physicians enter choices about a patient's treatment in the EHR. Dr. Rose says companies like Zynx Health compile and "grade" evidence so that the clinical decision support provided is based on the best evidence available. "If you get clinicians comfortable with alerts or reminders coming from a base of evidence that they trust, they change behavior," he says. "The major danger here is to barrage clinicians with alerts or reminders of little relevance in which case they may all be ignored because of 'alert fatigue.'" ■

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The Valued Partner: Q&A With Catholic Health Initiatives CMO Dr. Stephen Moore
(continued from page 1)

Stephen Moore, MD, is senior vice president and CMO at the Englewood, Colo.-based Catholic Health Initiatives, the country's third-largest Catholic healthcare system with 73 hospitals and other facilities in 19 states. Here, Dr. Moore explains how physicians have developed business skills out of necessity, how he stays attuned with CHI physicians and why CMOs have to prove themselves valuable to hospital CEOs right now.

Q: A recent report in the *New York Times* found more physicians across the country are thinking like entrepreneurs and adding an MBA to their title. Have you noticed this trend? How do you think it might change the industry, if at all?

Dr. Moore: I think the *New York Times* is probably about 10 years behind. What we've seen nationwide in physician markets is — as reimbursements declined and pressure began in the mid-90s and accelerated — a lot of physicians were driven to become entrepreneurs around diagnostic perspectives. Many started their own diagnostic centers. Orthopedic surgeons ended up going in on joint ventures or opening their own ambulatory centers.

I think the entrepreneurial [trend] has been going on for a number of years. As the business of medicine is becoming more complex, more physicians are going to earn MBAs. We're also seeing that in the CMO world. Probably 10 years ago, if you were going to have an additional degree, it would more likely be a master's degree in public health rather than business administration.

Q: There has been a much sharper focus on medical team-based care. Do you think that comes naturally to physicians? How can CMOs help their physicians work more collaboratively?

Dr. Moore: I'll give you my idea of what medical team-based care is all about. From a clinical quality and patient safety perspective, there's been more multi-disciplinary team rounding in inpatient services. In the [physician's] office — and again I think it was originally driven by financial issues —we've been seeing more physicians broadening their team. This might be with nurse practitioners, health coaches or leveraging people to much higher levels of their license. We've seen it within the orthopedic community, within the cardiology community and now primary care.

Physicians are looking at multiple different team members to perform patient care tasks. In managed care and HMO programs, more traditionally in California and Florida, we've seen a huge shift to that. I think in a continued traditional fee-for-service community hospital setting, we're still seeing some autonomy issues clearly being expressed by the physicians. But that's wearing away quite a bit as they realize the benefits of multi-disciplinary teams, how they help quality outcomes, [ease] time commitments and are financially necessary.

Q: What's your communication strategy with physicians? How do you stay in-the-loop with their concerns, opinions and ideas?

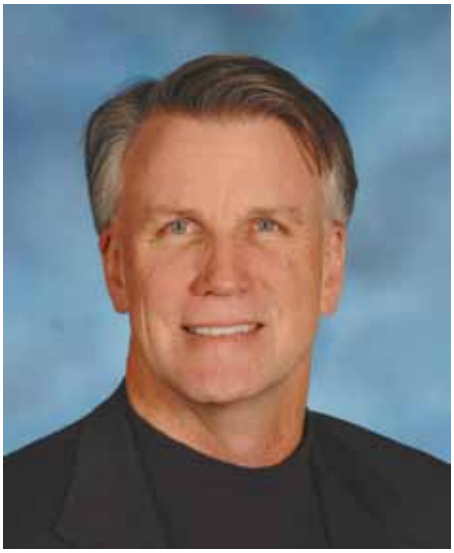
Dr. Moore: I think the answer is multi-dimensional. One of the key things we do within the organization is an annual survey of employed physicians and medical staff physicians. Catholic Health Initiatives is so large that many personal interactions, all the way down to hospital staff levels, are fairly limited.

It starts with the survey process, which gives us a glimpse at how we're viewed by physicians. We'll look at commonalities and put feedback loops and mechanisms into place. We have a physician executive counsel that has more than 25 members. We meet with them on a monthly basis and then face-to-face twice a year. I conduct hour-long, monthly calls with new CMOs at our hospitals for a 12-month period of time. We also have a communications specialist with us in clinical services who is a communication liaison and helps us develop key communication strategies through the CEO, CMO and other leaders of each hospital.

I try to visit 50 percent of facilities on an annual basis for key meetings with physician leadership. Maybe it's attending a medical committee or going to dinner with key physician leaders. It also involves social networking events, like celebratory staff parties and speaking events. I've been here almost three years now so I'm pretty well-known and sometimes invited to local-level events. Most of the folks we need to work through [to reach physicians] are our CMOs and CEOs, and the relationship we establish with those folks and intermittent relationships with physicians across the organization is our [communication] method.

Q: Can you share an accomplishment from this past year that you are most proud of, either on behalf of CHI or personally?

Dr. Moore: I think the most noteworthy thing we've done is to be extremely successful with an enormous HIT investment across the country. It's a $1.5 billion organization, [and we faced] all the complexities of putting in electronic health records, meeting [meaningful use] requirements, connecting physicians and staying on time and on budget. To date we've done this extremely well, and I've been really impressed with our ability as an organization to learn from others and learn from ourselves, quickly reinvent processes and approaches to this product. I'd say given the large size of it, and how nimble we've been, it's a huge accomplishment.



One of the key issues around EHRs is computerized physician ordering. We came out with a physician ordering process [organized by] six or seven physicians nationally, called OneCare. [They] developed order sets for physicians, and physicians then reacted to those sets. It was a pretty lukewarm reaction.

Our physicians in the field thought it was very limited. We started to get feedback that order sets were too simplistic and that physicians couldn't see feedback from physicians in their specialty. So now we've reorganized our approach. Utilizing tools, we've created a social network online for physicians to have open and transparent interactions around order sets. We've been nimble and understanding in that we're able to rework things in short period of time.

Q: Do you think CEOs and CMOs will work more closely than in the past?

Dr. Moore: That's a great question. I'll add the CNOs, since that's how things work at CHI. CMOs and CNOs co-lead. Senior vice president and CNO Kathleen Sanford and myself co-lead all of this. We've identified key talent and physicians in the organization who we will fall short without. The CEOs, CMOs and CNOs are all positions that have been identified. We've been working at a service-group level with human resource leadership. We'll officially launch an 18-month leadership development program under the guidance of CEOs for CMOs and CNOs this month.

We're committed to leadership development around key competencies that will allow our organizations and CEOs to be more successful. These competencies include conflict management, how you discuss difficult topics and how you align with the CEO to better realize clinical operation opportunities. How do you work with others in the C-suite team to improve outcomes? There is a tremendous amount of value in competencies for CEOs. This will naturally drive the

hospital CEO, CMO, CNO and even COO and CFO together in a better understanding of how to utilize one another's competencies and skills. It is very well thought out leadership development tied to CEOs' needs.

We're finding that there is a value question called around CMOs and CNOs, especially with costs being so important in these times. I think if there isn't that [valued] relationship, and if we're not working on key skills through additional degrees or development, there is a value equation that [might be off] and CEOs might ask if they have the right person on board. We want to give [hospital] CEOs a colleague to depend upon for operations and quality.

Q: Can you share a few exciting things going on at CHI right now?

Dr. Moore: There are a bunch of exciting things happening. There's the IT investment, but we're also collaborating on an innovation arm at CHI and doing virtual health nurse mentoring. It's a very exciting project around supporting nurses who are new grads working at night. There is a telehealth presence for them from an experienced nurse with an advanced practice degree and who is also trained in mentoring. Now those nurses have someone to bounce ideas off and answer questions.

We're also working on our virtual health service platform, which is organization-wide. That will allow us to provide services inside and outside CHI. There is big demand for access to services that maybe can't be delivered due to shortage issues with nurses and physicians.

There is also a very exciting patient-employee safety program. We also just had our AA-bond ratings reconfirmed by all of our rating agencies. That really meant that we continue to be not only innovative from our clinical side, but it also serves as a reaffirmation that our financial stability is there. ■

Using Bundled Payments to Drive Quality Improvement

By William C. Mohlenbrock, MD, FACS, Chief Medical Officer, Verras Ltd.

The 1965 implementation of Medicare has given American seniors a buttress against health and financial hardships but at the expense of uncontrolled costs that now threaten our nation's economic viability. In an effort to control costs and improve medical quality, Congress enacted the Patient Protection and Affordable Care Act in 2010, certain provisions of which promote the financial integration of hospitals and physicians through global budgeting.

Forces driving bundled payments

Highly integrated organizations such as Kaiser Permanente and clinic models, like Mayo, consistently document more effective and efficient medical outcomes as compared to less integrated provider groups. These integration successes, in part, stimulated the PPACA legislation provisions that seek to promote coordinated care across a broader spectrum of provider entities. In fact, CMS has already launched global reimbursement methods under acute-care episodes, which it will expand through its Bundled Payments for Care Improvement initiative. CMS' Shared Savings Program also lays the groundwork for bundled payments through the accountable care organization model. Commercial carriers will undoubtedly follow suit.

Under global payments, hospitals receive a single payment that administrators will be compelled to share with physicians. Unless these financial distributions are objective, transparent and prospectively designed to reward physicians for high quality, cost efficient care, the potential for acrimonious hospital-physician relations are significant. However, when astute community hospitals, health systems and physician groups properly prepare themselves for global budgeting, their hospital-physician relations will actually be enhanced through financial rewards generated by effective clinical and operational efficiencies.

Regardless of the specific integration models themselves, a single fundamental challenge is common to all global budgeting initiatives: How do health systems implement physician-directed, quality improvement activities that produce net-savings and then objectively and equitably distribute the dollars among the hospital and physicians who support the institution? Upon this potentially contentious distribution issue will rest the success or failure of most global budging initiatives.

Currently, hospital enterprises may or may not choose to participate in any one of several payment bundling models (e.g. , acute-care episode-only bundled payments, acute and post-acute bundled payments, ACO development). Although these payment models are often thought of in terms of reimbursement models for treating Medicare patients, they have taken on broader definitions and offerings. While multiple hospitals are now qualifying under the federal designation to manage defined groups of Medicare patients, provider groups are at the same time aligning and marketing themselves to commercial insurers and self-insured employers.

Linking payment models with quality

The goals of these various federal and commercial ACOs or other arrangements are to contain healthcare costs and improve quality. Medicare has defined quality using 33 specific indicators that each ACO must report in order to be eligible to receive additional reimbursements as shared net-savings. Whether these indicators will be sufficient to assist physicians in their efforts to improve clinical quality and cost efficiencies remains to be seen. Also unknown is the ability of the indicators to differentially quantify the various provider organizations' quality and cost-efficiency outcomes.

Several of the 33 indicators proposed by CMS can be described as covering specific experiences or conditions that may not apply to all patients within an ACO or covered by a bundled payment. For example, six of the 33 indicators apply only to patients at risk for diabetes. More comprehensive metrics of quality would both differentiate the provider groups and promote greater medical efficacies and efficiencies. Instead, metrics derived from hospitals' medical record data, which are used by many organizations as the basis of physicians' quality and cost improvement initiatives, could improve quality even more. Measures such as risk-adjusted morbidity and mortality rates are certainly important, but statistically significant reductions in variation of care processes are the more reliable means of assuring continuous financial and quality improvements. While it may be too late for CMS to change its final ACO rule, hospitals that participate in other payment models, especially those developed with private insurers, should consider these more comprehensive quality measures. When clinicians and hospital personnel create reductions in variation and document appropriate utilization of resources, the hospital-physician enterprise can be assured there will be net-savings for sharing.

A winning hospital strategy: Physician-directed best practices

Hospitals' medical records data are powerful but often under utilized quality improvement resources. The patient-level data must be risk-adjusted and formatted for ease of physicians' use and to assess the hospital's and clinical services' morbidity and morality rates. Financial (resource consumption) data must also be aggregated in an easily interpreted manner to demonstrate the wide variations that exist in physicians' care processes and outcomes. Charges are an excellent surrogate for the number of resources consumed since each hospital's charge master is the same for all resources and physicians. If costs are available, they should be used in place of charges. Ultimately, however, the data should be of sufficient granularity that the physicians can identify which specific resources demonstrate greater and lesser efficiencies. Length of stay should also be displayed along with charges to give a graphic display of the significant variations that exist within relatively homogeneous patient cohorts.

Drill-down techniques can be deployed to show each physician his/her own best-demonstrated performance. These best performances should then be compared to their own patients with inefficient outcomes, which documents their practice variations. Comparing every physician's performances using their own variations and outcomes with those of their hospital peers is a powerful way to rapidly effect behavior changes. The primary goal of these activities is to replicate the physician's own best practices within homogeneous patient groups. But hospitals' processes must also be examined in a like manner because the same the drill-down techniques can target hospital-induced inefficiencies that prevent physicians from reducing variations or effecting more expeditious patient throughput. Experience indicates that about half of the observed problems are secondary to hospital barriers and inefficiencies, the other half being physician induced.

These physician-directed best practices should be carried out using one-on-one, non-threatening physician education sessions. The vast majority of clinicians embrace these methods, but they are data-driven and need reliable clinical information with which to work. This desire to excel plus the financial incentives inherent in bundled payment methodologies are the basis for hospital and physician collaborations that can create continuous improvements and net savings.

Quality metrics for bundled-payments: The index of quality improvement

Physicians are often willing to adjust their own practices to fit best practices if data can be provided to support doing so will bring about improvements. However, some health systems fall into the trap of overwhelming physicians with data that they are unable to make sense of. In order to show quality improvement data in a straight-forward, easy-to-comprehend manner, Verras recently developed the Index of Quality Improvement 7 (IQI7). The IQI7 consists of six, industry-standard measures that many hospitals and physicians use to objectively improve their quality and cost-efficiency outcomes, as well as a seventh measure that encompasses the 33 ACO measures. In addition to quality improvement, the IQI7 affords a means for the hospital to market itself to local employers and governmental agencies. Its metrics are excellent for comparing the efficacies and efficiencies of local hospital enterprises.

The 33 ACOs measures are specific for that use and must be manually abstracted from patients' charts. The other six metrics represent standard, time-tested quality indicators that, for the most part, are readily available from all hospital medical records departments. The exception being the federally mandated National Hospital Quality Measures that, like the 33 ACO metrics, are manually abstracted from patients' charts. IQI7 utilizes a 1,000 total point score for three years of trended data that is presented as a stacked bar graph for easy interpretation.

The seven IQI7 indicators of quality are:

1. Accountable care organization measures. These 33 measures are federally mandated for hospitals that receive the ACO designation.
2. Financial (resource consumption) measures. Hospital inflation rates of charges trended over a three-year period (hospitals' internal costs can also be used).
3. Morbidity rates. Measured for top five DRGs and trended over three years.
4. Mortality rates. Measured for the top 10 major diagnostic categories over three years.
5. Reductions in variation. Measured for the top 10 DRGs, which constitute the majority of a hospital's patients.
6. Patient satisfaction. As reported to the federal government as a part of NHQM.
7. National Hospital Quality Measures. As reported to the federal government.

Health systems, hospital enterprises and physician groups that proactively integrate their financial incentives will prosper under all types of bundled payment scenarios. Their success will depend on utilizing physician-directed best practices that maximize efficiencies and net-savings. Equally important will be objective, transparent and equitable distributions of the net-saving between the hospital and physicians. Good physicians, given reliable information, will consistently improve due to their inherent quest for excellence. Bundled payments represent new financial incentives for physicians that will benefit their patients, hospitals, communities and themselves. It will take inspired leadership both at the hospital and physician levels to make bundled payments operational, but the resultant clinical and financial outcomes will justify their efforts. ■

Succeeding in Physician Preference Management: 5 Tested Imperatives to Boost Your Efforts

By Patricia Tyson, MSA, RN, Vice President, VHA

When I consult with healthcare organizations regarding their physician preference contracting initiatives, I often hear remarks such as "We haven't been successful in physician preference contracting because we can't get our physicians to cooperate." Sometimes, that lack of cooperation signifies a lack of trust, understanding or aligned incentives. But most often, it's due to a lack of communication and an inconsistently applied or poorly defined process.

These five proven imperatives will help improve your success in physician preference management and improve your bottom line.

Communication

Many organizations feel communications with their physicians are good, but are they? Often, supply chain professionals complain that their physicians are uncooperative, yet they never leave their office to visit the physician's workspace or attend physician meetings. To negotiate good physician preference contracts, it is vital to understand the product's purpose and the physician's need for the product or service.

Having crucial conversations with physicians around these issues will surface important facts. Their needs and preferences will likely involve patient outcomes and safety, perceptions of patient interests, their own experience, their comfort level with the product or service, the supplier's support and their medical training — not the cost of the product or service, how difficult it is to procure or primary concerns for supply chain staff. In addition, communication with physicians must be in a language they understand. Speaking with physicians in supply chain jargon — "duel source prime contract," for example — simply won't achieve the desired outcomes.

It is important to provide an avenue for physician feedback throughout the contracting process. This involves gathering physicians' input before the bid process begins, sharing information gleaned during the bid process, discussing available options and implications and working with the physicians to develop an action plan to implement the contract(s).

Consistency

To effectively build trust and credibility for your physician preference contracting process, you must have a well-defined, consistent and transparent process that is applied uniformly across the organization. Consistency in communication, product research, product evaluation, analysis and implementation is vital. Transparency will assure that physician stakeholders are aware of the initiatives that are underway as well as where each initiative resides in the process. Finally, to be viewed as credible, the process must be equitably applied across all physicians.

Physician champion

A physician champion should be enlisted for each physician contracting initiative. The physician champion should be someone who is both a subject matter expert and is well respected among his/her peers. In addition, he/she should be aware of the organization's financial goals and understand the rationale for the initiative within the financial framework.

Accountability

To help align incentives between physicians and the healthcare organization, some organizations are beginning to adopt a process known as economic credentialing that can be used when recruiting a new physician and when evaluating privileged physicians.

Economic credentialing involves physician profiling that compares physicians to their peers relative to their supply spend for a particular procedure. Physicians receive a chart that compares their average cost per case to their peers' cost per case. This process often spurs conversation between specialists regarding procedural differences. The information can also be used as a basis of discussion during the annual review of the physician.

For physician recruitment, economic credentialing involves determining the physician recruit's product use preferences compared to the hospital's product formulary. This information becomes a valuable component in the negotiations for the potential recruit and provides insight into increased costs the hospital could incur.

Executive support

One of the characteristics that successful physician preference management programs share is top-down support. Even if there is a well-defined, consistent and transparent process, an identified physician champion, and effective accountability and communication measures in place, a contracting initiative can fail without executive level support.

Commitment from executive leadership is crucial for success. Executives who understand and respect your processes and the value they bring to the organization will be more likely to support the program. Many organizations have instituted an executive oversight team or executive sponsor to help with this challenge.

For hospitals to succeed in this new world of healthcare, they must begin to aggressively pursue successful physician alignment activities. These five imperatives provide an excellent way to begin and sustain the process. ■

Ms. Tyson works with a team that provides hospitals with expert consulting and specialized software services that optimize cardiology, orthopedics and spine service lines. She has 25 years of cardiovascular, clinical and management experience and has consulted with more than 150 hospitals and healthcare systems throughout the United States.

Free Medication Improves Medication Adherence, Outcomes

By Jaimie Oh

Heart attack patients who received free medications had lower rates of rehospitalization for heart attack or heart failure compared to patients who had prescription co-pays, according to late-breaking research presented at the American Heart Association's Scientific Sessions 2011.

Despite those improvements, patients with free medications did not experience a lower reduction in the rate of revascularization to reopen clogged arteries. For their study, researchers analyzed 5,855 heart attack patients, 2,845 of whom paid nothing for their cholesterol-lowering drugs and other medications.

Their study also showed these patients were 4-6 percent more likely to take them than the 3,010 who had co-pays. Furthermore, patients saved 26 percent on their overall out-of-pocket healthcare costs due to savings from fewer copayments for physicians' visits and no co-pays. ■

Uninsured Patients Have Shorter Hospital Stays

By Molly Gamble

Patients without insurance have shorter hospital stays for both preventable and non-preventable conditions, according to a study published in the *Annals of Family Medicine*.

Researchers from the Medical University of South Carolina in Charleston analyzed hospitalizations in the National Hospital Discharge Survey from 2003-2007 for patients aged 18-64. Hospitalizations for ambulatory care-sensitive conditions, which are considered preventable, and non-ACSCs were examined.

After controlling variables, uninsured patients had a significant shorter length of stay. For instance, the mean length of stay for ACSCs was 2.77 days for patients without insurance. For those with private insurance, the mean was 2.89 days and for Medicaid it was 3.19.

The study's authors concluded that future research should examine whether uninsured patients are prematurely discharged. ■

Study: 83% of Americans Don't Follow Prescribed Treatment Plans

By Jaimie Oh

A recent study by TeleVox reveals that 83 percent of surveyed Americans admit they don't adhere to treatment plans prescribed by their physicians.

The survey responses are from 1,015 Americans and 2,200 healthcare providers. Results show healthcare professionals believe almost all (95 percent) of their patients fail to adhere to their treatment plans. In addition, 15 percent of healthcare professionals report feeling frustrated because patients fail to follow their treatment plans and only 7 percent feel they successfully help patients become healthier.

The survey also reveals some challenges and areas of opportunity for physicians and patients in maintaining health. Eighty percent of healthcare professionals agree motivation and coaching can help their patient take steps toward improving their health, and 42 percent of patients feel they could follow their treatment plans better if they received encouragement from physicians between visits.

Another 35 percent of patients believe they would better adhere to their treatment plans if they received reminders about specific steps they need to take, such as taking their medicine. Despite this, the survey also shows only 1 in 4 healthcare professionals believe it is their job to keep patients on track between office visits and more than half admit they don't communicate with their patients between visits. ■

Study: Disease Registries Improve Care, Reduce Costs

By Jaimie Oh

An international study of thirteen disease registries published in *Health Affairs* suggests that disease registries enable healthcare professionals to engage in continuous learning as well as identify and share best clinical practices.

The researchers relied on 13 disease registries in Australia, Denmark, Sweden, the United Kingdom and the United States that dealt with six medical conditions or procedures. In addition, the researchers interviewed 32 healthcare professionals to better understand how registries function and to identify ways they are able to influence clinical practice.

The researchers discovered many examples where the use of the registry was associated with improvements in health outcomes.

For example, Sweden began a registry for hip replacement surgery in 1979. Since then, Sweden has reduced the number of revision surgeries to 10 percent, resulting in $14 million in annual savings. The authors estimate that a similar registry in the United States would avoid some $2 billion of an expected $24 billion in total costs for these surgeries in 2015.

The authors have called on the U.S. government to create the necessary regulations and seed funding for the development of disease registries, which have been slow to grow in the United States. ■

10 Hospital Markets With the Highest, Lowest Patient Satisfaction Rates

Kaiser Health News has compiled a list of nearly 300 regional hospital markets ranked for patient satisfaction. *KHN* relied on 10 metrics used by CMS for its Hospital Compare website as well as geographic boundaries developed by the Dartmouth Atlas of Health Care to create these rankings.

Here are the 10 regional hospital markets with the highest average patient satisfaction rates, based on the average of the 10 metrics mentioned above:

1. Mason City, Iowa — 77.6 percent
2. Houma, La. — 77.17 percent
3. St. Cloud, Minn. — 76.97 percent
4. Monroe, La. — 76.56 percent
5. Topeka, Kan. — 76.29 percent
6. Tupelo, Miss. — 76.27 percent
7. Bryan, Texas — 76.2 percent
8. Dubuque, Iowa — 75.68 percent
9. Rapid City, S.D. — 75.67 percent
10. Bangor, Maine — 75.45 percent

Here are the 10 regional hospital markets with the lowest average patient satisfaction rates, based on the average of the 10 metrics mentioned above:

1. Manhattan, N.Y. — 58.84 percent
2. Takoma Park, Md. — 59.75 percent
3. Bronx, N.Y. — 59.75 percent
4. Chicago — 61.25 percent
5. Newark, N.J. — 62.11 percent
6. Fort Myers, Fla. — 62.7 percent
7. Paterson N.J. — 62.75 percent
8. East Long Island, N.Y. — 62.85 percent
9. Ocala, Fla. — 62.88 percent
10. Chico, Calif. — 62.88 percent ■

National Quality Forum Releases 21 Endorsed Surgical Care Measures

By Jaimie Oh

The National Quality Forum Board of Directors has recently approved endorsement for 21 quality measures concerning surgical care.

The measures — part of the Surgery Endorsement Maintenance 2010, Phase 1 and the National Voluntary Consensus Standards for Pediatric Cardiac Surgery projects — address a wide range of surgical procedures and considerations in caring for surgical patients. The 21 surgical care measures are as follows:

Cardiac-CABG

- 0114: Risk-adjusted post-operative renal failure (STS)
- 0115: Risk-adjusted surgical re-exploration (STS)
- 0129: Risk-adjusted prolonged intubation (ventilation) (STS)
- 0131: Risk-adjusted stroke/cerebrovascular accident (STS)
- 0119: Risk-adjusted operative mortality for CABG (STS)
- 0113: Participation in a database for cardiac surgery (STS) (reserve status)

Cardiac-CABG: Valve Replacement/Repair

- 0120: Risk-adjusted operative mortality for aortic valve replacement (AVR) (STS)
- 0121: Risk-adjusted operative mortality for mitral valve (MV) replacement (STS)
- 0122: Risk-adjusted operative mortality MV replacement + CABG surgery (STS)
- 0123: Risk-adjusted operative mortality for aortic valve replacement (AVR) + CABG surgery (STS)
- 1501: Risk-adjusted operative mortality for mitral valve (MV) repair (STS)
- 1502: Risk-adjusted operative mortality for MV repair + CABG surgery (STS)

Esophageal Resection and Transfusion

- 0360: Esophageal resection mortality rate (IQI 8) (AHRQ)
- 0361: Esophageal resection volume (IQI 1) (AHRQ)

Cardiac-CABG

- 0116: Anti-platelet medication at discharge (STS)
- 0118: Anti-lipid treatment discharge (STS)
- 0130: Risk-adjusted deep sternal wound infection rate (STS)

Venous Thromboembolism (VTE)

- 0218: Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to surgery to 24 hours after surgery end time (CMS)

Pediatric Cardiac Surgery Quality Measures

- 0733: Pre-Operative Mortality Stratified by the Five STS-EACTS Mortality Categories (STS)
- 0732: Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the Five STS-EACTS Mortality Levels (STS)
- 0734: Participation in a national database for pediatric and congenital health surgery (STS) ■

CMS Final Rule Allows Use of Medicare Claims to Assess Providers' Performance

By Jaimie Oh

CMS has released a final rule that allows for the use of standardized extracts of Medicare claims data for qualified entities to measure healthcare providers' and suppliers' performance.

Under the new final rule, entities can become qualified by CMS and pay to receive standardized extracts of claims data under Medicare Parts A, B and D for the purpose of evaluation of the performance of healthcare providers and suppliers.

The final rule makes this data less costly for qualified entities to acquire than the interim rule proposed; gives qualified organizations more flexibility in their use of Medicare data to create performance reports for consumers; and extends the time period for healthcare providers to confidentially review and appeal performance reports before they become public.

The rule also includes strict privacy and security requirements to protect patients, healthcare providers and suppliers as well as stringent penalties for any misuse of Medicare data. ■

Hospital and Health System CMOs on the Move

By Jaimie Oh

Here are eight recent hospital and health system chief medical officer appointments and resignations.

University Hospitals, based in Cleveland, named **Michael Anderson**, MD, CMO of University Hospitals Case Medical Center and Rainbow Babies & Children's Hospital.

Mystie Johnson, MD, was tapped CMO of Banner Del E. Webb Medical Center in Sun City West, Ariz.

Trinity Mother Frances Health System, based in Tyler, Texas, named **Steven P. Keuer**, MD, president and CMO.

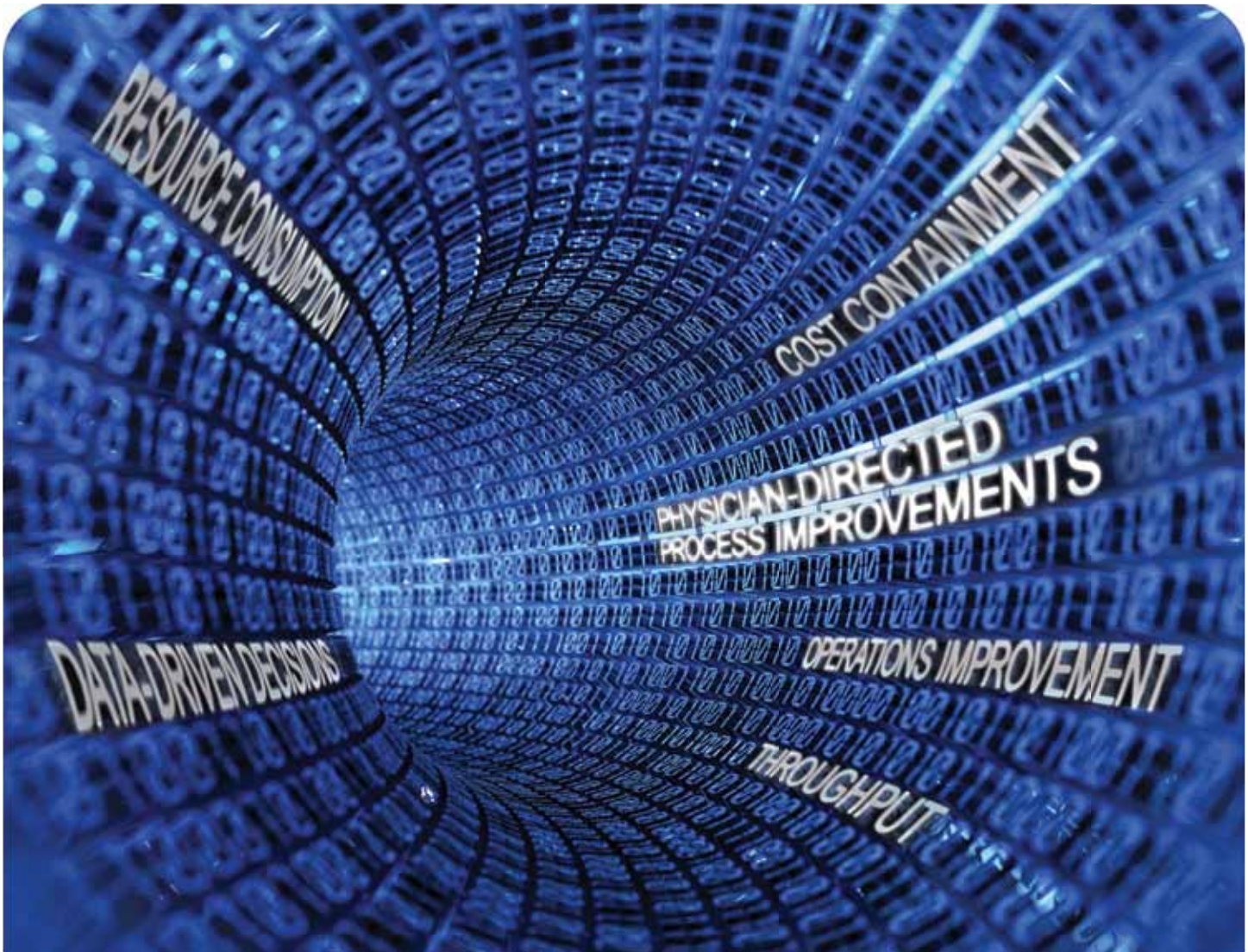
Stephen Leffler, MD, was appointed CMO at Fletcher Allen Health Care in Burlington, Vt.

Stuart Markowitz, MD, was appointed CMO for Hartford (Conn.) Hospital.

Tim Pike, DO, was appointed CMO of Portsmouth (N.H.) Regional Hospital.

CMO **Allen Schaffer**, MD, of The Acadia Hospital in Bangor, Maine, stepped down from his position.

Jeff Sperring, MD, was named president and CEO of Riley Hospital for Children at Indiana University Health. ■



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