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The Hospital Administrator's Guide to Understanding HAC Scores

Announcer:
You're listening to *Vascular Viewpoints* on ReachMD, sponsored by Becton Dickinson, advancing the world of health.

Here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Surveillance programs for hospital-acquired conditions, or HAC scores for short, are complex scoring systems guiding hospital protocols with the intent to reduce complications in vascular access. But a fair amount of confusion persists on how HAC scores are constructed and which practices influence them the most, creating therapeutic disconnects between hospital administrations, departments such as ERs and ICUs, and individual clinicians. That's why, today, we'll fill in some of these knowledge gaps surrounding HAC scores and their implications on vascular access care.

Welcome to *Vascular Viewpoints* on ReachMD. I'm Dr. Matt Birnholz, and joining me to help decode HAC scores for clinicians is April Taylor, the Senior Director of Improvement and Project Management at the Children's Hospital of Philadelphia and Assistant Director of Performance Improvement at the Center for Healthcare Improvement and Patient Safety at the University of Pennsylvania's Perelman School of Medicine. Ms. Taylor, welcome to the program.

Ms. Taylor:
Thank you for having me.

Dr. Birnholz:
It's great to have you. So, just to start, we know HAC scores are both complex, they're even a touchy subject to discuss given their wide-ranging impacts on hospital protocols and federal funding levels, but can you just give us a brief overview of HAC scoring's role in vascular access care?

Ms. Taylor:
So, as you mentioned, HAC stands for hospital-acquired conditions, and as part of the Affordable Care Act, there was a national effort to encourage the reduction of these conditions through this program: uh, the hospital-acquired condition reduction program. Now, there is – this program is actually what's called a penalty program. So what that means is that this program requires that the Center for Medicare and Medicaid Services, or also known as CMS, uh, reduces hospital payments by 1% for hospitals that rank among the lowest performing 25% with regards to these HACs, or hospital-acquired conditions. So, it's played a really important role in hospitals, um, in them helping them to form local improvement teams, but also in really having hospitals come together nationally through collaboratives to look at how to standardize vascular access care, uh, from insertion through maintenance, through the development of standardized protocols.

Dr. Birnholz:
Interesting. And, certainly, the analogy holds between the carrot and the stick, a penalty program is going to lean towards the stick. But I'm curious then, April, which factors, from your point of view, most prominently influence an institution's HAC score?

Ms. Taylor:
So, there's been some change in both the definition and – and calculation of HAC scores over time. They focus on two domains; uh, domain one is a composite of what's called PSIs, or - or patient safety indicators. The second domain, uh, which is probably more relevant for this discussion includes some specific measures, including things like CLABSIs, or the central line bloodstream associated

infections, CAUTIs, uh, which are catheter-associated urinary tract infections, surgical site infections, and – and a bundle of other measures. And what happened is that, in the past, these measures were weighted, uh, so that first domain, those patient safety indicators, were given a weight of about 15%. And then domain two, which included the very specific measures related to CLABSI and CAUTI had a weight of about 85%. But more recently in this past fiscal year, so starting with fiscal year 20, there's been a – a change to that calculation. So, what's starting in fiscal year 20 is that, um, CMS is eliminating what's called this two-tiered domain system. And instead, they're moving to more of an equal weight system, so each of these HAC measures will instead be equally weighted.

Dr. Birnholz:
So, that's really interesting, given that change to the weighting recently. I imagine then that that has some downstream impacts in incentivizing or penalizing hospitals based on the scores and the respective weights. Can you speak to that?

Ms. Taylor:
So, HAC scores have definitely gone mainstream. And – and hospitals have made many changes in care to try and reduce that potential reduction in funding from Medicare and Medicaid. And 1% doesn't really sound like a lot, but to some organizations, particularly smaller organizations, that can have a huge impact. So, you know, the benefit to HAC and HAC scores regardless of how they are measured or calculated, is that it really has mobilized hospitals to pull together resources to improve care. It's helped them to empower frontline teams, to develop strategies to reduce hospital-acquired conditions and infections through education, through development of standardized protocols, or care pathways, and so on. And so, these are all positive changes that pretty much no one would argue, um, is - is the wrong thing to do in healthcare. But, again, on the flip side, that 1% could mean a lot, uh, particularly to, not just smaller organizations, but organizations that are really challenging financial situations or – or markets. So, there's a lot of concern around these penalty programs, because with the penalty program, uh, you're not getting an added bonus, you're taking something away. And so for hospitals that are maybe already struggling financially to provide basic care, taking away that 1% not only prevents them from potentially improving their hospital-acquired condition rates and scores, but may prevent them even from doing some of the basic care provision, um, that's part of their overall mission. It's also worth mentioning that HAC scores, like many other publicly-reported measures don't typically take into account a lot of other local and contextual factors that may be hard to measure or – or report on, but can impact the outcome and can impact the score. So, these range from things like, um, employment, socioeconomic status, um, insurance coverage. These may actually impact the patient's risk of developing a HAC. That's not really part of – of the definition or the calculation. And so although there have been changes to that measurement definition and strategy, as I mentioned, moving from kind of this weighting to – to doing it more equally, um, this still remains a concern for many organizations for how it's calculated, the amount of resources they're putting in to turning out this data.

Dr. Birnholz:

Yeah, it's a really fascinating overview of the benefits and the possible limitations. It sounds like, among the limitations, there's the risk that some therapeutic protocols could get narrowed to try to fit a score-raising or maintaining standard, for instance. Or, on the other side, that, um, as you mentioned, certain contextual details about the patients might make it more difficult to prevent CLABSI or other HACs, um, and maybe other elements of the patients being overlooked. Can you speak to some of those risks from your vantage point?

Ms. Taylor:
So, there can certainly be tradeoffs between patient and family preference, and what may be the best or safest repair. Um, but actually what probably removed that from the context of just thinking about HAC scores, I mean, that honestly happens in these sort of discussions all the time in the care process, and often aren't related to scores and pay-for-performance or – or these penalty systems. Most clinicians I would venture are not going to be focused on scores when they're trying to make the best decision for their patient. Um, they're really focused on the patient. Now, does that mean that there aren't the standardized, you know, pathways and protocols that have been developed that now we expect clinicians to follow or nurses at the bedside to follow; that that may certainly dictate a little bit more of the care process? That is certainly there, but what I've found is that in systems that do this correctly, they understand where there may be deviations from standardized protocols. And they have a process in place to document that. And they understand that these deviations may be an important part of the care process and they don't do it in a way where either the patient or the provider is – is penalized in that way.

Dr. Birnholz:

That's certainly heartening to hear, Ms. Taylor. I'm wondering though, if we look at the broader administrative level, um, are the decisions made there potentially restricting access to, uh, certain types of approaches, devices, et cetera, when it comes to vascular access care that might have a ripple effect at the granular patient and clinician level?

Ms. Taylor:

So that – that may be a challenge, absolutely. Um, outside of standardized protocols and pathways where I think that there is some understanding where there may be a deviation and, of course, like I said, if there is appropriate documentation that's certainly understood, the place where it may be more restrictive on the care process, um, is really around a supply chain. Uh, so where, you know, in the past, maybe the, uh, provider could have had a little bit more leeway in terms of, uh, specific products or tools that they wanted to use, what's often happening now is that there is, um, a lot more, um, administrative decision-making around what will or won't be used within a certain healthcare setting. And so, from that standpoint, I think that there is, um, definitely a lot more restriction that is going to be placed on that care team.

Dr. Birnholz:
Well, for those just joining us, this is *Vascular Viewpoints* on ReachMD. I'm Dr. Matt Birnholz, and joining me today is April Taylor from the Children's Hospital Philadelphia, and we're talking about the impact that HAC scores have on vascular access care.

So, Ms. Taylor, you've given us a great understanding of some of these core components around HAC scores. I'm wondering if you can then extend that and share some of the ways you've seen them change practice paradigms for better and/or worse over time at the department levels.

Ms. Taylor:
For the better. Um, we're sharing data, um, and I think that many folks will not argue at this point that data transparency, um, the idea of sharing data can help to drive improvement. Um, teams cannot improve if they don't know how they're doing. Um, so both at a national level, data transparency has really helped with, um, a little bit of healthy competition, um, and having different healthcare organizations look at what are their opportunities for improvement, but on more of a local level within, you know, hospitals, across departments, or across units, again it promotes this idea that, um, there may be this healthy competition. But, you know, with that being said, I think that some of the early lessons learned with, uh, HAC scores and this type of data is around how it's presented to staff. Um, how they're able to ingest and utilize that data. And a lot of times, these – these national measures, these HAC scores, because they're composites that – that pull a whole bunch of data together, that's not easily digestible at – at the front line, and so – at more of that local level within departments, what I see is not a focus on this HAC score, as we call it, but really a focus on those individual, uh, domains or – or measures that make up that score. Having the data in a way that resonates with staff I think is really what truly makes the difference and, for the staff and – and the clinical care teams, it's often not about the metric, it's a lot more about – about the patient.

Dr. Birnholz:
How do you, in – in an interesting position that's overseeing all of these different departments and trying to reduce that risk, respond to those potential frictions between departments?

Ms. Taylor:
So, I think at a high level, again, is trying to move this away from being a penalty or – or a negative thing. Um, you're really trying to move towards that idea of we're all in this together for the patient and family. Um, and again, how can you make competition healthy versus harmful. And so, I think again, at the local level, typically, you know, what I see that works well is that we report out on what's going well in addition to what's not working. Um, so oftentimes with these measures, um, again we're looking at infection rates. Uh, we're looking at negative outcomes. Um, oftentimes, we also need to focus in on, you know, the positive outcomes. And there are lots of things to be celebrating within healthcare. So, you might bundle these outcome metrics with process metrics. So, what percent of the time are we following our – our bundles related to line maintenance and care. You know, what percent of the time are we following our protocols related to insertion? Those are all things to celebrate and – and honestly what you may see is that for some of those process metrics, we may be doing all of that right and still potentially have some challenges with these outcome measures. Um, and so, there's this element of what's within our control, um, and really having the clinical teams have input into what are the bundled measures we're going to be – we're going to look, um, and to have some level of control in reporting that out. That way, we can celebrate our wins.

Dr. Birnholz:
I want to also ask you then about whether that data transparency, the input that's coming in from the different departments, uh, and their – their clinicians, respectively, have an upstream impact back on the supply chain, uh, issues that you've mentioned can sometimes be a factor at the administrative level. Can you speak to that?

Ms. Taylor:
Yeah, so, I think that that can certainly, um, be uh, a win-win there. Although, you know, oftentimes things do start to sort of pop down, uh, where we're looking to implement into, you know, protocols, um, in terms of, again, equipment that's going to be used, um, or other tools within the clinical care environment. Um, that bubble-up, or sort of like microsystem improvement certainly can trickle back up the other way in informed decision-making. And that's really all about that empowerment piece and not really letting the HAC score

improvement be driven only at an administrative level, but really going to the care teams to say, 'Well, what are the challenges here? What are the problems? And what we actually have identified that's gone back up to influence the supply chain is that, you know, maybe there is a – a challenge with, um, current wipes that we're using, right? And that that's actually creating a challenge for staff in terms of maintaining cleanliness within that environment and that the staff have researched, and they have a better idea for a certain supply that we should be using.

Dr. Birnholz:
Excellent. Really great thoughts, Ms. Taylor. Well, we're almost out of time, unfortunately. I could speak to you for hours, but before we close, do you have any additional thoughts, comments that we should keep in mind when it comes to HAC scores and their place in vascular access care now or down the horizon?

Ms. Taylor:
So, there's really two things that I would want to end with. One, is coming back to this idea of the involvement of the patient, family, and chair in the decision-making process and not letting, um, this focus on data or HAC scores really overtake that patient-provider-clinician interaction. And lastly, I think what I would leave you with is that there still is a lot of research that needs to be done to really understand what is the impact of some of these programs that are out there, so whether they are penalty programs or – or pay-for-performance, the underlying, uh, goal is really admirable to improve patient care and to improve safety. Um, but research in terms of what's the best way to do that within each local context, because as I mentioned before, not every organization is going to have the same resources, and we certainly don't want to create a system where we penalize hospitals disproportionately, um, who are really struggling to do the right thing for their patients and for their families.

Dr. Birnholz:
With those great closing thoughts in mind, I very much want to thank Ms. April Taylor for joining me to help understand HAC scores in vascular access care. Ms. Taylor, it was fantastic having you on the program today.

Ms. Taylor:
And thank you for having me.

Announcer:
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