American Hospital Association™
*Advancing Health in America*

AHA Events

# Clinical Governance: Best Practices for Creating Consistency of Care and Reimbursement

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*Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.*

# Agenda

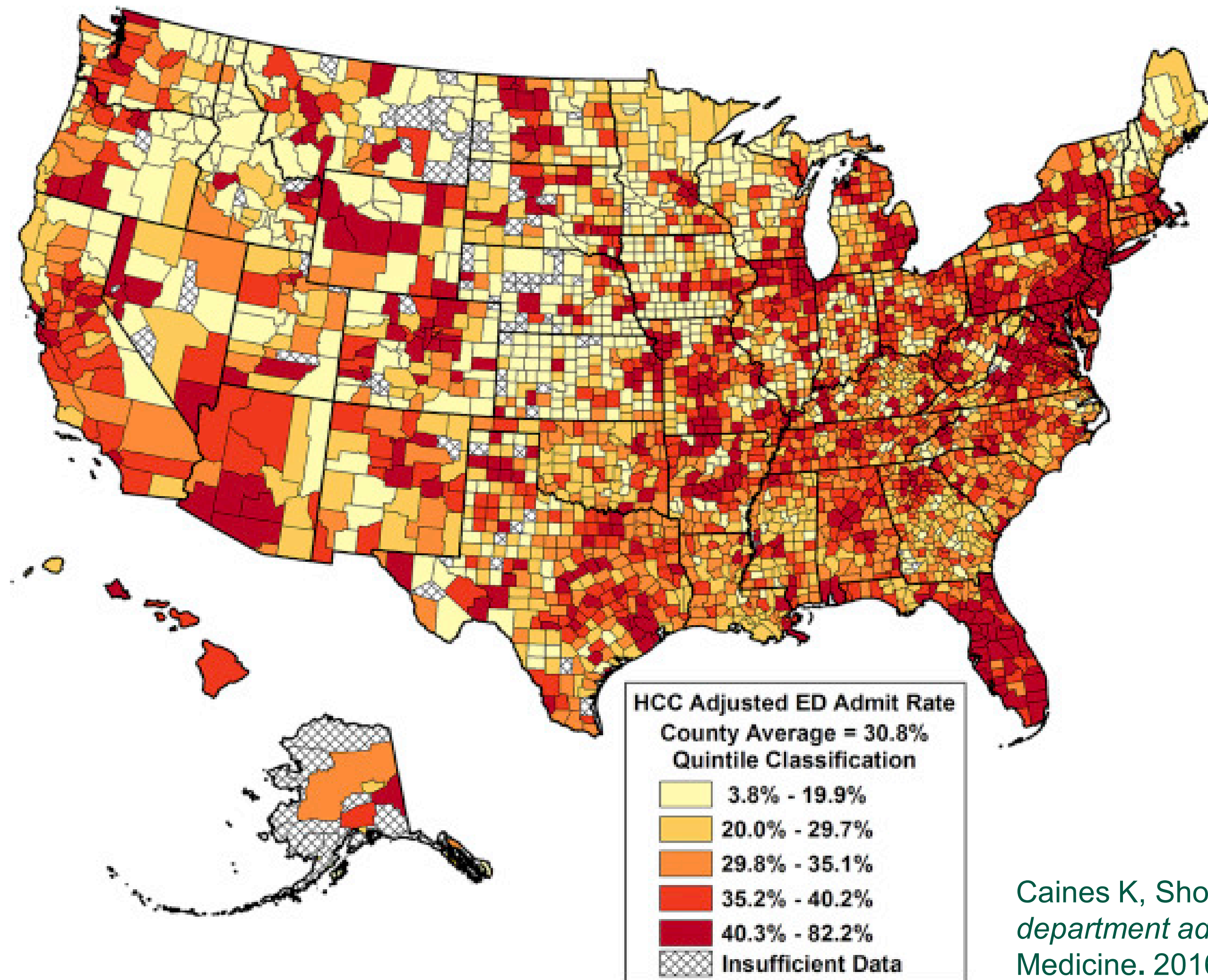
- Impact of unintended variation
- Clinical quality improvement vs. clinical compliance
- Clinical governance processes
- Board member roles

# Clinical Governance: Why?

- Health care field is evolving rapidly and becoming increasingly complex
- Not following evidence-based practice puts dollars at risk
- Variations in care create disparities
- Patients are sometimes harmed in the course of receiving care

# The Decision to Admit vs. Not Admit

## Risk-Standardized Hospitalizations in 2013 (per 100,000 person-years)

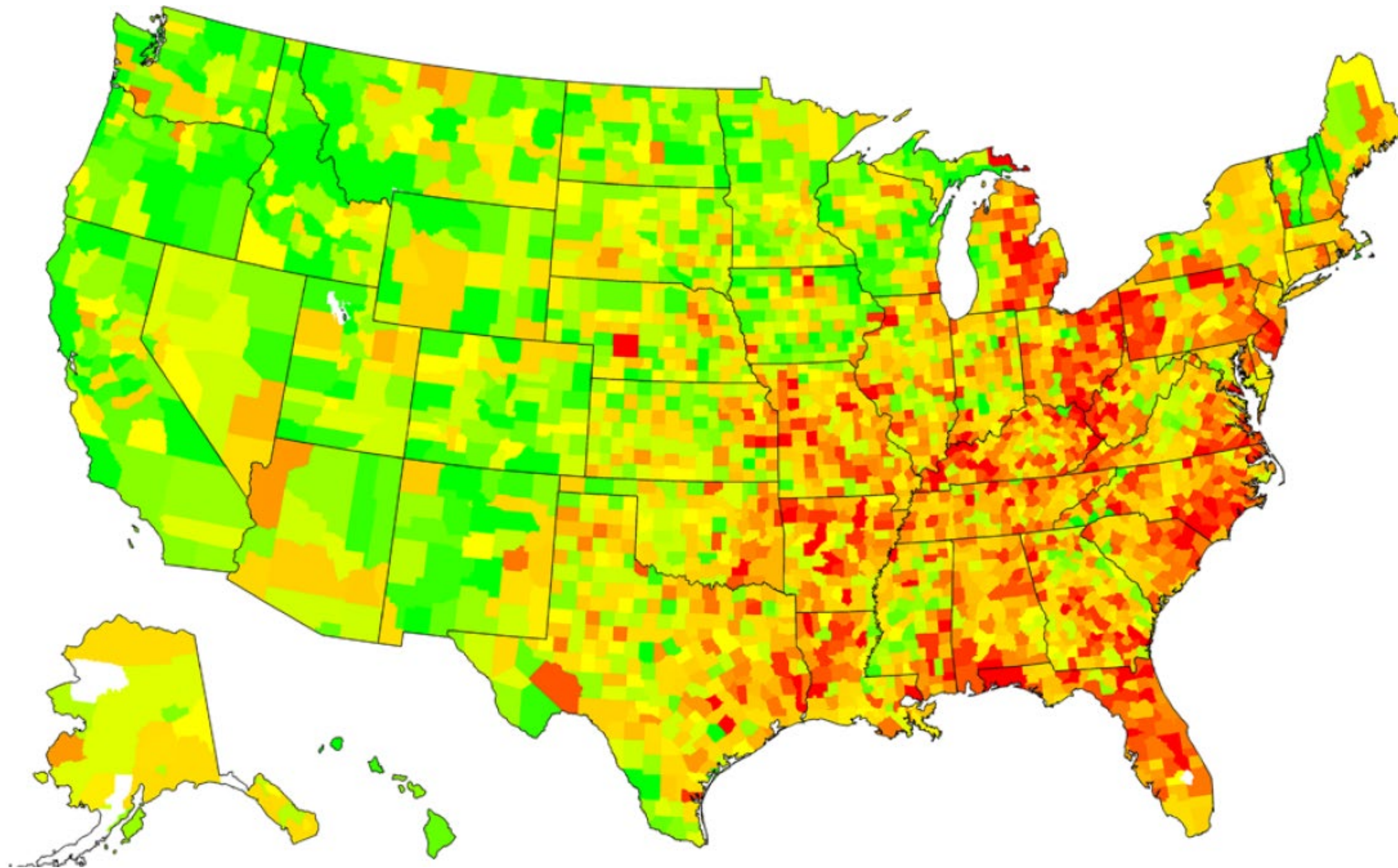



- 100% Medicare FFS, 2012
- 22.6 million ED visits
- Employed CMS standard risk adjustment
- At the 20th and 80th percentile, the admission rate varied two-fold (20% vs. 40%)
- Translates to a different decision (admit vs. not) every 5th patient
- Consistent and predictable geographic variation year after year

Caines K, Shoff C, Bott DM, Pines JM. *County-level variation in emergency department admission rates among US Medicare beneficiaries.* Annals of Emergency Medicine. 2016;68(4):456-60.

# Atrial Fibrillation Admission Rates

Risk-Standardized Hospitalizations in 2013 (per 100,000 person-years)



Per 100,000 person-years

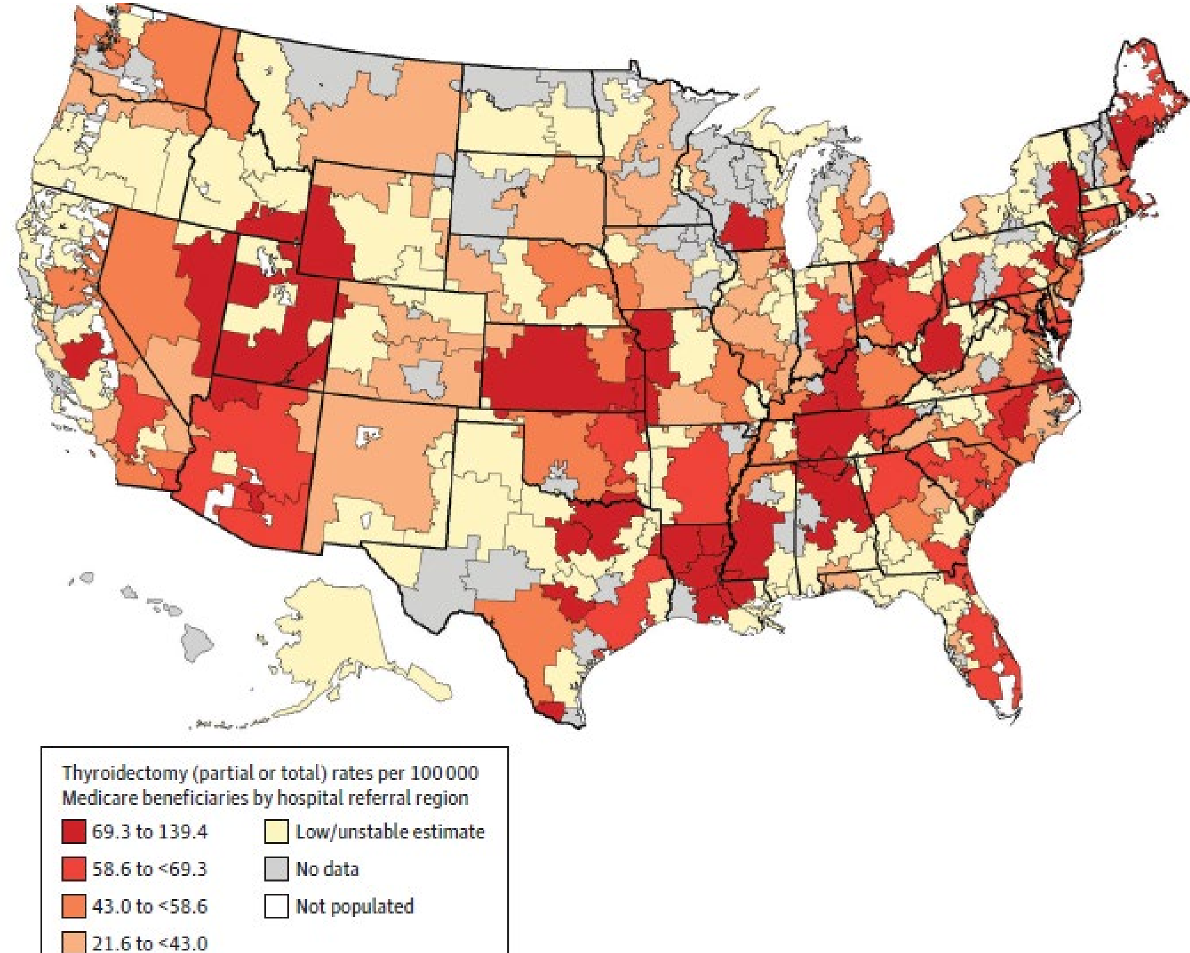
| | |
|---|---|
| Green: | 245-639 |
| Yellow: | 640-748 |
| Orange: | 749-1023 |
| Red: | 1,024-1,754 |

- Age, sex, race, and comorbidity adjusted
- 180,068 Medicare FFS admissions
- 6% cardioversion
- 2% ablation
- Vast majority RVR

Freeman JV, et al. National trends in atrial fibrillation hospitalization, readmission, and mortality for Medicare beneficiaries, 1999–2013. *Circulation* 2017;135(1227–1239).

# Variation in Procedure Performance: Thyroidectomy

- 2014, Medicare FFS, 306 HRR
- 15,888 partial or total thyroidectomies
- Range 6.5-fold variation
- 75th percentile 160% larger than 25th percentile
- Different decision every 4th patient that is seen in 75th percentile region rather than 25th percentile region




Francis DO, et al. *Nationwide variation in rates of thyroidectomy among US Medicare beneficiaries.* JAMA Otolaryngology Head Neck Surgery 2017;143(11):1122-1125.

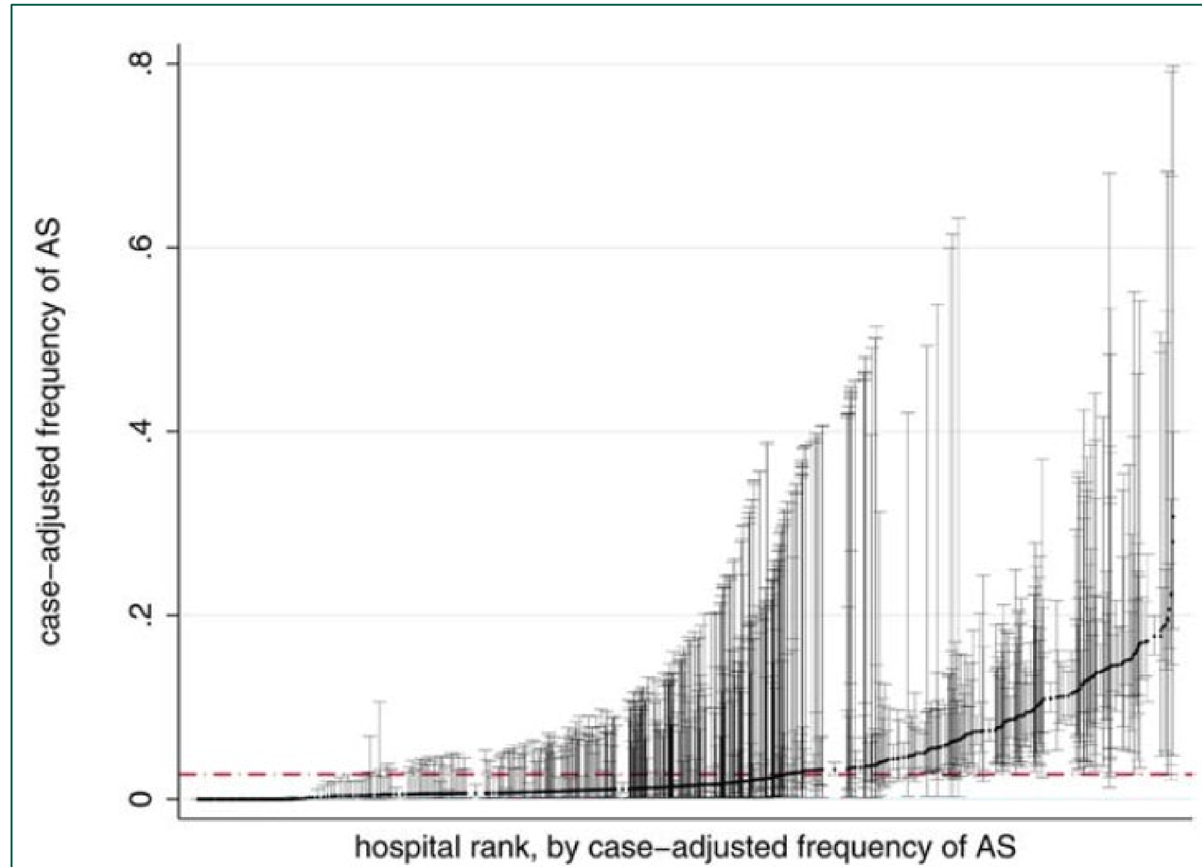
# Variation in Procedure Performance: Radical Prostatectomy

- 115,208 men aged 40-75 with low-risk prostate cancer
- Active surveillance a valid option, first line by some recommendations
- 1,194 community-cancer center designated facilities
- 2010-2014: 12.3% active surveillance

| Variables | OR | 95% CI |
|---|---|---|
| **Academic facility** | **2.47** | **1.81-3.37** |
| **Annual volume 201 - 426** | **2.41** | **1.61-3.61** |
| **Annual volume > 426** | **3.57** | **1.94-6.55** |
| Middle Atlantic vs. NE | 0.29 | 0.17-0.49 |
| West North Central vs. NE | 0.29 | 0.17-0.49 |

Björn Löppenberg, et al., *Variation in the Use of Active Surveillance for Low-Risk Prostate Cancer*. Cancer 2018;124:55-64.

# Influence of Facility




Largest single factor was the individual facility (facility culture/routine)

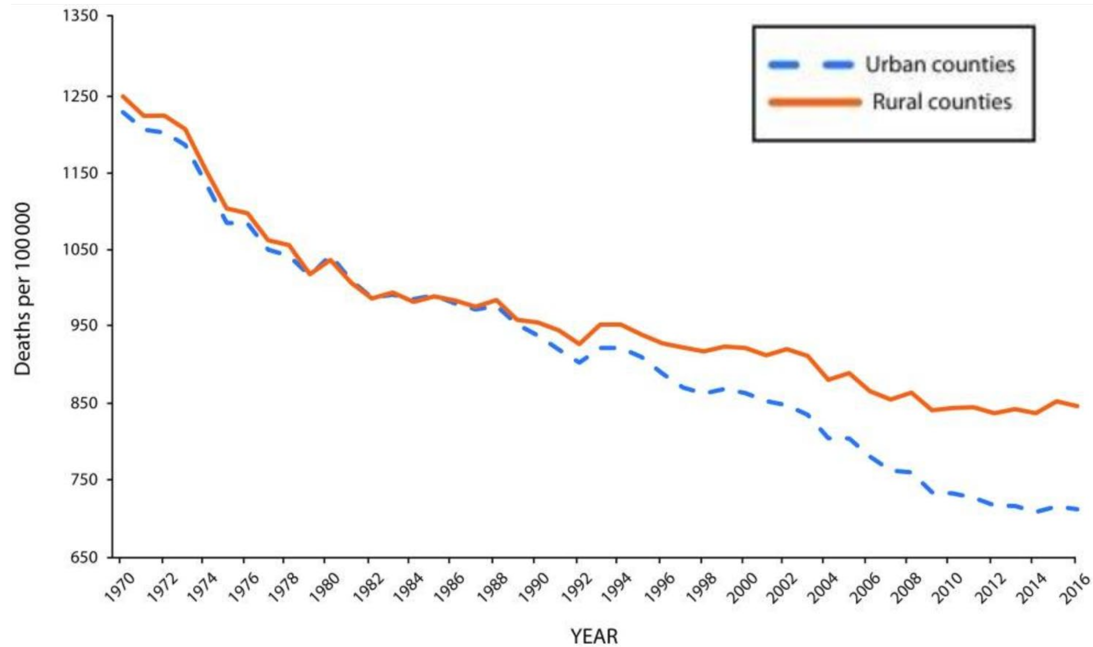
Diagnosis with very limited evidence of aggressive treatment benefit, and the treatments are unpleasant

*"…the institution at which one is treated matters as much as, if not more than, one's health status and beliefs regarding treatment selection."*

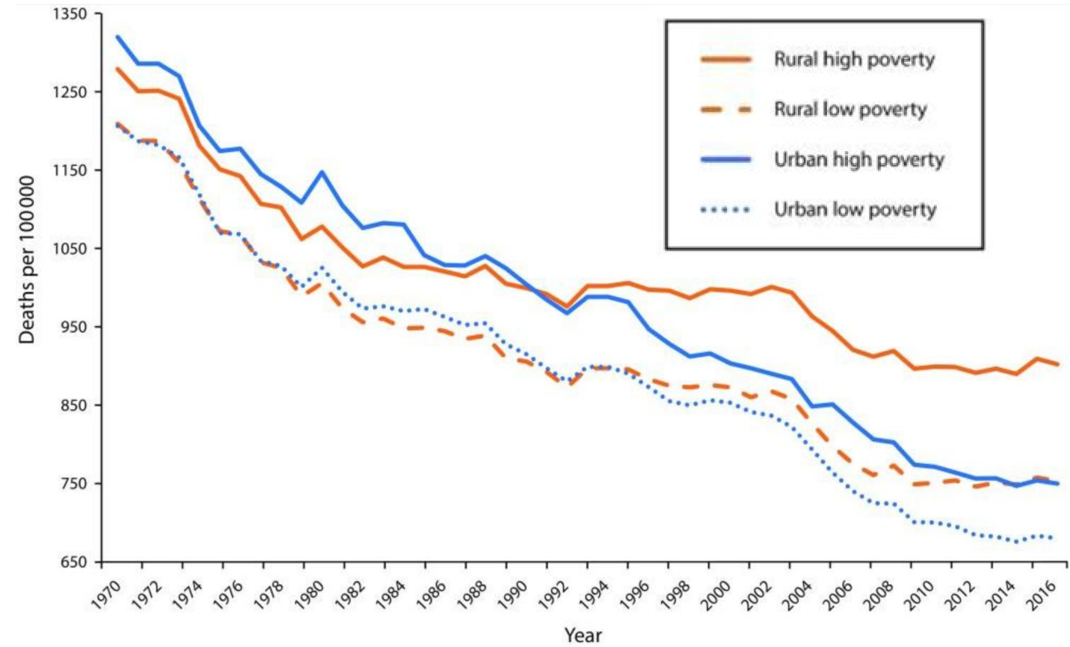
Björn Löppenberg, et al., *Variation in the Use of Active Surveillance for Low-Risk Prostate Cancer*. Cancer 2018;124:55-64.

# "Rural Mortality Penalty"

## Age-Adjusted (All-Cause) Mortality

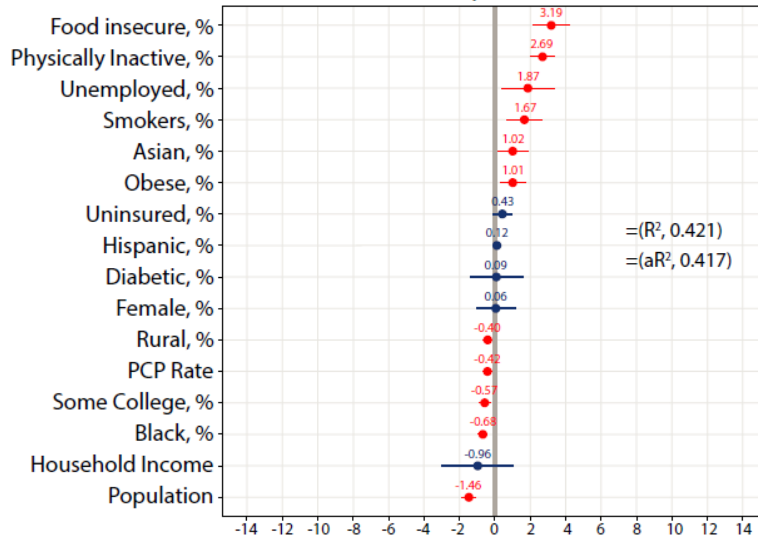


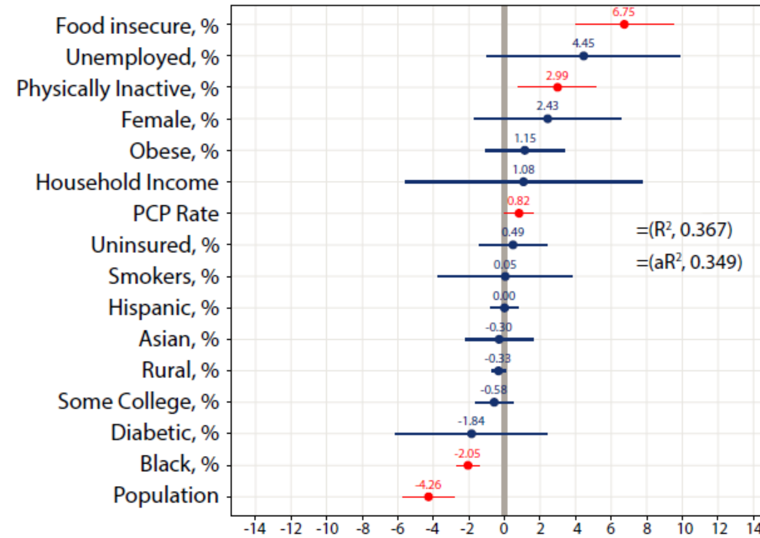

## Age-Adjusted All-Cause Mortality By Poverty

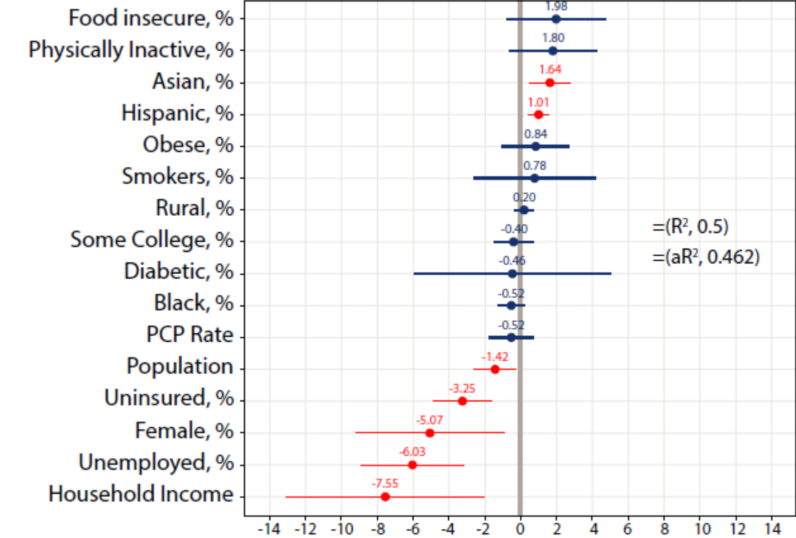



Cosby AG, McDoom-Echebiri MM, James W, Khandekar H, Brown W, Hanna HL. *Growth and Persistence of Place-Based Mortality in the United States: The Rural Mortality Penalty.* Am J Public Health. 2019 Jan;109(1):155-162.

# County-Level Factors & CV Mortality




Zuma BZ, Parizo JT, Valencia A, Spencer-Bonilla G, Blum MR, Scheinker D, Rodriguez F. *County-Level Factors Associated With Cardiovascular Mortality by Race/Ethnicity.* J Am Heart Assoc. 2021 Mar 16;10(6):e018835.

# Explanation of Differences in AAMR

- Persistent racial/ethnic disparities in cardiovascular disease (CVD) mortality were only partially explained by these factors
  - Non-Hispanic white – 41.7%
  - Black – 34.9%
  - Hispanic – 46.2%
- More than half of this disparity still unexplained

Zuma BZ, Parizo JT, Valencia A, Spencer-Bonilla G, Blum MR, Scheinker D, Rodriguez F. *County-Level Factors Associated With Cardiovascular Mortality by Race/Ethnicity.* J Am Heart Assoc. 2021 Mar 16;10(6):e018835.

# Evidence-Based Medicine

*Evidence-based medicine (EBM) is the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information.*

Guyatt GH, Haynes RB, Jaeschke RZ, et al. Users' Guides to the Medical Literature: XXV. Evidence-Based Medicine: Principles for Applying the Users' Guides to Patient Care. JAMA. 2000;284(10):1290–1296.

# Evidence-Based Medicine & Payers

- Used by all major third-party payers
- Implied in Medicare language
- Not sole coverage driver – but main driver
  - Varying thresholds for evidence
  - Low evidence with low or no additional cost

# Impact of Evidence-Based Medicine

- Improvement in patient care
- Helps to ensure right care at right time
- Consistency of decisions for patients with similar clinical pictures
  - Aids in correcting over and under utilization
  - Aids in reducing disparities
- Reduction in payer-provider conflict points

**Not sufficient to deliver highest quality care**

Lewis SJ, Orland BI. The importance and impact of evidence-based medicine. *J Manag Care Pharm*. 2004 Sep;10(5 Suppl A):S3-5.
Woolf, S H et al. “Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines.” BMJ (Clinical research ed.) vol. 318,7182 (1999): 527-30.

# How do we get there?

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# Clinical Quality Improvement

- Blend of evidence-based medicine and local factors
- Need varies by locality
- Insight from board members and community is critical to define
- Service agreement performance indicators – often considered “not important for us”
  - Clinical compliance vs. clinical improvement

# Quality Taskwork

- Evaluating and improving healthcare quality performance
- Setting and oversight of strategic quality priorities
- Ensuring effective systems and processes are in place to maintain and improve quality
- Promoting leadership and culture

# Key Board Activities

- Evaluating healthcare quality
- Overseeing quality priorities

**Can’t phone it in…must be engaged**

# Processes: Evaluating Healthcare Quality

- Regular robust reporting of a range of data through a range of formats
- Clear identification of variation and action taken in response
- Development and review of a detailed reporting framework

# Determining What to Report

- Agreement on definition of quality
- Intentional selection of data
- Calendar or schedule of reporting
- Periodic scheduled management and board review of reporting content

# Data: Not Just Dashboards

- Combination of dashboards and stand-alone reports
  - Dashboards: prior completed initiatives, quality maintenance
  - Stand-alone: in-process initiatives
- Additional content when variations are statistically significant
- Specific actions to address identified variation
  - Including “do nothing”

# Common Pitfalls in Reporting

- Use of less than 12 months data
- Unrealistic targets
  - Falls vs. preventable falls
- Misleading trend indicators without additional context
  - Traffic light coloring/trend arrows
- No allowance for natural variation

# Processes: Overseeing Quality Priorities

- Narrow the scope
- Collaborate with managers in development
- Develop a formal process for converting quality initiative into an action plan for subordinate units
- Use SMART goals: specific, measurable, achievable, relevant, and timely
- Check your work

# Take-Aways

- Board participation matters
- Evidence-based medicine is a good starting point
- Corporate governance of quality is critical
- Key activities: evaluation and oversight of quality priorities
- Must analyze current process for performing those functions

***Are you driving quality or going through the motions?***

# Thank you!

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