

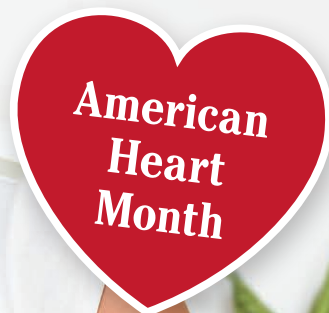
Today's Dietitian

Magazine for Nutrition Professionals

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Heart-Healthy Oils

Learn about the latest varieties and science on the healthful fats they contain.

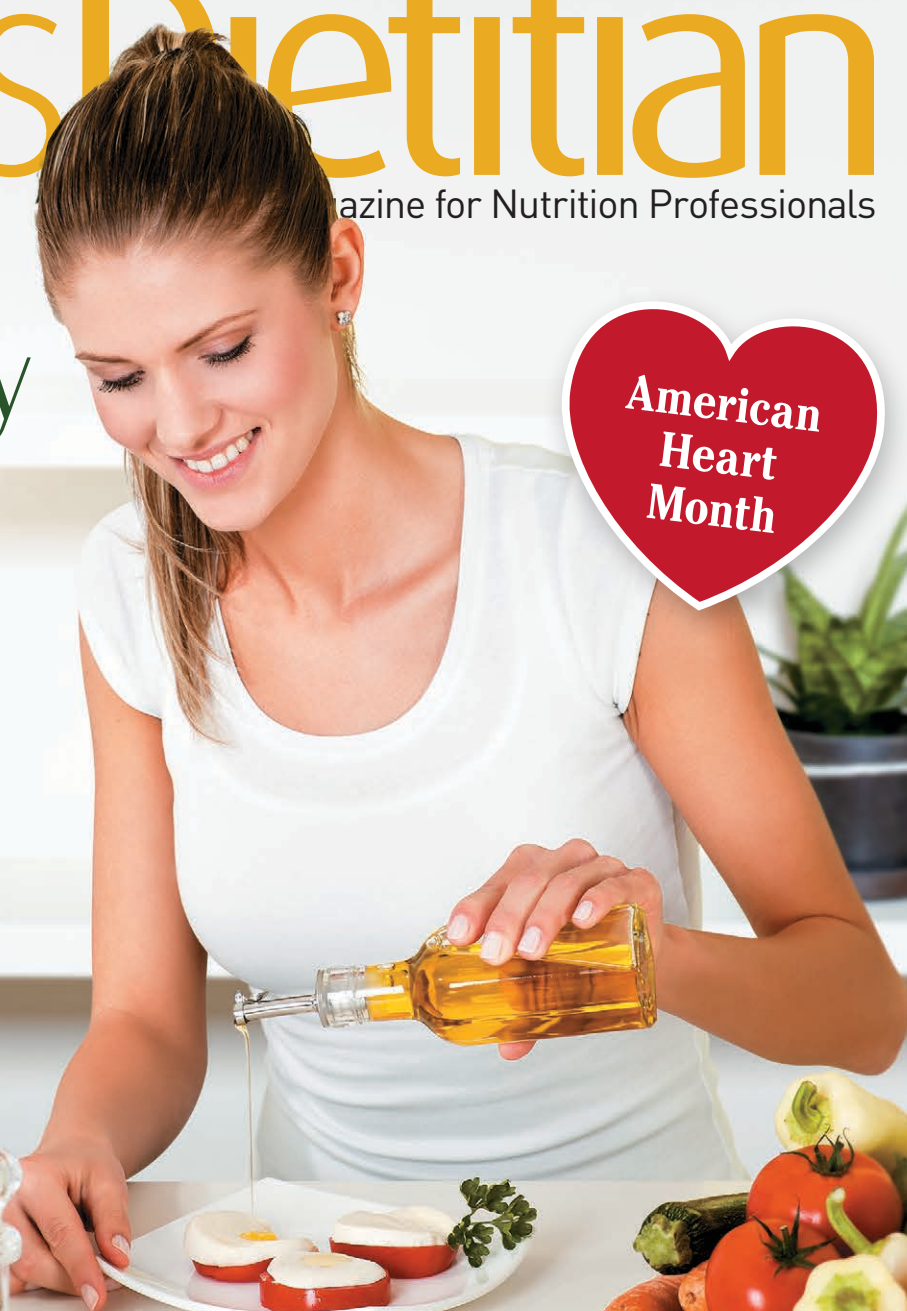


The Newest Trends in the Dairy-Free Aisle

Plan Healthful Vegan Diets

TD Q&A

Building a Private Practice



— *The* Value *of* — Benchmarking

By WENDY PHILLIPS, MS, RD, CNSC, CLE, FAND

Just as athletes compete with one another to win first place, health care institutions compete with each other to be ranked best in class for patient care and patient satisfaction. And just as sports leagues establish requirements for teams to become winners, governmental organizations set standards for health care organizations to meet and benchmarks to gauge their performance.

The American Society for Quality defines benchmarking as “a technique in which a company measures its performance against that of best-in-class companies, determines how those companies achieved their performance levels, and uses the information to improve its own performance. Subjects that can be benchmarked include strategies, operations, and processes.”¹ The benchmark is the performance measurement that defines success and is the standard against which other performance measurements are compared. A benchmarking program evaluates individual performance against the benchmark and determines where improvement is needed.

Health care organizations must participate in benchmarking programs, most often determined by the federal government, to receive funding and avoid penalties. In addition to participating in these required programs, many organizations choose to take part in voluntary benchmarking programs to help improve care in their facilities. Because some of these programs focus on delivery of nutrition care, or nutrition as a small component, RDs can play an important role in helping health care institutions meet patient care standards and measure optimal performance.

Mandatory Benchmarking Programs

The Centers for Medicare & Medicaid Services (CMS) provides insurance for millions of Americans who seek treatment at health care facilities, such as hospitals, and therefore offers the

largest source of revenue for these facilities. As a result, the CMS mandates that these facilities provide safe, high-quality care to Medicare and Medicaid beneficiaries. Most private insurance providers recognize these same quality standards set forth by the CMS as national benchmarks.

The CMS defines safe, quality care by setting standards (benchmarks) that health care facilities must achieve in various measurement areas. The facilities can then measure their own performance in these areas and compare it with the CMS benchmarks indicating success or failure.

Many of the health care facilities that treat Medicare and Medicaid beneficiaries are accredited by The Joint Commission, which uses the benchmarking program ORYX to determine whether facilities’ patient outcomes and other performance measurement data demonstrate the delivery of safe, quality care based on the established benchmarks. Joint Commission accreditation decisions, and therefore CMS funding decisions, are based on the data submitted as part of the benchmarking program.²

Health care facilities can collect and report the same data to both the CMS and The Joint Commission, since their quality measures are aligned. These standardized quality measures, known as accountability measures (previously core measures), are part of the collective Joint Commission Hospital Quality Measures.³ They’re examples of benchmarking programs health care facilities must use to meet specific aims such as financial reimbursement and accreditation status.

The Hospital Inpatient Value-Based Purchasing Program, established by the Affordable Care Act (ACA), is another CMS-required benchmarking program.⁴ As part of this program, several benchmarks define success in areas such as patient satisfaction and hospital readmission within 30 days of discharge. The benchmarks established to define success must be met or exceeded for facilities to receive their designated financial incentive.⁴

Today's Dietitian reviews the differences between required and voluntary benchmarking programs and offers RDs strategies for implementation to help improve delivery of clinical nutrition services.



To further promote accountability for results, health care facilities also must make data available on the CMS Hospital Compare website so patients can access this information to make informed decisions about where to receive health care services.⁵ This public reporting of data is necessary to avoid an annual payment reduction by CMS of 2% of the facilities' overall budgets, which could translate to millions of dollars for some facilities.

Dietitians play key roles in improving outcomes measured by many of the required benchmarking programs in the facilities where they work. For example, one Joint Commission accountability measure involves controlling cardiac surgery patients' 6 AM blood glucose following their procedures.³ RDs can help physicians and nurses implement perioperative nutrition interventions, such as decreasing the length of time *nil per os* (NPO), "nothing by mouth," as part of an overall glycemic control program to ensure that patients' 6 AM postop glucose is under control.

Additionally, reducing unplanned hospital readmissions within 30 days of discharge is a key focus of the ACA, with a financial incentive attached.⁴ To help address this measure, dietitians can help schedule outpatient nutrition follow-up appointments within the first 30 days of discharge. During these appointments, RDs can help identify and address unforeseen issues that otherwise can lead to malnutrition, dehydration, or other nutrition-related reasons for readmission. Examples of issues that can be addressed include access to necessary nutrition-related supplies such as enteral feeding pumps or adequate food supply, and/or nutrition education on sodium or fluid intake for patients with renal or cardiac dysfunction.

External and Internal Benchmarking

Organizations use external benchmarking to measure their performance against that of similar institutions. They use internal benchmarking to compare their own performance over time.

The CMS and The Joint Commission require external benchmarking against national standards, and voluntary programs also provide external benchmarks. For example, many academic teaching hospitals are part of the University Health System Consortium (UHC) and are compared with this large group for productivity, patient satisfaction, and quality metrics. These hospitals also may compare themselves with a more select group within the UHC for certain metrics. The administrations can choose a narrower compare group by selecting hospitals in similar geographic areas, of similar size, or with similar characteristics, such as the medical acuity level of babies admitted to the neonatal ICUs or disease states treated. For some metrics, percentile rankings can be assigned using both the select compare group and all UHC hospitals. It's important to clearly determine against what group an organization will be compared, as this can

affect the applicability of the results. Also as part of external benchmarking, organizations should be able to contact better-performing facilities to gain useful insights for practice improvements.

The targets of external benchmarks always are changing based on how facilities within a comparison group perform at any given time. For example, a score of 85.6 on patient satisfaction measures in one quarter may rank within the 75th percentile within the compare group, but based on the performance of facilities, this same raw score during the next quarter could put the facility in the 50th percentile. Therefore, facilities always should strive for quality improvement in their processes.

With internal benchmarking, facilities can benefit by seeing how their performance changes over time in addition to comparing it with the external benchmark. For example, a facility could examine how a pressure ulcer prevalence of 1.2% this year compares with the prevalence last year. The 1.2% prevalence this year may place the facility in the top ranks of its compare group, but if this is a higher prevalence rate than the previous year, then a problem still exists and steps must be taken to reduce this rate.

Voluntary Benchmarking Programs

In addition to the required benchmarking programs in which health care facilities must participate to receive funding, there are voluntary programs in which facilities or certain care teams may choose to get involved.

Examples of voluntary benchmarking programs that are relevant to RDs include the Sustain registry for home parenteral nutrition patients and nutritionDay for malnutrition prevalence tracking. Sustain's purpose is to maintain a prospective national patient registry for patients receiving long-term, home



parenteral nutrition to provide benchmarking of data as a way to measure performance of outcome metrics and determine standards of care that should be offered to ensure optimal patient outcomes.⁶

nutritionDay provides standard assessment tools and collects data from health care facilities so they can compare themselves with similar institutions to determine whether improvements are needed in patient nutrition delivery. nutritionDay aims to raise awareness of the high prevalence of health care malnutrition, offer resources to assess and minimize it, and provide benchmarking reports so individual facilities know where to focus improvement efforts.

One hospital's participation in nutritionDay will be discussed at the end of this article as an example of a benchmarking program beneficial for RDs.

Why should RDs participate in benchmarking programs? With dietitians' involvement in mandatory benchmarking programs, they can demonstrate value for patients as part of the overall care team and show how nutrition plays an important role in all aspects of the facilities' care, ultimately positively impacting both patient and facility funding.

Selecting a Voluntary Benchmarking Program

Voluntary benchmarking programs can provide value to health care facilities beyond what mandatory programs require. The goals of participating in a voluntary benchmarking program are threefold: Identify whether a problem exists, pinpoint what improvements can be made, and periodically reevaluate against the benchmark provided in the program to determine whether intervention efforts are effective.

To start, a health care facility's nutrition care team should evaluate high-volume diagnoses in the institution. The quality, patient financial services, and coding departments usually are the best places to gather information to help determine which diagnoses are commonly seen in the facility. For example, a facility may have a high volume of complex wound cases due to the presence of a unit dedicated to such treatment. Since nutrition plays an important role in wound healing, this may be a good focus area to identify whether improvements are needed.

Once a focus area has been selected, the nutrition care team must choose a benchmarking program that best addresses the situation. The team then must determine whether benefits that could be gained by participating in the benchmarking program will outweigh the time and resources required to carry it out. This involves a thorough review of the entire benchmarking program, including the measurements that define success, the data that need to be submitted, and any stipulations on how those data are collected and reported. Discussions with other RDs who have participated in these programs can be helpful in determining the costs vs benefits of the programs. Often, it's possible to use a program for a trial run before fully committing to participation in a voluntary program.

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Performance Improvement at a University Medical Center

Malnutrition in the hospital setting greatly contributes to increased morbidity and mortality, decreased function, reduced quality of life, longer hospitalizations, higher frequency of hospitalizations, and greater health care costs.⁷ Improving the nutritional status of hospitalized patients can lead to improved outcomes, including those reported as part of the Value-Based Purchasing Program. Although the clinical nutrition team may be able to identify targeted, hospitalwide interventions to improve nutrition care, support for these programs may be limited due to factors such as time, cost, and utilization of health care resources. One benefit of participating in a national benchmarking program is the ability to demonstrate to health care administrators, physicians, and other key decision makers the specific areas that can be improved to be considered best in class.

Morrison Healthcare is a foodservice and clinical nutrition contract management company that provides services to about 600 hospitals throughout the United States.⁸ With the implementation of the ACA and the publication of research regarding malnutrition,⁷ senior nutrition leadership for Morrison recognized the need to decrease the effects of malnutrition on patients hospitalized in its facilities and sought a benchmarking program to help the clinical nutrition teams understand how they compare with the national standards on factors influencing their patients' nutrition status. Each hospital's goal was to target two to three key interventions each year based on their individual results from nutritionDay. Morrison, therefore, formed a partnership with nutritionDay to provide this benchmarking program.

nutritionDay, as part of its benchmarking program, provides protocols and standardized data collection forms and maintains an online database for data entry, which allows for external benchmarking so individual hospitals can compare their data with similar participating facilities. Data collection occurs on one designated day each year since this is a prevalence study, and is repeated annually at each participating facility to allow for internal benchmarking that monitors progress of minimizing health care malnutrition.

As part of its nutritionDay participation, the clinical nutrition manager (CNM) at a hospital evaluated the time needed to execute the benchmarking program, including to prepare and review data collection forms; train RDs, dietetic interns, and nursing students to collect data; and enter the data into the online database. Since the time to complete these activities on the actual day of participation was estimated to be at least eight hours and required assistance from multiple people, the CNM reviewed sample reports from other facilities that previously had participated in nutritionDay benchmarking to decide whether the benefits of participation outweighed the expenditure of staff time that would be involved. In addition, the clinical team factored in the benefit of being able to benchmark internally from year to year.

The involvement of the hospital's nursing leadership at the program's outset also was instrumental to this facility's success. The director of nursing research committed time and expertise to collecting and reporting data, interpreting results, and presenting information regarding nutritionDay to nursing leadership to gain buy-in for performance improvement initiatives resulting from participation.

Upon deciding to participate in nutritionDay's benchmarking program, the clinical nutrition team worked to ensure the quality of the data that would be collected. The CNM and other RDs reviewed all data collection forms and the online database for submission of results and contacted nutritionDay staff with questions. This provided assurance that the results would be interpreted correctly and be applicable to the facility once returned. Nursing and nutrition staff collected data on November 8, 2012, the same day all other participating hospitals collected data throughout the United States and the world.

The results of the first-year participation demonstrated that the hospital was doing well in many areas of nutrition care, but there was room for improvement. For example, more patients were NPO on the day of data collection in this hospital

compared with other facilities. Although nutritionDay is a prevalence study and looked at only one day throughout the patients' hospital stays, these results helped to confirm suspicions already held by the clinical nutrition staff that patients were being kept NPO for longer than necessary according to established evidence-based practice guidelines.

Adding the nutritionDay data to other data that had been collected as part of a departmental performance improvement project, such as total length of time patients were NPO pre- and postprocedure, helped demonstrate the need to implement interventions to reduce the length of time patients are NPO to improve malnutrition rates. Having nationally benchmarked data helped secure hospital administration commitment to supporting these efforts.

As a result of the findings, the nutrition managers made plans to work with other disciplines, such as nurses and physicians, to revise policies and procedures to reduce the length of time patients are kept NPO before procedures, transition patients to solid foods more quickly after surgery, and improve communication with nursing staff when procedures are canceled or postponed so that normal diets can be resumed sooner.

An unexpected finding from the nutritionDay data was that the readmission rate for the patient population studied was higher than average among the participating hospitals. As a prevalence study, these results didn't provide additional information for understanding the increased readmission rates but did alert the CNM, clinical nutrition team, nursing, and hospital leadership to focus on this issue.

This hospital is part of a health system that includes RDs in many outpatient settings, such as the cancer center and the digestive health and heart center clinics. As a result of the nutritionDay report showing a need to decrease readmission rates, the CNM intensified efforts to increase referrals to the RDs in these settings within the first 30 days of discharge

in an effort to enhance the continuum of nutrition care and try to prevent readmissions. In addition, to further understand the results provided by nutritionDay, the clinical nutrition team launched an internal study to determine readmission rates based on degree of malnutrition diagnosed during the first admission.

Successful participation in a benchmarking program by the clinical nutrition team in any health care facility requires multidisciplinary involvement and awareness. Results of this facility's nutritionDay participation were presented at its Evidence-Based Practice Symposium. Nurses in attendance provided feedback on recommended interventions to improve performance in accordance with the benchmarking program.

Voluntary Benchmarking Resources

- The Academy of Nutrition and Dietetics (membership required)
 - Quality Management: www.eatright.org/quality
 - Dietetic Practice Groups for specialty specific benchmarking programs (additional membership fee required): www.eatright.org/dpgs/
- SUSTAIN Registry for home parenteral nutrition patients: www.nutritioncare.org/ASPEN_Sustain/Sustain_FAQ/
- nutritionDay: www.nutritionday.org

In addition to eliciting ideas for the practical implementation of planned strategies from more than 50 nurses in attendance, the presentation created an increased awareness of the issue of malnutrition and the clinical nutrition team's partnership with nursing leadership to address the underlying factors. A similar presentation was given to the hospital's medical executive committee to gain support for necessary authority to implement planned interventions because of the benchmarking results.

Getting Involved and Making a Difference

Morrison Healthcare's partnership with nutritionDay is one example of a clinical nutrition team selecting a voluntary benchmarking program relevant to its most significant focus areas. As discussed, many required and voluntary benchmarking programs exist, and clinical nutrition teams need to decide whether participation in such programs will help meet the overall goals of the department and institution.

A facility's CNM should review all benchmarking programs in which the hospital is participating to determine which metrics within these programs can be influenced by nutrition. A meeting should then be scheduled with nursing and hospital leadership to explain this influence, offer assistance for programs to improve the metric, and accept feedback from nursing on how the clinical nutrition or food-service teams can assist efforts already being implemented. Moreover, the CNM should meet with hospital administration to ensure it understands the value the clinical nutrition team adds to these efforts and garner the needed support for nutrition interventions. Finally, the CNM should present to the quality committee on a regular basis, explaining the benchmarking results, the interventions implemented in response to those results, and the improvement in metrics related to nutrition interventions.

Often, benchmarking programs in which the hospital is already participating may benefit the nutrition team, but may not directly address all areas in which nutrition care delivery can be improved. The clinical nutrition team may believe that a specific aspect of nutrition can be improved but may have difficulty convincing nursing or other management within the hospital that it's an issue to which resources need to be dedicated. This may be the time to search for appropriate external benchmarking programs to help establish the need for improvement.

Alternatively, nursing or other leadership within the hospital may believe that the nutrition care may be lagging in a certain area in that institution. Participation in an appropriate benchmarking program may help the nutrition team demonstrate acceptable performance.

Consulting industry-specific listservs such as the dietetic practice groups of the Academy of Nutrition and Dietetics (the Academy) or professional journals such as the *Journal of Enteral and Parenteral Nutrition* are good places to begin

looking for comparison standards and benchmarking programs. Clinicians should ask respected leaders in their profession for ideas on where to start. National quality organizations that include voluntary and required benchmarking programs are listed under the Quality Management section of the Academy's website.

Whichever benchmarking program is chosen, communication is an essential component of the process. Applicability of results and planned interventions must be communicated to the clinical nutrition team, nursing and other disciplines, and hospital management to gain needed support and maintain momentum and accountability. The nutrition literature is enriched and best practices are shared when the results of benchmarking studies and patient outcomes from resultant interventions are published.

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