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U.S. News Expands Physician Eligibility, Moves to SAF

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U.S. News & World Report's annual "Best Hospitals" report is arguably the health care industry's most recognized and most trusted quality ranking program. These rankings matter because they impact patient behavior and your hospital's bottom line: 25% of patients switch hospitals based on *U.S. News'* Top Hospitals rankings and 60% switch hospitals when they learn about low ratings at their first-choice hospital.*

The patients who rely on *U.S. News* rankings when choosing where to get care tend to have higher education, higher income, and comprehensive health insurance. These are the very patients hospitals need to attract the most – and can't afford to lose, given today's increasingly tough reimbursement environment.

U.S. News publishes three sets of hospital rankings each year; Best Hospitals (including both specialties and procedures), Best Children's Hospitals and Best Regional Hospitals.

Savvy hospital executives recognize that in order to thrive now and in the future, they need to maintain or improve their rankings on a continuing basis. Attracting and retaining these patients by improving your rankings also has a positive downstream net effect for the physicians who refer to and/or are employed by your hospital.

It is important to note the hospitals should not make quality improvements for the sole purpose of boosting their rankings. Rather, they should develop and execute on strategies that ensure that the quality improvement processes and patient safety enhancements that are already underway are adequately captured and reflected in the rankings. If improvements to quality and patient safety are necessary, they should be implemented primarily to enhance patient care – with a secondary impact on rankings improvement.

Hospital executives are challenged with understanding the implications of changes to the constantly evolving methodology utilized by *U.S. News*. Following I will have described some of the key methodology changes *U.S. News* has implemented over the

past two years, and the possible implications for hospitals. I have also outlined steps hospital executives should take now to proactively and effectively prepare your organization to fare well now and in the future.

Expanded Eligibility to Vote

U.S. News has expanded the voting eligibility criteria for some specialties, as summarized below.

- **Cardiology & Heart Surgery**. Added to the eligibility are physicians certified in Vascular Surgery by the American Board of Surgery; as well as those certified in Adult Congenital Heart Disease, Advanced Heart Failure and Transplant, or Interventional Cardiology from the American Board of Internal Medicine (ABIM), even if are not certified in Cardiovascular Disease
- **Gastroenterology and GI Surgery**. Several new certifications and memberships now qualify physicians to vote: certified in Transplant Hepatology by the ABIM, or members of the American Society for Metabolic and Bariatric Surgery, American Society of Colon and Rectal Surgeons, or Americas Hepato-Pancreato-Biliary Association.
- **Neurology and Neurosurgery**. Newly eligible are neuroradiologists, as certified by the American Board of Radiology.
- **Rehabilitation**. Qualifications have been expanded to include physicians certified in sports medicine by either the American Board of Emergency Medicine or the American Board of Family Medicine.
- **Pediatric Gastroenterology and GI Surgery**. An American Board of Pediatrics certification in transplant hepatology will now qualify a physician.

Implication for Hospitals: Overall, this is a positive for hospitals. Newly-eligible physicians may be more likely to vote during their first year of eligibility. Hospitals must focus on making sure that all physicians are registered with Doximity, especially those who may not have been included in targeted communications in the past. Just as importantly, they must consistently remind eligible physicians of the importance of casting a ballot.

Use of SAF dataset.

U.S. News changed from the MedPAR to the SAF datasets for all volume, mortality, and patient safety calculations; however, the Health Services Cost Review Commission all-payer database continues to be used for the Patient Safety Score calculations for hospitals located in Maryland. The SAF datasets only include patients receiving care through traditional Medicare (fee-for-service).

Implication for Hospitals: Hospitals across the country experienced reduced hospital volumes due to the lack of CMS managed care patients in the SAF datasets.

Volume adjustment for loss of Medicare Advantage.

Volumes were estimated for hospitals in each specialty using an adjustment to account for the loss of Medicare Advantage patients from the analyses. The numerator for the volume calculation was the number of fee-for-service discharges meeting the criteria for inclusion in the specialty. The denominator was the proportion of Medicare beneficiaries enrolled in fee-for-service (as opposed to Medicare Advantage) in the county in which the hospital is located. The denominator was calculated by subtracting from 1.0 the CMS Medicare Advantage penetration estimates, expressed as a decimal less than 1.0, for June 2013.

Implication for Hospitals: The volumes reported represent estimates rather than observed volumes of care at each hospital.

Socioeconomic status (SES) adjustment to the survival score.

The rankings now incorporate a new adjustment at the patient level for dual-eligibility for Medicare and Medicaid. The dual eligible flag is set to either 0 (not present) or 1 (present) for each case entering the risk-adjusted mortality equation. This was done to address known differences in morbidity and mortality with hospital patients associated with lower SES; dual-eligibility, or more specifically eligibility for Medicaid, is being used in this case to represent lower SES.

Implication for Hospitals: The impact of this changes is minor, but will result in scores that better represent patient survival in hospitals evaluated.

Intensivists.

Hospitals now receive 1 point for having at least one intensivist FTE reported as being available in any adult-focused intensive care unit within the hospital.

Implication for Hospitals: This change provides broader credit to hospitals for having intensivists available.

Nurse Magnet.

The Nurse Magnet measure was updated to better reflect program coverage for hospitals that are part of a multi-campus system or an arrangement with another hospital outside the system. Hospitals received 1 point for being recognized as a Nurse Magnet hospital. For hospitals that are part of a special merger or a multiplex

healthcare system, the primary hospital is required to have Magnet Recognition status for the combination hospital to receive 1 point. If there is no defined primary hospital, both hospitals will receive credit if either has Magnet Recognition status. Partial credit was not offered in the 2017-2018 rankings.

Patient safety score. Two of the PSIs used in the patient safety score—PSI 06 (Iatrogenic Pneumothorax) and PSI 14 (Postoperative Wound Dehiscence)—were dropped due to concerns that low base rates could lead to unreliable measurement. The scoring for the remaining individual PSIs was also revised to a three-point scale with the middle category defined as the mean +/- 2 standard deviations. The individual PSI scores were combined to form a 1-9-point Patient Safety Score with higher numbers indicating better performance (i.e., lower rates of patient safety events).

Nurse staffing score adjustments.
The project implemented three changes to the nurse staffing score for the 2017-18 rankings. First, the calculation now includes a correction for hospitals that provide onsite skilled nursing and report their nursing inclusive of both the inpatient and skilled nursing. The nursing FTEs associated with the skilled nursing are removed from the numerator and a corrected adjusted average daily census is used for the denominator. The corrected adjusted average daily census values for hospitals affected by this change are calculated and provided directly to the project by the AHA. Second, to address problems with missing data—in particular the primary nursing FTEs variable (FTEN)—the rankings impute missing FTEN values. For the imputation, hospitals that do not have extreme nurse staffing ratios are selected and the calculation incorporates data from current values for FTEN (Full time equivalent registered nurses reported), FTERN (Full time equivalent registered nurses estimated), ADJADC (Adjusted Average Daily Census) and BDTOT (total hospital beds set up and staffed). Third, to address volatility in the nurse staffing measure for hospitals with relatively low numbers of patients, we adjust the nurse staffing values for hospitals in the lowest quartile of adjusted average daily census by blending their rate with that of the average adjusted nurse staffing rate for hospitals eligible for the rankings.

Surgical Minimums for Eligibility in Neurology and Neurosurgery.
To be eligible for evaluation in the neurology and neurosurgery specialty hospitals are now required to be at the 25th percentile or higher in terms of the ratio of surgical to total discharges within the DRGs evaluated for the specialty. This change was made to address excessive bias in mortality rates for hospitals with a very low ratio of surgical-to-total discharges.

Implication for Hospitals: Some hospitals that previously evaluated for this category were not evaluated this year.

Quality Assurance Initiatives Added to Children's Hospitals Surveys

In the absence of available claims data to draw upon, *U.S. News* previously relied solely on hospital-reported data to generate the Best Children's Hospitals list. As with any self-reported data, errors sometimes occurred without a system for *U.S. News* to verify it. Beginning this year, *U.S. News* has implemented a quality assurance initiative that will enable it to verify the data being reported by the 100-some children's hospitals throughout the country who dedicate the resources to completing the annual survey.

This year's quality initiatives are outlined below.

Collect supporting data. In certain questions on the Pediatric Hospital Survey, we have requested that hospitals submit supporting data that will enable us to check their calculations. For example, the survey this year requests anonymized tables of hemoglobin A1c test results along with certain patient characteristics. In past years, generating such tables would have been a step necessary to complete the Pediatric Endocrinology section of the survey, but hospitals weren't expected to supply the tables to RTI for review.

Use data-entry alerts. RTI International, the data contractor for *U.S. News*, has implemented more validation logic in the Pediatric Hospital Survey, to provide immediate alerts about potential data-entry errors or inadvertent omissions to individuals who are inputting data on behalf of their hospital.

Perform additional analytical checks. After hospitals have completed their data submissions, RTI will perform a series of new analytical checks on the submitted data, including flagging outlier values such as unexpected changes from prior years and unexpectedly large differences from national averages. RTI and *U.S. News* will review the results of these analyses.

Verify flagged values. Hospitals may hear from RTI and/or *U.S. News* this spring as we seek to verify the accuracy of certain flagged values prior to publication of the 2018-19 Best Children's Hospitals rankings.

Conduct editorial review. If, after publication of the rankings, *U.S. News* concludes in its editorial judgment that data submitted by a hospital were inaccurate or unacceptable,

U.S. News may retract any ranking of that hospital that was based on the data in question, and it may limit the hospital's opportunities to participate in future pediatric surveys.

U.S. News is Seeking Input on Move to ICD-10 Codes

The use of CMS billing codes has been a part of the *U.S. News and World Report's* Procedures & Conditions rankings for nine common surgical procedures and chronic conditions: abdominal aortic aneurysm repair, aortic valve surgery, heart bypass surgery, total hip replacement, total knee replacement, colon cancer surgery, lung cancer surgery, COPD and heart failure. This is the first year that will incorporate ICD-10 codes in the Procedures & Conditions ranking, and *U.S. News* is seeking input on that transition from hospitals.

CMS required that providers move to ICD-10s in October 2015. The rankings due to be released this summer will include Medicare claims from 2011-2016, spanning both the previous use of ICD-9 codes and the current ICD-10 codes. The ICD transition affects the Procedure & Conditions ratings because cohorts and outcome measures are defined using inclusionary and exclusionary ICD procedure and diagnosis codes.

What They've Done

U.S. News entered the existing ICD-9 inclusion and exclusion criteria into the Agency for Healthcare Research and Quality's MapIt tool, which uses General Equivalence Mapping files produced by CMS to convert ICD-9 codes to ICD-10. They shared the ICD-9 cohort definitions and proposed equivalent ICD-10 cohort definitions with clinical experts in the relevant fields. After revising our cohort definitions to reflect feedback from these experts, they ran diagnostics comparing our cohorts before and after the ICD transition.

Results and Interpretation

When comparing aggregate national volume by *U.S. News*-defined cohorts for the last 12 months of the ICD-9 usage with the first 12 months of the ICD-10 usage, all cohorts demonstrate minimal change in volume. *U.S. News* subsequently compared volumes only for volumes from hospitals that were related last year, and hospital-level correlations between the volumes for the same time frame. The correlations ranged from 0.917 to 0.985 comparing the ICD-9 and -10 years and from 0.926 to 0.986 between the two ICD-9 years. This comparison confirmed that the changes observed across the ICD transition were in line with year-to-year fluctuations and so may not be driven by code-related changes.

U.S. News also investigated the breakdown of DRG codes within each cohort across the ICD transition to ensure that they were similar, as DRG codes generally did not change

with the ICD transition. The DRG makeup of the ICD-9 and ICD-10-defined cohorts were within a few percentage points in all cohorts.

Invitation for Feedback

U.S. News is soliciting public input to enhance transparency and validate its translations. You can review *U.S. News'* entire article and cohort definitions, or contact us for more information and assistance in interpreting these results.

Hospitals Should Take a Big Picture Approach

While it is important for hospitals to be aware of changes to the *U.S. News* Best Hospitals ranking, it is more important that hospital executives take a longer-term, big picture approach to managing quality and rankings over the long-term, rather than respond to any anticipated change or set of changes in isolation. Hospital leadership should not conduct quality improvements with the exclusive intent to improve rankings status, but as part of its dedication to improving patient care – which will organically improve rankings, volume and overall hospital performance.

That said, having a clearly defined strategy and process to align your current quality improvement and patient safety initiatives so they are captured and adequately reflected in the rankings is a worthwhile and necessary goal. Understanding *U.S. News'* measures allows hospitals to benchmark themselves against these measures to determine where further quality improvement processes can be made. And that is a good thing for everyone.

I have outlined a crucial five-step process hospitals can use for understanding where they fall within the rankings and what they can do to improve those rankings. Equally important is prioritizing your service lines to optimize positive ranking opportunities. Finally, developing and executing an effective reputation management plan is also a critical factor in getting positive rankings.

Crucial Step 1: Benchmark mortality, patient safety, HCAPS and physician reputation.

Crucial Step 2: Outline strategies, critical success factors and tactical steps for improvements.

Crucial Step 3: Prioritize service lines to maximize ranking opportunities.

Crucial Step 4: Create dashboards to track progress and results.

Crucial Step 5: Develop a marketing plan for reputation improvement.

This process will not guarantee that your facility will land a national Top Hospitals spot. But it will guarantee essential benchmarks, improved outcomes, increased leverage when recruiting physicians and a more powerful brand – all of which are equally important when attracting and retaining patients.

Everything your hospital or system does to improve your rankings should positively improve patients care and outcomes. That, after all, should be the ultimate goal of your organization, regardless of rankings. Improving quality and outcomes will help hospitals obtain Medicare reimbursement incentives established under the Affordable Care Act. Performing the right analysis and benchmarking now can help you determine precisely where you should improve your processes to avoid financial penalties.

Summary

Whether your hospital or your physicians like the rankings or not, such rankings are clearly here to stay and will continue to evolve over time. In addition, more publically reported data on performance is being collected than at any other time in history. This information will be published not just by *U.S. News*, but by other recognized, even if less influential, sources, including HealthGrades, ProPublica, and many others. Individual consumers, further emboldened by increasing out-of-pocket costs and accustomed to researching companies and products on-line, will proactively seek out information on health provider performance. The time to get on board with the trend is now, if you haven't already done so.

References:

** Source: Thomson Reuters 2010*
Expanding Eligibility for the Physician Survey
Enhancing Pediatric Data Integrity
The Transition to ICD-10: Invitation for Feedback

About Gabrielle DeTora

Gabrielle is a healthcare marketing strategist with nearly two decades of executive experience and a proven track record of driving ROI. Gabrielle has worked with the CEOs and leadership teams of nearly 50 health systems, representing over 100 hospitals nationwide. She has served as the strategic leader for health systems, brand marketing agencies, and consultancies.

Earlier in her career, Gabrielle served as the Vice President of Health Strategy for a major advertising agency. There, she oversaw all strategic business planning, branding, marketing, and execution for more than a dozen large healthcare systems, healthcare organizations, and insurance companies.

Her past experience also includes top executive strategic planning and marketing roles at St. Joseph's Healthcare System, Hunterdon Healthcare System, the Cure for Lymphoma Foundation, and the Leukemia & Lymphoma Society. This deep experience gives her a keen understanding of the healthcare industry, which she uses to deliver highly effective strategic marketing plans for her clients.

Beyond the work Gabrielle conducts for her clients, she is also called upon regularly to speak at national healthcare conferences, and is a regular contributor to a variety of healthcare publications. Gabrielle has an MBA from Kennedy-Western University and a BBA from the Zicklin School of Business (CUNY).

To ask questions or inquire about consultant services for effective and efficient strategic planning execution, please contact Gabrielle DeTora at gabrielle@detoraconsulting.com or 908-447-9231.

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