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## **Benchmarking for Cardiovascular Program Success**

By Katherine Kay Brown, RN, MSN

Cardiovascular disease continues to be a major health concern, responsible for 41% of all deaths in the United States. Nationally, and even in highly managed care areas such as California, the number of cardiovascular procedures continues to grow at 6-10%. Due to the large elderly population in western Pennsylvania, the total number of patients requiring cardiovascular intervention is also increasing. In 1998, \$275 billion was spent on cardiovascular care, with 44% of expenditures directed at hospitals. The high volume, high revenue nature of cardiovascular care has spurred hospitals to fiercely compete for this patient population. The intense level of competition has challenged hospitals with utilizing strategies such as benchmarking to maximize outcomes, positioning them for future success.

The cardiovascular patient population usually accounts for up to 40% of a hospital's revenue. To counteract the effects of reduced reimbursement, hospitals must strategize not only to be efficient with utilization of bed days and resources, but must also increase their cardiovascular volume. Intense competition in the western Pennsylvania area is dramatically shifting cardiovascular volumes. Institutions "well-known" for their cardiovascular services, which in the past, relied on their reputation to bring in referrals, patients, and dollars, have lost considerable volume.

Competition is largely mastered by achieving, and then marketing, superior outcomes. Insurers mandate low costs, referral physicians direct patients to providers with quality clinical outcomes, and all consumers demand highly satisfying experiences. To be successful, hospitals must focus on clinical, financial, and satisfaction goals.

Within the "clinical" category typical measures of cardiovascular quality outcomes include mortality, PTCI success rates, post-PTCI/post-CABG complications, and readmission rates. Intermediate outcomes during the hospital stay such as intubation time and ambulation delays influence the ultimate clinical outcome and must be attained in the prescribed time.

For financial viability the following elements must be measured and maximized 1) procedure volumes, 2) cost per case which consists of hospital length of stay, catheterization lab/operating room cost, and supply/equipment utilization, 3) profit per case which takes into consideration the costs, payor mix, reimbursement contracts, and coding

issues. The satisfaction category is directed to all consumers of cardiovascular care including patients, families, referring physicians, and payors. Patients and families are frequently concerned with staff and physician responsiveness and empathy, technical competence, control of pain, and access to information. Referral and primary care physicians are often focused on ease of entry into the system, positive clinical outcomes, and timely communication from the interventionalist or surgeon.

How does a hospital maximize its cardiovascular outcomes? All disciplines caring for the cardiovascular patient should be integral in the process of improving outcomes. This includes involving key physicians from the beginning. The cardiovascular program should be assessed within the context of clinical, financial, and satisfaction outcomes. Performance in these areas must be measured and reported across the patient's entire hospital stay from the pre-procedure phase. Often this information is segregated by departments and not shared across the continuum of care, limiting improvements in processes and outcomes. After analyzing this data, a multidisciplinary leadership team should determine areas for improvement, set goals, delegate to responsible parties, and assist them in maximizing the outcomes.

The time has come for healthcare to improve its outcomes through a practice standard in most other industries – benchmarking. Simply defined, benchmarking is the practice of using comparative data to examine and measure the processes and outcomes within an organization. By benchmarking against similar institutions, a great potential exists to use the other institutions' experiences and create innovative solutions to issues. This allows the organization to quickly improve processes and outcomes instead of "reinventing the wheel."

In the past when hospitals and physicians did not agree with data reported publicly, they simply "blamed" the negative reports on inaccuracy. Now due to the onslaught of information reaching the consumer from a multitude of sources, hospitals must be ready to respond to negative data, correct misconceptions due to erroneous data and take full marketing advantage of positive information. Public interest regarding cardiovascular outcomes has never been more intense. Multiple public and private sources of benchmark data are available from consultants, decision support vendors, the

government, and even on the Internet (healthcarereportcards.com, marketinginsights.com). Medicare maintains the Medpar database, one of the largest databases in health care. The Agency for Health Care Policy and Research (AHCPR) has developed and sold hundreds of copies of their inpatient database. The National Council for Quality Assurance (NCQA) sells its Quality Compass database of HEDIS results. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recently begun collecting outcome data for their ORYX initiative. Specifically focused on cardiac surgery is the Pennsylvania Health Care Cost Containment Council's (PHC4) Guide to Coronary Artery Bypass Graft Surgery. Even professional societies such as the American College of Cardiology (ACC) and The Society of Thoracic Surgeons (STS) have begun national clinical databases for benchmarking purposes of participating organizations.

Hospitals can either wait for external agencies to develop and publish questionable report cards examining cardiovascular care or they can define meaningful outcomes in the evaluation of the care they give. With fierce competition for the growing cardiovascular population, hospitals who are able to assess and improve their internal performance using "best practice" benchmarks as a guide, and who are able to market their superior clinical, financial, and satisfaction outcomes, will have the market advantage.



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