A “rising star,” too

UCH Reaches #8 Among U.S. Academic Hospitals

“Life is a process, not a destination,” agreed Steven Ringel, MD, the hospital’s vice president of Clinical Excellence and Patient Safety.

“Being top 10 is not just a destination. It is an indication of what we’re capable of.”

Ringel, Clinical Excellence and Patient Safety Director Susan West, RN, and their team have led UCH’s clinical improvement efforts since 2007. West was quick to credit staff for the success. “Connie Chambers, Carol Ruscin, Holly Saratella and Jamie Le-Lazar of our team have really put their blood, sweat and tears into this thing, identifying what needed to be done, working with the departments and really living and breathing this data,” she pointed out.

UCH’s rankings differ from other, more highly recognizable attempts to identify “best” or “top” hospitals. For example, rankings by organizations like US News & World Report and Healthgrades focus exclusively on Medicare patients, while UHC looks at outcomes for all patient populations.

Objective data. And while US News and the 5280 magazine “Top Docs” rankings rest largely on subjective factors like “reputation” and personal popularity, the UHC ratings come exclusively from outcomes and process data.

“This is based on real, objective data. All the others have some subjective elements to them,” Schroffel pointed out.

Asked on which top 10 list he hoped the hospital would be included — the comprehensive data-driven one from UHC or the more subjective and narrower one from US News — Schroffel replied, “all of the above.” Indeed, the magazine also ranked four UCH specialties – pulmonology/respiratory, kidney diseases, rheumatology and cancer – among the nation’s best for 2010.

Specifically, UHC tracks performance data that measure hospitals’ mortality rates, clinical effectiveness, patient safety, equity, and “patient centeredness.”
Those categories, in turn, include factors that range from 30-day readmission rates to incidence of pressure ulcers to pain management to making sure that care is delivered equally for all patients, regardless of race, gender or socioeconomic status.

UHC collects these data from its member hospitals – which as academic medical centers tend to deliver the most complex, high-acuity care in their respective home areas – each quarter.

The consortium compiles the performance data not as a way to rank its members, but to help its member hospitals improve their most-important clinical and cost-effective processes. Illuminating best practices, moreover, allows others to adopt them.

**Quality vs. cost?** Figuring that on balance academic hospitals – as opposed to community hospitals – typically offer the most sophisticated and effective complex care, UCH leaders have been using the data to identify places where the hospital can improve its care of patients.

“As a patient, you want high-quality care. You don’t care if it’s the cheapest, you want it to be the most effective and you want it to be safe,” Ringel said. As a hospital, he added, “you want to deliver high-quality, cost-effective care.”

But delivering “high quality” and “safe” care, both of which are hard to define and expensive, is easier said than done. Moreover, reconciling a worried patient’s understandable focus on relieving pain or returning to normal life – in many cases without regard to cost – with the hospital’s need to deliver cost-effective care and health insurance plans’ insistence that the care be delivered at the lowest-possible cost makes the job exceedingly difficult.

So in 2007, Ringel recalls, “we compared ourselves to other academic hospitals, and we saw that there were areas where we weren’t doing as well as we wanted.” Ringel and his team not only communicated where UCH lagged, but worked with many other departments to plan improvements and measure the hospital’s progress toward the goals.

Among them: improving its smoking cessation programs, broadening its immunization efforts (especially for pneumonia and influenza), making coding more accurate and eliminating post-operative infections. Half jokingly, Ringel characterized the latter as a question of “getting catheters out of people faster.”

“More seriously, he added, “if you get a hospital-acquired infection, shame on us.”

Quality improvement requires a “team effort,” said team member and database analyst Holly Saratella.

“Every time we go into a report and drill down on the data, we find things that can affect outcomes,” she noted. “We try to figure out why a process was done and its impact. That requires open communication with finance, billing, coding, physicians and others.”

Schroffel separately cited such multi-group efforts as the real force that’s driving the hospital upward in national rankings. Many providers have improvement programs, but making them work “comes down to people caring, really. Passion is the most important thing. It’s faculty and staff working together and collaborating closely.”

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**University HealthSystems Consortium’s composite scores for UCH, which place it as 8th best in the country, earned the hospital a rare “five star” recognition.**
Top 10 Hospital? Depends on Whom You Ask

The most recent “Best Hospitals” ranking from *US News & World Report*, released in July, features 10 academic hospitals in its list of the 10 highest-scoring hospitals in the land.

The most recent academic hospital performance scores from University HealthSystems Consortium, released on September 30, generally found different and less well-known academic hospitals among its 10 highest scorers.

The difference: the magazine looks only at Medicare patients and bases almost a third of a hospital’s total score on a subjective “reputation” survey of some 200 physicians in each of 16 specialties nationwide.

University HealthSystems Consortium’s scores do not include any subjective survey results, and are based on clinical and operational performance for all the hospitals’ patients, not only those paying through Medicare.

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