

Dashboard Benchmark Evaluation

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The use of dashboards has grown into a necessary part of the healthcare scene in order to use data to track performance. Health information technology (HIT) dashboards that assimilate evidence-based practice quality metrics can expertly and precisely present risk information on patients which can encourage quicker interventions and boost patient care quality (Schall et al., 2017). Quality dashboards are one form of HIT that make evident areas in need of improvement with data displays for administration and management (Schall et al., 2017). Along with dashboards comes the term benchmarking which is used to advance the performance, expenditure, and overall quality of services provided to patients. “Benchmarking is about comparing, learning from the outcomes of such comparisons, and consequently learning how to do the job better” (Anderson-Miles, 1994). Health care policy and laws are implemented and regulated by federal, state, and local levels which also extends to private organizations and sectors. These laws and regulations are introduced in order to maintain compliance and standards to ensure that health care delivery is safe and accessible to all.

Mercy Medical Center (MCM) maintains public health dashboards and benchmarks in a number of areas, however for the purposes of this paper there will be a sole focus on heart failure readmission rates, healthcare policies surrounding these readmission rates, challenges to meet readmission rate benchmarks, and avenues towards improvement. Upon analysis of the hospital CEO dashboard that maintains local readmission rates and compares them to national averages, heart failure is listed at 26.4 (40%) and the national rates are 22.0 (37%) (Capella University (n.d.)). This data is an indication that MCM is not meeting national benchmarks and therefore are likely paying penalties on these patients being readmitted within 30 days. The 30-day

readmission rates were established by the Centers for Medicare and Medicaid Services (CMS) who allow for risk adjustments based on the case differences between hospitals and then any remaining variations are attributed to discrepancies in hospitals quality (Thompson, Kaplan, Cao, Bazzoli, & Waters, 2016). At MCM these heart failure readmissions that occur within 30 days of hospital discharge pose an area of likely correctable burden on this health care system (Thompson et al., 2016). “To incentivize hospitals to reduce hospital readmissions, the Affordable Care Act (ACA) established the Hospital Readmission Reduction Program (HRRP), which levies financial penalties against hospitals with higher than expected readmission rates” (Thompson et al., 2016).

Mercy Medical Center faces a few challenges to meeting readmission rates set by national benchmarks. One such challenge posed is unreliable measures bear risks to financial incentives that are used in the HRRP, by creating an increase in false positive or false negatives in the expected readmission rates (Thompson et al., 2016). Hence, unreliable measures distort the link between rates, penalties, or reimbursement, while lowering quality improvement initiatives for organizations (Thompson et al., 2016). Another challenge posed is that the risk adjustment unreasonably chastens hospitals that treat higher numbers of minorities and low-income patients, which then causes the reliability of measures to deteriorate further (Thompson, 2016). Other challenges that come into play is the lack of provider engagement with these extremely ill patients, motivation of the patients to follow through with their plans of care, and the ability of health care professionals to collaborate with communities.

Evidence based practice interventions can help MCM achieve a reduction in heart failure admission rates as long as providers and multidisciplinary team members can work together to

implement desired goals. Some areas of focus for MCM to work on improving is the areas of medication reconciliation, post-discharge appointments, post-discharge phone calls, and teach back interventions (Health Catalyst, 2017). It is imperative that health care professionals and providers check patients' medications and how they are supposed to take them, since medication errors can occur as patients transition through the health care system. Next area of focus is to ensure patients are scheduled for a follow-up appointment prior to being discharged, high risk patients should be seen within 7 days and non-high risk seen within 14 days (Health Catalyst, 2017). Establishing protocols for post discharge follow-up calls based on risk criteria, can ensure that the patient's condition and any concerns they have can potentially be resolved (Health Catalyst, 2017). Lastly, implementing teach back can help assure health care providers that patients understand the information that has been given to them.

Gone are the days of fee-for-service payments and Mercy Medical Center needs to take note of the improvements that must be made since value-based care is the new norm. MCM should no longer have patients returning to be treated for a condition that they weren't effectively treated for initially, as this wastes resources, time, energy, and money. Hospital readmission reduction can be complicated issues, however implementing evidence-based care practices, increasing provider engagement, and ensuring patients are set up to succeed will only reduce readmission rates, penalties, and increase overall satisfaction.

References

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