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# The hospital executive's star rating playbook: The 5-point guide to improving your rating

*This is the second of two articles focusing on the the CMS 5-Star Ratings. The first discussed the impact of the ratings. This article focuses on what providers can do to improve ratings.*

*Three experts — including the chief clinical officer of Houston-based Memorial Hermann Health System — gauge the ratings' repercussions and share observations on their aftermath.*

In late July, CMS unveiled the Overall Hospital Quality Star Ratings on its Hospital Compare website. The rating system combines 64 public measures into a single, one-to-five star rating. CMS rated 3,617 hospitals on the star scale. Only 102 hospitals received five stars, the highest rating, while 129 hospitals received one star, the lowest rating. The others fell somewhere in between.

Shortly after the star ratings went public, *Becker's Hospital Review* talked to experts to gauge repercussions of the ratings and observations on their aftermath. Here, M. Michael Shabot, MD, chief clinical officer of Houston-based Memorial Hermann Health System, along with George Whetsell, FACHE, managing partner with Chicago-based Prism Healthcare Partners, and Doug Monroe, MD, a physician with Prism and formerly the system director of quality and patient safety at Memorial Hermann discuss the critical success factors related to achieving and maintaining high CMS 5-star ratings, including:

**1.** Leadership and Culture
**2.** Management Structure and Reporting Processes
**3.** Physician and Clinician Engagement
**4.** Data Availability and Analysis
**5.** Sustainable Performance Improvement

**1. It starts at the top: Leadership and Culture**

"Clinical staff are the most valuable healthcare resources, but hospitals often limit their expertise to the treatment of patients. Top performing systems have found ways to harvest additional value from their clinical staff by expanding their focus beyond care delivery to *improving* the care they deliver," Mr. Whetsell remarks. In order to accomplish this, healthcare leaders – administrative and clinical - need to accept that their role in the hospital might change.

"It's really about leadership granting decision rights to the physicians and clinicians, and then helping them achieve and holding them accountable for the decisions they make. That is where it all starts. By granting them ownership of the entire improvement process, and then facilitating their work, you engage them," says Dr. Monroe. Once leadership has engaged clinicians, successful leaders find ways to set ambitious goals, help remove barriers, maintain reporting and accountability, and acknowledge and encourage continuous improvement.

"One of the most important things our leadership team did, right at the beginning, was acknowledge that the way we were performing - status quo - was no longer acceptable. We had to make improvements to the goal every year," Dr. Shabot says. With this in mind, the leadership team at Memorial Hermann began to set expectations for themselves and the Board. "The expectation was, and continues to be, 100% compliance with process quality metrics, and 0% incidence of avoidable harm. However, in order to meet those expectations we had to find new ways of working. And that's where our clinical staff had the most crucial role," Dr. Shabot adds.

"When a physician and staff – line or leader – presents an improvement like zero bloodstream infections for a number of years to our Board, you can see how much it means to them. This is about preventing life-threatening events in the first place, whenever possible. There are proactive and reactive ways to improve care and save lives. We measure and celebrate the impact of both approaches," Dr. Shabot added.

Memorial Hermann created a "Certified Zero" program that recognizes sustained elimination of harm for a year or more in its hospitals. These awards, presented as certificates,

are not for the *reduction* of harm, but harm *elimination* - they recognize only zero harm. The awards comply with CMS, AHRQ and NHSN definitions for Hospital Acquired Conditions, Patient Safety Indicators and Hospital Acquired Infections. "We reward our hospitals for performing well on the very metrics the Star Ratings are based on, and have for over 10 years. Some of our hospitals have gone 3 years without a high level Serious Safety Event," said Dr. Shabot. Since 2011, 231 certificates have been presented at Memorial Hermann facilities, and other organizations, like Mercy Health in St. Louis and the South Carolina Hospital Association, now have programs based on Memorial Hermann's success.

"You'll note that these incentives are not related to financial recognition, but still hold deep meaning to the clinical and administrative staff and rightly so. It's one tool among many that leaders can use to track the value of improvement in tangible ways," says Dr. Monroe.

**2. Unite the Board and Bedside: Management Structure and Reporting Processes**

Given the complexity of health systems today, reducing the distance between executive leadership and the bedside is crucial. Memorial Hermann addresses this through structure and reporting processes. For example, Quality, Patient Safety and Infection Control resources report centrally but operate locally and have co-responsibility for local metrics and goals. "We've ensured that all quality and safety data is transparent across the System, and any issues are reported to local and System leadership simultaneously. Everyone knows everything at the same time, and System resources can work with local resources to solve problems and transfer best practices quickly and seamlessly. Our System resources are service oriented," said Dr. Shabot.

Dr. Monroe emphasized that sustaining performance relies upon robust reporting. At Memorial Hermann, events and issues are communicated through regular reporting processes that incorporate administrative and clinical representation – usually the CEO and CMO of each hospital. "Memorial Hermann has disciplined reporting practices. Every single variance is discussed, and action plans are tied to each. Each meeting involves not only new variances, but a follow-up of all historic variances that are currently being improved. That review of historic variance continues until a solution is hardwired across the system, and is monitored even then. It's how you preserve, or sustain, the value provided by the project in the first place," explains Dr. Monroe.

**3. Including physicians is often anxiety-inducing, but necessary: Physician and Clinician Engagement**

"Top performing systems give their medical staff, as well as nurses, other clinicians, and ancillary staff, the structure and the resources to change the processes themselves, and own their results," said Mr. Whetsell.

"One of our Certified Zero awards is for hospitals that go a year without a retained foreign body anywhere in the hospital — we've given out 43 since 2011," says Dr. Shabot, who attributes this success to formal processes adopted System-wide — all of which were driven by physicians, nurses, pharmacists and other clinicians. "Just telling the operating room clinicians and other personnel to count harder doesn't work," he says.

"You can't simply tell them what to do, and you can't do it for them – mostly because they are the ones with the expertise," Dr. Monroe says. "Trying to control physician behavior often results in mistrust and tension, and is frankly misguided."

A more effective strategy is to get their input and support their efforts. "If a leader wants to take a quick pulse of their own organization, the best place to start is the – usually brutally honest - medical staff. When you ask physicians certain questions, it becomes pretty easy to identify how a hospital is doing," said Dr. Monroe.

Some key questions to ask physicians include:

- Does leadership understand your challenges?
- Can you easily obtain data, and do you have the ability to analyze it?
- If you identify a challenge, do you know who to call for help, and how fast can you expect a response?
- What resources are at your disposal to address challenges in your work flow?
- How often does administration tell you what to do versus asking you what to do?

"Physicians and clinicians react poorly to plans presented as *'fait accompli'*, and well they should," says Dr. Monroe. "Many of these challenges are as complex and nuanced as the human bodies they try to heal. If you haven't included your clinical staff in decision making – haven't provided them with the appropriate structure, improvement resources, or clinician-vetted and validated data, you may encounter skepticism and resistance. Making them part of the process at the beginning, and at important waypoints throughout, moves you past resistance to true engagement, and real value provision," concluded Dr. Monroe.

**4. Leverage your data: Data Availability and Analysis**

Baseline reporting and submission criteria are a must for any healthcare system. But how do you move beyond reporting to use the data you have, in spite of limitations, to facilitate improvement? "You have to start with the physicians and clinicians again,"

says Mr. Whetsell. "They need to be able to interact with the data as much as possible, to pull it apart and find causality. Improvement initiatives shouldn't be haphazard – they need to be evidence-based."

"Standing reports are helpful and allow us to measure the outcome of our work. We use them wherever we can. But our improvement teams, clinicians and support staff often require more detailed or novel analyses for initiative planning and implementation," says Dr. Shabot. Leadership must make sure that information and resources are available to bedside staff. He continues, "So we have two main responsibilities for our clinical data management team: standing reports that may change slowly over time, and dynamic analytics that are provided upon request. It's a big operation."

That can lead to a lot of demands for data provision and analysis. Dr. Monroe notes that it's important to involve physicians and clinicians in the prioritization and data request processes. "You can't do everything at once. A system like Memorial Hermann is lucky to have so many caregivers who want to be involved in improvement. For other organizations, the sheer volume of requests can be overwhelming without a management process in place," he added.

"Top performers train a wide variety of folks to handle data and help lead improvement processes. They initiate a viral spread of improvement expertise," said Dr. Monroe. Paired with decision rights, the right data helps accelerate improvement efforts. "It's an entire performance improvement enterprise – and it works somewhat on its own."

**5. Approach matters just as much as talent, maybe more: Sustainable Performance Improvement**

A performance improvement enterprise begins with a core team of resources that focus on individual improvement initiatives as well as training staff System-wide as mini performance improvement experts. Dr. Shabot remarks, "Memorial Hermann's ongoing performance improvement training involves four sessions incorporating a real project for each participant. We train them in our standardized Robust Performance Improvement (RPI) methodology, which is embraced by the Joint Commission's Center for Transforming Healthcare, of which Memorial Hermann is a founding member. We connect our bedside resources to central tools and expertise like Quality, Patient Safety, Infection Control and Clinical Data Management. Not only do staff complete a project, they have the ability to identify and implement improvements going forward."

To improve star ratings, organizations must first change the processes that drive them. This work is not temporary or a one-and-done fix. Hospitals must take the long view. Mr. Whetsell adds, "5-star systems spend as much time sustaining as they do improving. They're not just fixing one problem, they're hardwiring a process – changing it forever. Their structure and processes are built as cycles, not as straight lines with starts and stops. As soon as you complete one review, one improvement, the next cycle begins. It's a completely different way of working, and one that produces lasting results. Disciplined reporting processes drive sustainment, and allow variance to be identified immediately."

Those cycles begin to add up. Dr. Monroe added, "After a few rounds of training, the number of resources grows, and you begin to see projects popping up in unexpected places. You realize that those are your people out there, identifying and improving challenges that are often only visible at the bedside. As a leader, you can help prioritize, but you also become focused on removing roadblocks and facilitating clinician-driven change."

Once hospitals have a performance improvement infrastructure in place, they'll notice a change in workflow. But as Mr. Whetsell indicated, the process can take years — not months. "You get limited returns in the first year, but those initiatives begin to gain momentum year after year. At end of 4 to 5 years, hospitals are tracking the financial, operational and clinical value of each initiative and seeing a compounding effect. You can attack individual metrics and have some success, but achieving and sustaining top performance requires an organization that builds upon its progress systematically."

Dr. Shabot continued, "So many RPI projects are in progress across the System that we hold a RPI Exposition each year to showcase those with recently completed results. At the 4th Expo last April, 60 RPI projects were presented, including a number led by physicians."

"It's a new way of working for many providers," notes Mr. Whetsell, "But you can't argue with their consistency and results. We recommend that hospitals and health systems with Star Rating opportunities begin by assessing themselves relative to the critical success factors, and then planning next steps based on any gaps."

"When performance improvement becomes performance evolution, your Star Ratings, and comparisons to national averages, will reflect the impact," says Dr. Monroe. "And by the way, you don't have to be a huge system to achieve this. The approach is entirely customizable for anyone, from a Critical Access or Community Hospital, to Regional Health Systems and larger. Talking about all of it is a good start, but understanding the actual concrete steps for implementation is crucial. If you haven't already, it's probably time to get started." ■