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Last-minute survey preparation can pay off with big dividends

Set up 'war room' to attend to surveyor needs

Preparing for a Joint Commission survey is not something that can happen overnight, warns **Ann Kobs**, MS, RN, former director of the department of standards at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL. "This is supposed to be a way of life, and to have teams that have never met until immediately before the survey is no way to do business.

"The care of a patient requires a multidisciplinary approach at all times, which means that various departments must talk to one another," says Kobs, who now serves as president of Type One Solutions in Fort Myers, FL. "Getting ready means being ready every day and making sure you are taking care of your patient's rights every day."

Regina Walczak, director of organizational performance at Saddleback Memorial Medical Center in Laguna Hills, CA, agrees that trying to accomplish too much just before a JCAHO survey spells trouble. But she also argues that numerous steps can be taken immediately prior to a survey as well as during the survey to facilitate a successful outcome.

In fact, Walczak, a former surveyor herself, lists a range of measures that her facility recently employed that helped bring about a very successful survey outcome.

For starters, Walczak says there are important logistical "dos and don'ts" that hospitals should

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keep in mind prior to a survey, such as convenient parking and making sure surveyors have a comfortable, private workroom that includes food and beverages and outlets for their computers.

"First impressions are always important," she explains. "Having parking spaces for them and having people direct where they go all help send a signal that you are ready for this process."

Walczak says her staff also made sure that every surveyor had an escort who accompanied him or her at all times throughout the survey. She says that person's sole responsibility was to take notes regarding any recommendations surveyors made. At the end of the day, those comments were transcribed, and staff reviewed them early the following day.

Susan Goodwin, a consultant with the Hospital Company in Nashville, TN, says that staff escorts, functional team leaders, and managers who participated in the survey process should always conduct a debriefing. She adds that debriefing with staff should take place the night before as well as the following morning.

Advanced notice given on Type 1s

If any Type 1 recommendations come out of the survey, the hospital will receive notice of that in its final report from JCAHO, she notes. "They get a heads up about that from the surveyors on the last day of survey, and the written progress report is what the hospital has to send back to [JCAHO] to show that they have corrected the problem," she says. **(For a list of 1999's most common Type 1 recommendations, see box, p. 3.)**

Walczak reports that once the surveyors left, her staff immediately convened and passed out copies for all the key managers and directors so they could review the recommendations and determine whether there was anything that needed to be corrected immediately.

"That was very helpful," she says. "If there were any agenda changes that required changing assignments, they could take that agenda and make the revisions and get copies out to everyone as assigned."

Walczak says her hospital also staffed a "war room" accessible via wireless phones placed throughout the hospital, so that anytime a surveyor made a request it could be met immediately. The first rule was that no phone went unanswered. Whenever surveyors had a request, runners could immediately respond.

In addition, scribes would bring down their

Joint Commission Surveys' Top 10 Trouble Spots for 1999

The charts listed below show the top ten problematic standards in four health care settings that received the most scores of 3, 4, or 5 for surveys conducted in 1999, according to the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

Hospital

Rank	Grid Element	Standard
1	Competence Assessment	HR.5
2	Care	TX.3.5
3	Patient Data	IM.7.7
4	Assessment	PE.1.6.1
5	Staff Education	HR.4.3
6	Patient Data	IM.7.3.2.2
7	Assessment	PE.1.7
8	Infection Control	IC.4
9	Leadership	LD.1.3.4.2
10	Assessment	PE.1.3

Ambulatory Care

Rank	Grid Element	Standard
1	Competence Assessment	HR.5
2	Competence Assessment	HR.4.2
3	Credentialing	HR.7.1
4	Credentialing	HR.7.2.1
5	Infection Control	IC.4
6	EC Implementation	EC.2.9
7	Performance Improvement	PI.4
8	Leadership	LD.1.9
9	Care	TX.3.4
10	Care	TX.3.9

Home Health Care

Rank	Grid Element	Standard
1	Care	TX.2
2	Information Management	IM.9.20
3	Human Resources	HR.4
4	Human Resources	HR.6.2
5	Care	TX.1.4
6	Information Management	IM.9.15
7	Information Management	IM.9.25
8	Human Resources	HR.4.1
9	Care	TX.2.1.1
10	Human Resources	HR.3.2

Behavioral Health Care

Rank	Grid Element	Standard
1	Assessment	PE.2
2	Care	TX.1.7
3	Assessment	PE.1.7.1.3
4	EC Design	EC.3.1.2
5	Performance Improvement	PI.4
6	Human Resources	HR.3.4
7	Assessment	PE.1.7.1.8
8	Human Resources	HR.4.1
9	Human Resources	HR.4
10	Care	TX.1.11

notes, and someone in the war room would be assigned to type the findings and have them finished by the end of the day.

"Hospitals are dynamic places," Walczak cautions. That means hospitals should have people scanning the halls to make sure things don't end up in the hallways. In fact, Walczak says, hospitals should have somebody almost one step ahead of the surveyor at all times to make sure items are on the right side of the hall, rooms are clean and locked, and logs are complete. "Those are things you can do until the minute before the team shows up on the floor," she explains.

She notes that one time a surveyor was in the OB/GYN area. An anesthesiologist had left an anesthesia cart in the hallway while finishing up with a patient.

"It turned out to be on the wrong side of the hall," she reports. "The surveyor simultaneously turned the corner, and we got dinged."

Walczak adds that opening remarks are very important in terms of setting the tone of the survey. She says hospitals should try to "sensitize" surveyors about certain issues. For example, she says, her facility treats an aging geriatric population where the average patient age is about 80 years old. The hospital also faces a challenge in terms of capacity, she reports.

"We are filled to the gills and, at times, we have patients who are brought in and they sometimes have to wait for a bed," she says. "Those are things you want to share with them so they know it is an issue you are grappling with and not something that you are trying to hide."

Finally, Walczak stresses that it is important to keep in mind that once the surveyors walk through the door, they are in charge. "A lot of hospitals try to fight that and instead try to create

their own agenda." But she says surveyors may see that as a diversionary tactic.

"Surveyors see through those things in a heartbeat," asserts Walczak. "It is not a bad thing to showcase other areas as long as you do it in the background and don't try to devote survey time."

Goodwin also notes that JCAHO requires public notification prior to the survey. Hospitals are required to post notice in the newspaper as well as on a publicly accessible bulletin board within the hospital.

"That is something that some hospitals forget to do, and they end up with a Type 1 recommendation based on that technicality," she warns. "Public notice has to be posted 30 days prior to survey." ■

Improve survey success with documentation review

You have to speak the surveyors' language

Among the last-minute steps that can be taken just before a Joint Commission on Accreditation of Healthcare Organizations survey begins, none is more important than a final review of record keeping. In part, that's because the document-review process begins just two hours after the first interview.

"The order or accessibility of the information that they need in that document review really sets the tone for the survey," asserts **Regina Walczak**, director of organizational performance at Saddleback Memorial Medical Center in Laguna Hills, CA.

"If they get what they want in that document review, there is a comfort level that the hospital understands the standards." After that, Walczak says, surveyors mainly seek to confirm that through interviews.

According to Walczak, the more clearly the documents are tagged using the Joint Commission's standard numbers rather than words, the better. "You have to talk their language and not expect them to know your language. At the very least, you have to educate them as to what your language is."

Susan Goodwin, a consultant with the Hospital Company in Nashville, TN, notes that the Joint Commission routinely sends its guidelines to hospitals scheduled for surveys. She says some hospitals respond by assembling all their policies and procedures for every single standard in massive books. But in reality, she says, surveyors really want to look at a handful of key documents.

"They don't have a document on their list that is going to match up to every single standard in the chapter," she explains. "You want to simply follow the instructions in the survey guidelines to make it as easy as possible."

Goodwin points to one hospital that assembled all the key documents in one notebook that was tabbed by function for each of the three surveyors. "The surveyors loved that because they each had their own book, and they didn't have to share materials," she reports.

She says the other key ingredient is to have a functional team or standing groups that are responsible for ongoing compliance and that can look over the documents to make sure that everything is complete and up-to-date. That will avoid having somebody get his or her hands on an outdated policy that later ends up in the documents review book.

Providing examples to convey compliance

Walczak says the other import ingredient in the document review is to think of materials that would convey compliance, such as patient rights, which may demonstrate that patients are informed about their privacy. That means not only showing them a policy that demonstrates that patients understand their rights but other evidence as well.

"You can assemble letters, pamphlets, brochures, and anything that you think will convey compliance so they know that you are thinking outside the box," she explains.

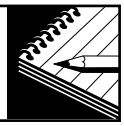
Walczak also points to "nonconventional" patient care areas. For example, at her hospital, when a patient goes into a bed, staff fill out an interdisciplinary patient assessment form (IPA) that explains what the patient's needs are. "If you just stick that IPA in a book and say that this is evidence of our patient assessment practice, that won't always work."

It might work for a medical/surgical patient but not for an emergency room patient or a patient who is in partial hospitalization, Walczak explains. Likewise, she points to patients who come in for same-day surgery and newborns, who may lack that documentation.

"What we found is that not every patient or every department has an IPA," says Walczak. "Where we were short, we had to come up with an equivalent form to demonstrate how we evaluated these patients."

"You have to slice and dice your population and think of other alternative types of documents that demonstrate compliance," she adds. "Your 'bread-and-butter' materials will not necessarily cover that in same way." ■

GUEST COLUMN



Data processes: JCAHO's 'data-driven' agenda

By **Paula Swain**, RN, MSN, CPHQ
Swain & Associates
St. Petersburg, FL

Over the past several years, the emphasis on data used to describe processes has largely driven the changes implemented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL. That was most apparent in the changes made to the performance improvement (PI), information management (IM), and leadership standards (LD).

The journal articles and educational sessions stressed graduating data into information to make "informed decisions" in care and management. Some people may have wondered what a survey would look like if it had an emphasis on data. Below are a few ideas that the JCAHO surveyors are projecting for the new year:

1. Data-driven agendas.

More observations will be made to increase the denominator numbers. For example, there will be more observations of patient care processes. Since there is a focus on patient safety, there will be a review of the medication use process. The surveyors will combine many standards by looking at one patient situation. An example would be observing the nurse administer a drug.

There are several processes involved in that function. Determination that the patient assessment (PE) by the nurse shows the patient condition for administration of the drug (TX), i.e., Fosamax, a calcium-sparing drug, that must be given on an empty stomach with water only, and the patient should not lie down for at least 30 minutes. In addition, the surveyor will observe for the nurse completing the patient education (PF) on the drug's side effects, and that the nurse is competent to administer the medications provided by the unit's scope of services (HR).

This type of surveying requires much more time than previously required on each patient unit; thus, many more interviews and observations can be carried out.

The open medical record review must be understood by the unit staff as well as those who support the unit through their services, such as the therapies — respiratory, physical, occupational, and speech — and nutrition and other services. Staff assist the surveyor when finding information in the open chart.

Be prepared to have all staff notes easily retrievable in the record. If nutrition staff customarily carry their notes back to the office, make sure there is an integrated document of some type to write an action plan or recommendation. If the other services and nursing cannot find the evidence of the nutritionist's visit, it is hard to defend an integrated records or collaborative approach to care.

Other types of observation include watching staff, including physicians, wash their hands between patients and questioning staff who are wearing gloves outside of patient care areas. Patient safety is a prevailing concept, so keep answers focused on that as staff are asked questions about separation of clean and dirty — supplies, food, linens, equipment.

In addition, more than one surveyor may descend upon a unit, which adds more to the denominator. The surveyors aggregate their data to provide the final scoring of the observed and interviewed standards.

The new scheduling allows much more time on each unit. Where just a year ago a unit visit might take less than an hour, the new survey process requires twice that time. It is common to see 1.5 hour visits. For example, while moving through a maternity unit, it might take an entire afternoon from 1 to 4.

There also is time in the schedule to allow surveyors to go back and continue their analysis of important findings that surfaced during the first pass of the survey process. These time slots will be listed on the survey schedule as "special interview / issue resolution or patient care visit."

Expect patients and their families to be questioned. Do not be concerned when staff accompanying the surveyor are left outside. That is customary and shows respect to the patient being interviewed.

Finally, ORYX data have graduated from a review of the data alone to an evaluation of the use and response to the data. Data are provided to make a difference — what difference did the organization make. Answers can range from, "we chose to do nothing" to "these are the findings from changes made. . . ." If there were changes based on ORYX, be sure that the findings have been communicated to the area where the change occurred.

It is very common to connect the initial interview information with validation at the unit level. An example might be "length of stay in orthopedics" as an ORYX measure. If stay has changed, be sure the orthopedic unit knows about the change and can speak to "sustaining the gain."

2. Survey process changes.

In the 2001 surveys, look forward to seeing more of the surveyors throughout the day. Visiting staff on other shifts, namely evenings and nights, has proven successful, so the "off shift" will be a methodology used in the future.

Also, four interviews will be eliminated. The patient and family education, continuum of care, medication use and nutrition, and the anesthesia and operative interviews will be incorporated into other interviews.

For instance, the querying done in the unit interviews and other specialty interviews such as medical staff leaders and directors will cover some of these topics.

The patient care interview will remain, and findings from the open record review will help fuel the questions. That is, if the surveyor's experience shows very poor compliance with the facility's use of the patient education document, it will be addressed here. Also, if the screening criteria are not used and referrals are not made throughout the patient process, the continuum of care questions will be consolidated into the patient care interview.

3. Random unannounced surveys.

Many organizations will not have a planned three-year survey in 2001. Because the window for random unannounced surveys is from nine to 30 months after the previous survey, many organizations will have that type of survey to look forward to. There are a few things that can be prepared for, such as:

• There are fixed elements established by JCAHO. Fixed elements tend to be previous recommendations from other surveys and how the action plan is being addressed. Is the organization finished with the action plan and in the monitoring mode, or has there been no action on the plan at all? Plus, there are always those predictable infection control and management of the environment of care review elements such as cleanliness and fire safety that are fixed elements.

• There are variable elements that take their direction from a variety of areas. For example, JCAHO will come supplied with data from its complaint "hotline" and data obtained by state surveyors. JCAHO reports it will have a conference call with the Health Care Financing Administration to determine the priorities for 2001.

Surveyors will be taken through medication review process training for use with the survey process changes **(see item 2, at left)**. This is consistent with using every opportunity to reduce medical errors and enhance the patient safety in health care today.

4. Assorted other survey issues.

While preparing, keep a focus on survey caps. That is the "training period" allowed by the JCAHO. While in training with a new standard, the scoring is more lenient. For example, pain management has been "in training" throughout all of 2000, and will be fully scored, without caps, in 2001. Also, the new restraint standards are not capped; they will be fully scored in 2001. If a hospital is a critical access hospital — a small rural facility with unique conditions of participation — the survey process will be tailored for it.

An assisted living facility that is part of a hospital will be surveyed with the hospital.

A long-term care facility that has exclusionary criteria of an average length of stay less than 30 days and an average daily census of less than 20 should not pass the *Consolidated Accreditation Manual for Hospitals* (CAMH). Rather, the unit will have a tailored survey with the hospital, using the long-term care standards.

There will be more in-depth assessment of credentialing and peer review consistent with the changes in the standards introduced during the summer of 2000.

5. Survey day reminders.

Document review session. Do not put more into the document review than that requested in the survey guide book. It is laborious and time-consuming to have to review excess material.

(Continued on page 11)

Discharge Planning Advisor®

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Patients placed quickly with software combo

Coding, documentation happen concurrently

Case managers at Arnot Ogden Medical Center in Elmira, NY, use a combination of high-powered software systems to ensure the proper placement and care of patients — and documentation of their decisions occurs in the computer, says **Tina Davis**, RN, MS, CNS, senior director of continuum of care.

The software is an interface between Health Data Management (HDM), a 3M software that examines coding, and InterQual software, a systematic approach to determining who should be an inpatient, she notes. "As the case managers review a case, they use HDM to code the patient to come up with a concurrent working DRG [diagnosis-related group]. After the patient is coded, the case managers access the InterQual program to identify if the patient meets the criteria for admission."

The beauty of combining the two programs, Davis says, is that the case manager reviews the chart and documents the results of that chart review in the computer.

"The system is an actual database that we can run reports from," she adds. "We run reports to identify how many patients meet the admission criteria, and we can compare the results [according to] physician and payer. This information is shared with the hospital's utilization review committee to act upon."

Since many insurers use InterQual criteria to determine whether, for example, a patient should be an inpatient or an observation patient, she adds, the process allows hospital to make the same determinations, and to have documentation should it have to fight a denial of reimbursement.

Arnot Ogden's case managers use a Patient Review Instrument (PRI), a tool that is unique to the state of New York, to identify what level of nursing home placement is appropriate for the patient, Davis says. (**See chart, p. 8.)**

Soon after Medicare began using resource utilization groups (RUGs) in 1986 to determine reimbursement for nursing home placement, the PRI was developed by the Professional Standards Review Council of America (PSRCA) to facilitate that process, she explains.

Nursing homes use the PRI for reimbursement purposes, Davis adds, while hospitals and community agencies use it to identify the level of care the patient will need.

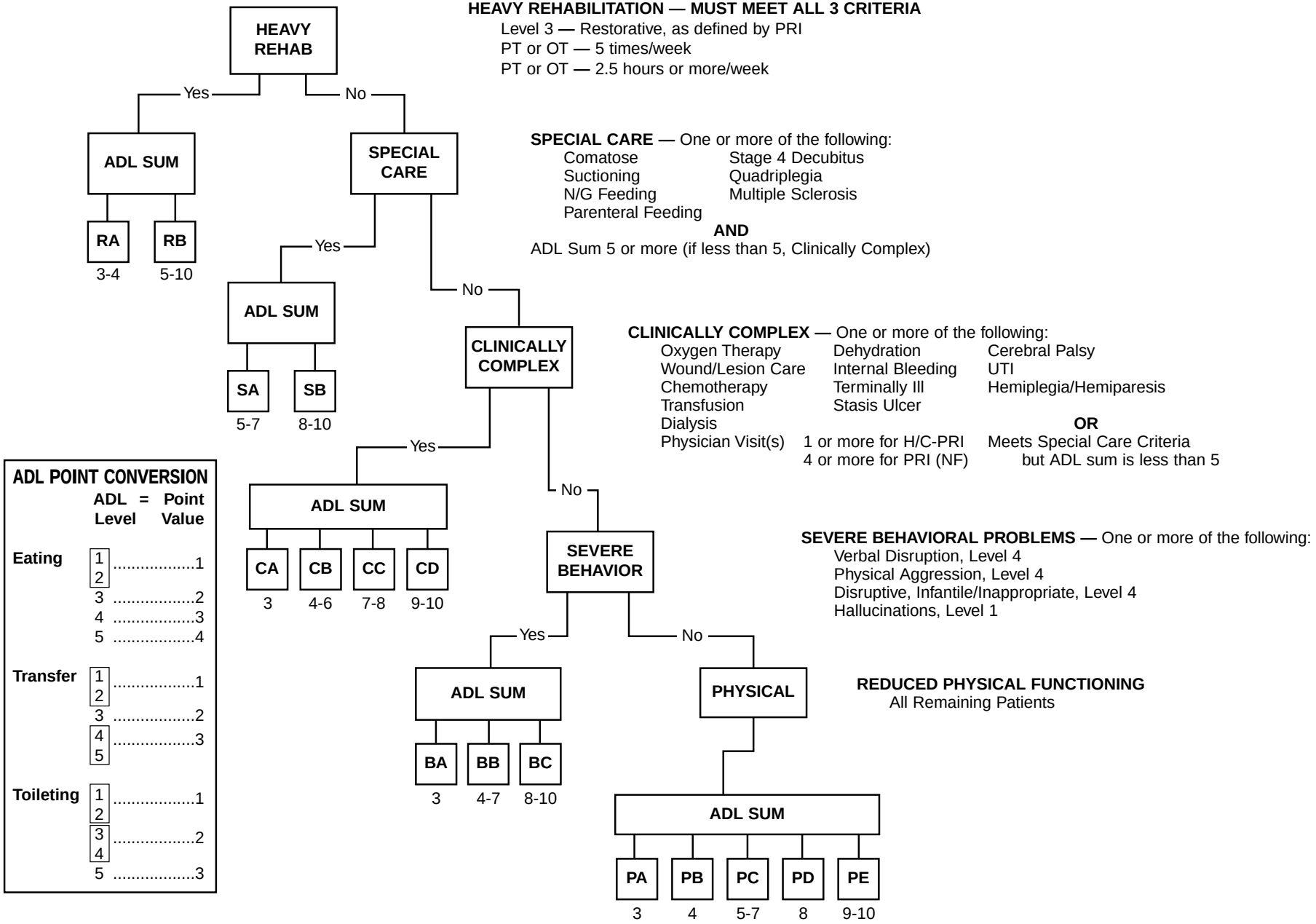
"When the case manager, the social worker, the physician, and the family all identify that the patient can be moved to an alternate level of care, the case manager fills out a PRI form for the patient and comes up with a RUGs classification score," she says. "Depending on the score, we know whether the patient is a nursing home patient or an adult home care patient."

In screening for admission to their facility, nursing home officials look at the PRI score to see what level of care the patient will need, Davis points out. "It's a neat classification system, which helps us understand exactly what the patients' needs are — if they're clinically complex, need rehab, and so forth."

The state requires an eight-hour training class — which all of Arnot Ogden's case managers have attended — for those who complete the PRI, she says. Those who are certified receive a card with an

(Continued on page 9)

RUGS-II Classification



HEAVY REHABILITATION — MUST MEET ALL 3 CRITERIA
Level 3 — Restorative, as defined by PRI
PT or OT — 5 times/week
PT or OT — 2.5 hours or more/week

SPECIAL CARE — One or more of the following:

Comatose	Stage 4 Decubitus
Suctioning	Quadriplegia
N/G Feeding	Multiple Sclerosis
Parenteral Feeding	

AND
ADL Sum 5 or more (if less than 5, Clinically Complex)

CLINICALLY COMPLEX — One or more of the following:

Oxygen Therapy	Dehydration	Cerebral Palsy
Wound/Lesion Care	Internal Bleeding	UTI
Chemotherapy	Terminally Ill	Hemiplegia/Hemiparesis
Transfusion	Stasis Ulcer	
Dialysis		**OR**
Physician Visit(s)	1 or more for H/C-PRI 4 or more for PRI (NF)	Meets Special Care Criteria but ADL sum is less than 5

SEVERE BEHAVIORAL PROBLEMS — One or more of the following:
Verbal Disruption, Level 4
Physical Aggression, Level 4
Disruptive, Infantile/Inappropriate, Level 4
Hallucinations, Level 1

REDUCED PHYSICAL FUNCTIONING
All Remaining Patients

ADL POINT CONVERSION

	ADL Level	= Point Value
Eating	1 2	1
	3	2
	4	3
	5	4
Transfer	1 2	1
	3	2
	4 5	3
Toileting	1 2	1
	3 4	2
	5	3

Source: Professional Standards Review Council of America, New York City.

identification number, and that number must be written on each PRI, which is then signed by the person completing it, Davis adds.

[InterQual Products Group, Marlborough, MA, is a subsidiary of McKesson-HBOC. For more information on the system, call (800) 582-1738 or visit the Web at www.InterQual.com.] ■

Daily care rounds put all staff in the know

One of the most effective innovations at Arnot Ogden Medical Center in Elmira, NY, has been the institution of "daily care rounds" for every patient in the hospital, says **Tina Davis**, RN, MS, CNS, senior director of continuum of care.

"This is a multidisciplinary forum where we identify an interdisciplinary plan of care for the patient." There are representatives from case management, social work, nursing, respiratory therapy, pharmacy, physical therapy, occupational therapy and the dietary department, she notes. "We're all sitting at the table, discussing the patient, and this includes every patient in every nursing unit."

For eight units, the process happens every day; for the long-term care unit, it occurs once a week, Davis says. "We spend 20 to 30 minutes for each unit, depending on the unit."

The goal, she explains, is to move the patient through the system in such a way that all disciplines know what's going on and exactly what they are to do for each patient. "Nursing knows what physical therapy is doing, and dietary [staff] know what they're supposed to do. It's wonderful because a lot of the assessment piece happens here and it is concurrent. We know now what has to happen with the patient, not tomorrow after reading the chart."

Although daily care rounds have been in place for three years, in the past year the process has been taken to a new level, Davis notes. In conjunction with the implementation of new computer systems at Arnot Ogden, she sat down with an analyst from Atlanta-based Per Se Technologies and developed a documentation tool for the process.

"Every day, for each patient, we document that this is happening," she says. "We used to just write things down on a sheet of paper and archive those pieces of paper separately from the medical record, but now the information is in the patient's chart. Anybody who wants to see what's going on with the patient from daily rounds can see this. It's a very integral piece of communication that benefits the patients."

The case manager who is present does the documentation and is responsible for entering it into the computerized medical record, she notes. "From the daily rounds format, case management can move forward into doing a more in-depth assessment if needed."

That might include, for example, determining if the patient should go to a nursing home, Davis says. "Once we identify that the patient could benefit from nursing home placement and the patient agrees, the social work department facilitates this process, because of all the emotional issues involved. It may be difficult for the patient's family to get used to the idea of moving [the family member] into a nursing home."

This part of the process is where social work "really excels," she points out. "They identify all the emotional baggage, all the support the family and patient need, and then bring that information to daily rounds, when we decide the patient is going to be placed." ■

On CM frontier, defining care model is crucial

Case managers who are in one of the newest frontiers of the profession, the physician practice, may find themselves in an isolated environment with no clear blueprint as to the skill set and resources they'll need, says **Sandra Lowery**, RN, BSN, CRRN, CCM, president of the Case Management Society of America (CMSA) in Little Rock, AR.

Many of the professionals in this position, notes Lowery, who also is president of CCMI Associates, a consulting firm in Francestown, NH, come from a hospital or physician-hospital organization background, and may not have the experience that will prepare them for the unique demands of the physician practice.

Capitation typically is the reason case managers find themselves in this setting, she notes. "It's wherever there is a transfer of financial risk." In some cases, Lowery explains, a health plan allows a provider to manage utilization — this is called "delegation" — while the health plan gives oversight and holds the provider accountable through "report cards" and evaluation.

Such case managers are often in the position of trying to avoid the need for hospitalization and of making sure an individual's health needs are met, she says. This can be difficult, Lowery adds, if the case manager doesn't have a knowledge base of community resources, assessments, and community needs. Additionally, in some cases, she suggests, neither the case manager nor the physician truly knows how to make the best use of the case management function in this setting.

"Most case managers are there because the physician [or physician group] has taken on capitation of some sort, whether just for primary care or more globally," Lowery says. "The physician often thinks the case manager's primary role is just to manage the utilization of the patients in a hospital setting, which really isn't going to be the best bang for your buck."

Depending on his or her exposure to and understanding of case management, she adds, "the physician may not know that the 'gatekeeper model' — managing utilization of resources through managing access, which isn't really case management — won't result in the ultimate desired outcome.

"What we're seeing in terms of the best outcome is a community-based model, where financial risk is assessed in the community — whether in the physician's office or in the patient's home — by using certain triggers," she explains. Those triggers, she says, may be that someone is taking five or more medications, has an inadequate support system, or has had two or more hospitalizations in the past six months.

With this approach, Lowery adds, "the case manager can be much more proactive in achieving a better outcome before the individual reaches a higher intensity and need. This is the ideal model." What's also unique is that while both may be employed in a physician practice setting, there are typically far more nurses than social workers performing the case management function, she points out. "Whoever does it should have a solid knowledge base of psychosocial needs and resources, as well as medical needs and resources. A high-risk individual needs both."

That usually means the case manager needs more training in one area or the other, she adds. "Physicians may not realize they need these resources. They assume 'a nurse is a nurse' and a natural case manager."

For outside support and resources, Lowery says, case managers in physician practices should take advantage of whatever professional associations are available to them.

"I certainly recommend they become part of a professional society, and of course, I recommend CMSA. If there's a local chapter, they should join that, and minimally they should get connected to a national society." At the least, Lowery notes, these groups can provide standards of practice and information about certification.

Although the CMSA doesn't have a special interest group as yet for case managers in physician practices, she adds, "I wouldn't be surprised if that is coming. When individuals join or renew, we get information about where they practice, and we do member surveys."

[Editor's note: Discharge Planning Advisor *would like to hear from case managers working in physician practices. Please share your concerns and experiences by contacting editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.]* ■

Certifying group updates Web site

To help case managers become certified quickly, the Chicago-based Commission for Case Manager Certification (CCMC) has revised and updated its Web site: www.ccmcertification.org. The site features a brief tour designed to facilitate the certification process. The application form, as well as the recently published newsletter, can be downloaded from the site.

"The new Web site responds to the health care industry's need for certified case managers," **Susan L. Gilpin**, CEO, announced. "An increasing percentage of employers are requesting certified case managers; certification is regularly specified in career advertisements; states are beginning to require certification; and we are responding to those needs."

CCMC recently was granted accreditation by the National Commission for Certifying Agencies (NCCA), the only national accreditation body for private certification organizations in all disciplines. An NCCA panel of experts reviewed all aspects of the Commission for Case Management certification process, including validation of the methodology used in the certification examination.

The NCCA helps to ensure the health, welfare, and safety of the public through the accreditation of certification programs that assess professional competency. ■

(Continued from page 6)

Oftentimes, the survey element being searched for cannot be found due to all the extemporaneous material in the manual. Keep a runner handy in case material cannot be found.

The daily briefings are set up for the surveyors to get clarification for their needs, not the facility. However, if there is a question about a finding, or the data have been found for a poorly answered question, disclose it during the briefings session.

The Human Resources interview can be improved greatly by organizing the staff folders prior to the survey. Just separating hiring and benefits data from mandatory material such as performance evaluations and education helps. Organize in chronological order; put the newest material on the top, and put a model personnel file together with tabs and landmarks "Post-it noted." The model can be used as a reference. That way, if any documents are missing, at least the surveyor has a clue as to what he or she is looking for.

Standardize what is being done at the multiple anesthetizing sites. Since all of the sites are going to be reviewed for their consistency and compliance to the sedation and anesthesia standards and patient rights issues, have staff crisscross into each others' units to see how care is conducted.

By having the staff from other anesthetizing units check on each other, they can see differences in practice. It is then easy enough to recognize the logic of the difference and document it, or change the practice.

Remember, the surveyors see the organization from a bird's-eye view. That perspective provides insight to an organization that might otherwise be missed. As much as an organization might feel it communicates well internally, it probably does not. Staff in one area will do things their way, and in another area a different track will be followed. Surveyors see this and will use it to their advantage. Although mock surveying helps bring consistency to the process, new policies continue to roll out. Remember to require the policy-makers to define what the implementation and evaluation components of those new policies are.

If there is not a good metric to measure the impact of the new policy, it is likely that a flawed policy will not be identified until a negative event occurs. Improvement means to reduce variation. These are the days of patient safety. Be proactive in your approach; it will surely be noticed by the surveyors on survey days and by your patients everyday. ■

Evaluating QI efforts through collection tools

Identify objectives, determine quality indicators

Without appropriate data collection tools, hospitals will find it impossible to determine whether or not quality improvement (QI) programs are making a difference, says **Peg Mason**, RHIT, CPHQ, director of government quality improvement programs at Iowa Foundation for Medical Care in West Des Moines, who oversees all QI projects for Medicare and Medicaid contracts in Iowa, Nebraska, and Illinois.

According to Mason, a range of mechanisms can be used to improve quality. She says the first step is to look at care processes, outcomes, and customer satisfaction as areas that offer opportunities for improvement. For example, hospitals can use aspirin or beta-blockers for patients with acute heart conditions or periodic eye and foot exams for patients with diabetes.

Mason says improved outcomes objectives can include anything from reductions in average length of stay to decreased mortality rates. Customer satisfaction objectives can range from reduced waiting time to a determination of whether physicians offer adequate explanations of the treatment plan.

Once hospitals have identified their objectives, she says, they should determine what their quality indicators are going to be. While the best approach is through the development of a mutidisciplinary team, she says it also pays to involve hospital staff who are not directly involved in the process who can offer divergent perspectives.

Mason says that once a quality indicator has been selected, hospitals must determine how they are going to evaluate the process. "You may have a team of people involved in the process who will then tear it apart in each step and find areas of improvement," she explains. For example, if the mechanism is the early administration of aspirin, it may fall on the emergency department or the intensive care unit.

Mason highlights several possible interventions including education for health care professionals or consumers as well as system or process changes such as care maps or care protocols. For example, standing orders may be revised because patients with immunizations may not require a physician any longer.

"Maybe your hospital protocol says you need

one, but that may be something that you can set up that nurses can administer," she says.

Hospitals also might consider some type of electronic or passive reminder system that includes medical record stickers for physician order sheets to remind them of best practices for particular conditions, says Mason. She notes that computerized systems can be prompted for certain conditions. Hospitals may want to look at employee competencies in a particular treatment area to recognize accomplishments, she adds.

Once hospitals reach the re-evaluation stage, Mason says, they must allow sufficient time to determine whether the intervention has been effective. That includes periodic monitoring and the establishment of checkpoints.

Once these steps are taken, **Crystal Kallem**, RHIT, manager of government quality improvement programs at the Iowa Foundation, says the first step is to determine what data elements must be collected. "To identify those data elements, you must identify the specific pieces of information that are going to be used to calculate your quality indicator rates," she says. "You should only collect the specific information necessary for the analysis of the quality indicator rates."

Don't collect data you don't need

Kallem warns that if hospitals decide to collect additional information, it may become too cumbersome and hospitals may wind up with a lot of information that is difficult to present in analysis or evaluating quality indicators.

It is also time-consuming to collect all of that information, she adds. "You are better off using your resources to implement interventions related to your quality indicators rather than exhausting all your resources in collecting additional information that you don't need."

Kallem says it is important to develop detailed definitions in order to assure the consistency of the data being collected. In reviewing the components of data definitions, she says hospitals must start by stating what information should be obtained from the medical record in specific detail so that hospital personnel with diverse technical knowledge can abstract that information.

She adds that detailed options for the answers that will be selected during the abstraction process should also be developed. Also, Kallem says hospitals should include the location in the medical record where that information can be obtained. For example, if information will be obtained from patient history and physical or the nurses' or physicians' notes, that should be specified.

All inclusion and exclusion criteria that would be used for abstracting the project information should also be included, Kallem says. That includes any synonyms or abbreviations that would be allowed within the medical record. "It is important to spell out all of that information," she warns. If necessary, it also makes sense to include attachments for abstractors to use such as a list of antibiotics or ACE inhibitors or other criteria that might have severity classifications.

In the case of her program, Kallem says that once hospitals have developed a preliminary draft of their data-collection tools, her organization typically conducts an alpha test process that uses two different abstractors to extract 10 to 25 medical records and compares the results of the abstraction from those medical records to determine if any mismatches have occurred during the abstraction process.

Once mismatches are identified, she says the two abstractors discuss whether additional detail must be added to the definitions of the data elements in the abstraction tool. She says another reason that it is helpful to conduct an alpha test is that unexpected information in the medical record may be uncovered.

After any modifications to the data collection tool have been made, Kallem says a beta test of the extraction tool is then conducted. At that point, several abstractors extract 25 to 50 medical records depending on the complexity of the data collection tool and the availability of the specific types of records that are available.

The results are then compared, and any mismatches are identified. The abstractors determine if any additional detail is required. "At this point, there should not be many modifications to the tool itself," she says. Instead, this phase should be confined to adding certain edits to the different variables. However, if there are substantial modifications such as changing the definition of a data element, Kallem says a second beta test should be conducted at this point.

Prior to distributing data-collection tools on a statewide basis to all of its providers, Kallem says her program asks several providers in each state to conduct a pilot test of their data-collection tools to assure that the tools are user-friendly for facility abstractors and to ensure the definitions are easy to understand and meaningful.

As part of the distribution process after the

data collection tools are collected on a statewide basis, Kallem says her program provides extraction training for providers using several different methods to ensure that data are being collected consistently and accurately so the data can be compiled for statewide analysis. ■

Part 1 of a 2-part series

Performance measures depend on effective use of good data

By **Patrice Spath**, RHIT
Brown-Spath Consultants
Forest Grove, OR

"Is performance acceptable?" is an important and fundamental question that can be asked of any health care process. Performance measures can help answer this question, but only if the data are used effectively. Too often, performance is judged by whether standards are achieved. Suppose the nursing department sets the standard, "we will not have more than 10 patient falls in any month." Typical actions that might come from this standard are:

- soliciting reasons why some months have more than 10 patient falls;
- comparing data on months with more than 10 falls to the data on the "good" months;
- having celebrations for months where the standard is met;
- taking disciplinary action on people who are deemed responsible for patient falls or on supervisors when expectations are not met;
- reducing the number of patient falls that are reported to supervisors.

While the intention of keeping the number of patient falls to a minimum is good, any of these actions can be harmful. They can lead to fear, cover-up of problem areas, and breakdown of teamwork.

While standards play an important role in defining correct actions individuals should take when caring for patients, standards may not be the best way to evaluate the results of performance measures. Measures tell us how a process is performing. To judge the quality of process performance we must study the pattern of variation revealed by the measurement results. If the process is controlled, meaning observations or results fall seemingly at random within some overall natural pattern, then the process is performing at its natural capability. Measurement variation in a stable process is termed, "common cause variation." For a manager or committee to react to normal process variation and expect explanations or "quick-fix" corrective actions is wasteful.

Well-intentioned actions made to correct common cause variation can potentially increase variation and negatively impact process performance. Adjusting a process when adjustments are not needed is called "tampering." Consider a hospital pharmacy technician who monitors the completeness of incoming physicians' orders. Every day, he tallies the number of incomplete orders that require pharmacy intervention prior to filling the request.

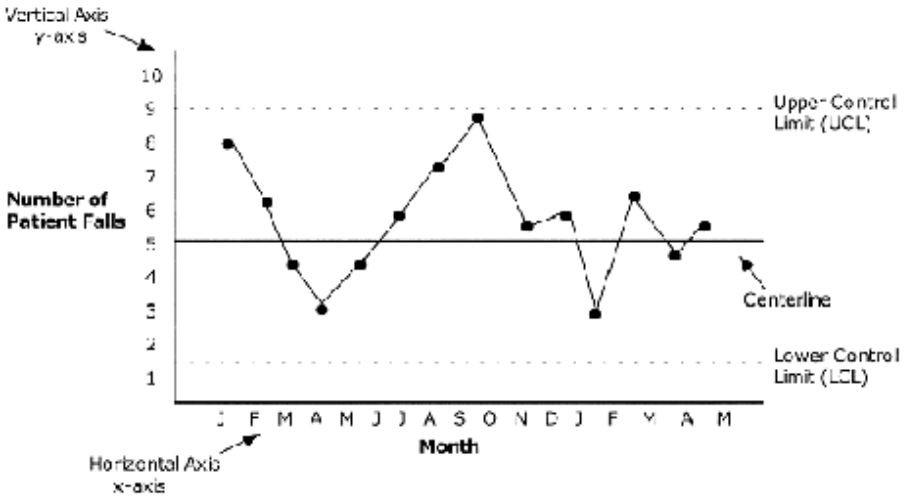
Avoiding unnecessary variation

If in one month the total number of incomplete orders goes up, the pharmacy director asks the nursing staff to add a double-check into the process for obtaining physician orders. If the number of incomplete orders goes down, the nurses are told it's OK to relax their vigilance. The pharmacy director sounds like a conscientious person when in fact, he is unnecessarily adding variation to the process.

If the process is out-of-control or unstable, meaning the observations fall in patterns that seem to defy the laws of probability, then special causes of variation are present. People involved in the process ought to be able to identify these special causes because of their closeness to the process. For example, if the number of patient falls significantly rises in one month, one possible cause of this variation might a short-term change in the nurse / patient ratio on a particular unit. The methods used to prevent patients from falling (the process) have not changed; however, something out of the ordinary occurred. Random or special causes tend to cluster by person, place, and time.

The goal of performance improvement is to eliminate special cause variation in a process, and

Control Chart: Rate of Patient Falls



where desirable, reduce common cause variation. The less the process varies, the more confidant you can be about the output. Furthermore, variation in clinical process is associated with a higher risk of error or patient harm.

To identify the extent of variation in a process, a technique known as statistical process control is used. This technique involves the use of control charts to plot measurement results. A control chart is a time-series graph of performance measurement data, similar to a run chart. **A control chart showing the rate of patient falls is shown in the box above.** The number of patient falls is shown on the vertical or Y-axis. The horizontal or X-axis represents the time interval for taking measurements. In this example, measurements are taken monthly; however, the frequency for measuring or monitoring performance may be hourly, daily, or weekly. As data become available, they are entered chronologically onto the chart. The data points are connected with a line. A centerline is added as a visual reference for detecting process shifts or trends. The centerline represents the mean or median of the charted data. In addition, control limits computed from the data are placed at equal distances on both sides of the central line.

The control chart is a useful tool for displaying data in the order that they occur with statistically determined upper and lower limits of expected process variation. It is one of the best methods for identifying special causes of process variation, monitoring process performance, and determining if process changes have had the desired effect.

A control chart can be a very powerful performance management tool. The following is an example of how a control chart can be used by managers in day-to-day situations:

Using a control chart to monitoring test turnaround times, the laboratory staff know the process as it exists today. They know they cannot meet their test report turnaround expectations 100% of the time. At best, 1% of the test results they send out in a day will be late (more than one hour beyond the established threshold), and at worst, 13.4% of the results will be late. A team of laboratory staff reviews the special causes or the out-of-control points and identifies a common theme among them.

Every time someone is out sick, the process goes out of control. To eliminate this special cause of variation, the supervisor obtains permission to call in a temporary employee to cover for the absent regular employee. The control chart of test turnaround times helps the staff monitor whether special cause variation has been eliminated with this intervention.

To reduce common cause variation in the process, the laboratory must change the testing process. The laboratory director organizes another team to work on improving the overall process. Using process improvement techniques, the team

will work to identify and reduce common causes of variation in the process. If they are successful, they will have to have new control charts made up, because the mean turnaround times will have decreased and the upper and lower control limits will be lower and closer together than the ones used on the old control chart.

It is in detection of situations where the process appears to act differently from its predicted pattern that the control chart proves its value. If the process output (in this case, test report turnaround times) exceeds a control limit (upper or lower) or reveals suspicious trends or patterns, those situations need to be investigated and resolved. Once the process output remains within the control limits and is stable, it does not necessarily mean that the process is acceptable — only that the process output is more predictable and that further reduction of variation will require a significant process revision.

(Next month's Cost-Quality Connection *column will discuss the use of the individual and moving range chart to evaluate the results of common health care performance measures.)* ■

Orion Project proves fruitful 'lab' for JCAHO

Now under the microscope: Staffing effectiveness

Since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) launched the Orion Project in 1995, **Russell Masaro**, executive vice president of the Joint Commission's accreditation operations, reports that several important innovations in the survey process have been gleaned and tested and spun off from the organizations that participated.

Currently, Orion's attention is focused on staffing effectiveness, the use of self-assessments, and continuous survey readiness.

"Orion was and still is a research lab for the Joint Commission," says Masaro. According to JCAHO, the primary objective of the project is to provide the organization with an opportunity to continually test and refine new accreditation concepts, products, and services and eventually transition them into the mainstream accreditation process. Testing is done primarily in specific areas in Pennsylvania, Arizona, Tennessee, and Georgia.

"The major product of that activity early on was the continuous survey readiness service product that we now have available through our subsidiary," reports Masaro. But that was soon followed by an integrated survey process and a special survey process for smaller hospitals, he adds.

Among the ongoing innovations, Masaro says JCAHO plans to continue to develop and test are "the use of self-assessments and outcomes data as well as electronic interface with [JCAHO] and the future review of actions for reviewing staffing effectiveness."

In terms of staffing effectiveness, Masaro

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

stresses, "we are not looking at staffing per se. The key here is that it is a broad subject and not merely staffing in terms of numbers but rather staffing effectiveness, which includes how staff are trained and how many staff are available with different backgrounds and experience."

According to Masaro, another innovation is modifying the way JCAHO conducts on-site survey processes. He says the Joint Commission's Small and Rural Work Group was instrumental in that regard. That group, together with the Orion states, helped JCAHO develop services such as an integrated survey process as well as special kinds of survey processes that are more appropriate for smaller hospitals.

Automated interface set for 2003

Masaro says those states are now helping JCAHO test and implement innovations for future accreditation processes, such as the possible use of self-assessment and outcomes data as part of the assessment with certain standards. That process also includes the use of an Internet-based automated interface with the Joint Commission, which he predicts will be up and running in 2003. "We will be testing that over the next year in the Orion states."

Masaro says each of JCAHO's "customers" will have a private, secure Web site for on-line applications. "We can interact in an on-line fashion much like other businesses are doing," he says. "That will be tested with them, and the possible development of an approach to reviewing staffing effectiveness in organizations is going to be tested in the Orion states as well."

Jan Severance, PhD, associate project director, division of research, says more activity also can be expected in the area of continuous survey readiness.

The Orion-Georgia project was established in January 1997 by JCAHO and the Georgia Hospital Association. Now several other states are implementing similar programs. But she notes the Orion label is not being used in order to avoid confusion.

"We are working with the hospital associations in Arizona and New York," Severance reports. She says those states are being used for the Joint Commission's Accreditation Process Improvement Initiative. She adds that New York is still in the preliminary stages in this area, while Arizona is just beginning to work on the research component. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review*, CE participants should be able to meet the following objectives after reading each issue:

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PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Has the nursing shortage decreased health care quality?

Physicans say time constraints, managed care share in the blame

In what some in the industry are calling a "landmark" study, more than half the U.S. physicians surveyed said their ability to provide quality health care to patients has deteriorated over the past five years, and fewer than one in six said that ability had improved over the same period.

"These findings are alarming," notes **Robert Blendon**, ScD, survey author and professor of health policy and management at Harvard. "What's worse is that many doctors fear this decline in quality will continue."

The study, conducted jointly by the Harvard University School of Public Health in Boston and The Commonwealth Fund in New York City, surveyed 528 practicing generalists and specialists (cardiologists, gastroenterologists, and oncologists) in the United States and approximately 2,000 physicians in Australia, Canada, New Zealand, and the United Kingdom.

Survey respondents cited several key factors in the decline of quality:

- Nursing staff levels are inadequate.
- Primary physicians don't have enough time to spend with patients.
- Hospitals do a poor job finding and addressing errors.
- Doctors are not encouraged to report medical errors.
- Physicians are concerned about their ability to keep abreast of new medical developments.

American physicians said their greatest concern about hospital resources was inadequate nursing staff levels. **Steve Eilen**, MD, a physician with Atlanta Cardiology Group, couldn't agree more. "Hospitals can't hire enough nurses to fill their staffs," he says. "What happens is they hire agency nurses who don't know where anything is, how to do anything, or who to call to get anything done. Ironically, on a per-hour basis they're much more expensive than permanent nurses, so hospitals are forced to spend more money for inferior care."

"There clearly is a shortage," offers **Richard A. Lewis**, MD, FACC, a partner in Cardiology Associates of Fredericksburg (VA), although he says he does not have a problem with the quality of the nurses with whom he works. "The nurses we have are very qualified and dedicated, but they are being stretched thin. Supply has been decreased because there are so many other career opportunities today, hospital administrations are stretched thin; their reimbursements keep coming down; and the biggest expense is salary."

"In some institutions they have really reduced staff below what I call a safe level," asserts **Dave Spencer**, CEO of Tampa, FL-based Safety-Centered Solutions Inc., a vendor of medical error reporting systems. "We have seen clearly that as staff reductions are made, the incidence of medical errors goes up."

These staff reductions have a real, and sometimes critical, impact on the ability to deliver quality care. "I had an indigent patient with an aortic dissection and tried to get him moved to a tertiary care center for specialized surgery," recalls Eilen. "The hospital wouldn't take him, citing a lack of beds. I talked to a thoracic surgeon, who told me the administrators no longer wanted to

As patient safety issues gain importance, American Health Consultants has created this supplement as a service to our readers, to provide up-to-date information on patient safety issues and trends, together with expert advice on how to meet the coming imperative for better quality and safety in patient care. Special thanks to Safety-Centered Solutions Inc. for help in preparing this issue.

accept indigent patients. They were in such dire straits that they could no longer do surgery after hours. There are only so many nurses to go around, and the hospital did not want them to work after hours because they'd have to pay overtime."

"The busier each nurse is, the more errors they can make," adds Lewis. "They're under stress; there's not as much time for review; and there's not as much time for teaching. Nurses have more bedside time than doctors, and they can help reassure and educate patients if they have the time to do it."

Patients do notice the difference, says Eilen. "I've had patients in telemetry beds who vehemently refused to stay at a specific hospital because the nursing care was so bad. With fewer nurses per patient, the patients become frustrated because they don't get bathed; beds don't get changed; they don't get to the procedures they're supposed to go to; doctors' written orders are not followed; or their medicines are late."

Compounding the problem is that at the same time the quality of care is dropping, the patients' level of sickness has increased, Spencer adds. "We're compressing the length of stay. People are being discharged earlier, so while they are in the hospital, they are sicker on the average. Also, people don't get admitted for less acute conditions. So we are faced with these two converging forces."

Eilen concurs with the survey respondents who noted that physicians don't have enough time to spend with patients. He places the blame squarely on managed care. "Here's what happens: A patient walks into the office, and he has a [copayment] of $10. You make $40 from that patient. That hardly pays for you to walk in the door, not to mention your overhead," he says. "So you need to see more patients or reduce your overhead in order to try to compensate for that. You can use [physician's assistants], which a lot of people do, but many patients are not happy about it; they want to see the physician. And my personal opinion is that the quality of care is not as good."

Lewis says he also feels frustrated by managed care. "It has definitely driven quality down from many aspects. There are increased demands for record keeping, which detract from the amount of time you can spend with each patient. With decreased reimbursement, you need to see more patients, so you have less time with each individual patient."

Lewis says the "gatekeeper" structure actually restricts access to specialty care. "The primary physician may not be qualified to determine if there is a need for specialty care. Sometimes, the patients know best, and some-times just the reassurance a specialist can provide is therapeutic."

He adds that nonphysician reviews of charts and cases that "second guess" a physician's diagnosis and treatment plan can put pressure on physicians. That could cause them to "discharge a patient before [they] think [that patient] is ready and to restrict access to testing [the reviewers] feel is inappropriate but that the practitioner feels is medically necessary. They're not doctors; they don't have the experience with patient contact that we do. They go by written guidelines, but every patient is different, and every case is different. Unfortunately, managed care discourages individualism and creativity and doesn't reward experience."

The good news from the survey is that not all respondents said a continued decline in quality is inevitable. They said that technology, especially electronic record keeping, can serve to curtail a significant number of errors.

"I would think that's true," says Lewis. "We spend a lot of time documenting, and technology would help. It also may cut down on errors; for example, a lot of programs identify potential drug interactions."

"It's a very legitimate claim," adds Spencer. "A tremendous number of things can be done to increase the accuracy of reporting and to give caregivers more access to data. Most of the errors can be eliminated if we will use the information and technology intelligently."

Eilen says he has mixed feelings. "I've looked into electronic prescription, and in its current state, it's more labor-intensive, at least in the beginning. For me, it's not a great timesaver. Electronic record keeping will be good for a lot of reasons, but only if records are centralized."

[For more information, contact:

Steve Eilen, MD, Atlanta Cardiology Group, 33 Upper Riverdale Road, Riverdale, GA 30274. Telephone: (770) 991-9166.

Dave Spencer, CEO, Safety-Centered Solutions Inc., 7650 W. Courtney Campbell Causeway, Suite 400, Tampa, FL 33607. Telephone: (877) 739-6751. Fax: (813) 623-1228. E-mail: Info@scCARE.com.

Richard A. Lewis, MD, FACC, Cardiology Associates of Fredericksburg, 2500 Charles St., Fredericksburg, VA 22401. Telephone: (540) 374-3144.

Robert J. Blendon, ScD, Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115. Telephone: (617) 432-4502.] ■

Study targets errors in ambulatory setting

Seeking to close a cavernous information gap, The Robert Graham Center for Policy Studies in Family Practice and Primary Care in Washington, DC, has launched a nationwide study of family physicians to identify medical errors in an ambulatory setting. According to the organization, most medical-error research to date has focused on inpatient information.

"I arrived in the U.S. [from New Zealand] in 1999, at about the same time as the Institute of Medicine's *To Err is Human*[1] study came out, and I was assigned to the topic of medical errors," recalls **Susan Dovey**, MPH, a Graham Center analyst and head investigator for the study. "I quickly became aware that virtually all discussion of medical errors is focused on hospital care. But our organization's focus is primary care."

In fact, Dovey's initial efforts involved a major study of exactly where people encounter the health care system in the United States, which was when she discovered that 25 times as many people in this country have experiences with office-based providers than with hospital-based providers. "This sort of crossed over into the current study," Dovey explains. "Everyone talks about medical errors in terms of problems such as wrong-sided surgery, but relatively very few people have those sorts of problems."

Dovey is clear that one of her goals is to fill an information gap in the medical literature.

Linda C. Stone, MD, president of the Ohio Academy of Family Physicians and a member of the faculty at The Ohio State University in Columbus, says Dovey's on the right track.

"There's currently a big push in family medicine," she says. "But if we're really going to advocate for our patients, we need to have practice-based research. Most of our patients don't go to the hospital. We should be looking at our outcomes. Are we proving over time that the things we're doing continue to work? At Ohio State, our big push is practice-based research, to in turn make sure our ongoing family practices are evidenced-based."

In all, 42 family physicians filled in Dovey's data form between May and August 2000. She is adamant about the fact that the focus of her study is errors.

"People often confuse terms," she explains. "For example, there are adverse events, which may or may not be due to a mistake. A certain number of people will always have an adverse reaction to the 'right' medication.

"Then there are critical incidents, or near-misses, which are sometimes adverse events but not always. Then you must distinguish between mistakes and medical errors; there can be times when the wrong thing clearly happened, but it may or may not result in an adverse outcome. We were very focused on medical errors," Stone says.

She also makes it clear that all errors merit attention. "Little errors sometimes progress and kill people," she notes. "Hospital protocols can help prevent that kind of progression, but there are no equivalents for primary care or for laboratory tests. That's why we needed to collect these data." **(The progression of a little error can result in what Dovey calls a "Toxic Cascade." See related story, p. 4.)**

Whatever the survey turns up, Stone says all errors will be divisible into what she calls "two piles:" low-tech and high-tech errors. "To me, the most important is low-tech. As family physicians, the most important thing we establish with a patient is a relationship. If we communicate really well back and forth, that will be the first big step to eliminating errors. If you go where the patients are, you will serve them better."

For example, she says, when you tell patients the tests show they have cancer, you must be aware they will hear nothing else you say, which makes it that much more critical to write down your discussion. "The patient will get home and not remember what to tell family members."

As for the high-tech role in eliminating errors, Stone encourages her patients to explore the Internet. "They will feel empowered to communicate with you. Otherwise, they may miss pieces of information and be sent down the wrong path."

Dovey says her hopes for future studies reflect a similar respect for the collaborative role between patient and physician.

"Our current study is only from the doctor's world view," she admits. "Studies also need to be done from the patient's world view and from the clinician's world view."

[For more information, contact:

Susan Dovey, MPH, The Robert Graham Center for Policy Studies in Family Practice and Primary Care, 2023 Massachusetts Ave. N.W., Washington, DC 20036. Telephone: (202) 986-5708. Fax: (202) 986-7034. E-mail: policy@aafp.org.

Linda C. Stone, MD, The Ohio State University, 456 W. 10th Ave., Room 1114, Columbus, OH 43210. Telephone: (614) 293-7099.]

Reference

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Survey leads to new model for illustrating errors

A funny thing happened to **Susan Dovey**, MPH, as she was conducting a study for The Robert Graham Center for Policy Studies in Family Practice and Primary Care in Washington, DC. She developed a new model for illustrating and analyzing medical errors.

Dovey, an analyst with the center, was lead investigator in a study examining medical errors in an ambulatory setting. As the study progressed, she created a model for illustrating what she calls "Toxic Cascades" and "The Patient Safety Grid." **(See box, below.)**

"As the data started coming in, we became immersed in them," she says. "It soon became clear that current models . . . were not appropriate for us."

The Toxic Cascade refers to four separate categories of errors, each progressively serious:

1. trickles, e.g., misfiled records;
2. creeks, e.g., prescribing contraindicated medications;
3. rivers, e.g., undiagnosed fractures;
4. torrents, e.g., amputating the wrong leg.

Errors in the less-serious categories progress into the more serious categories in some cases, while in others they do not. The Patient Safety Grid, in turn, incorporates the Toxic Cascade model into four different settings:

1. self-care;
2. clinicians' offices;
3. institutional-based ambulatory care;
4. hospitals.

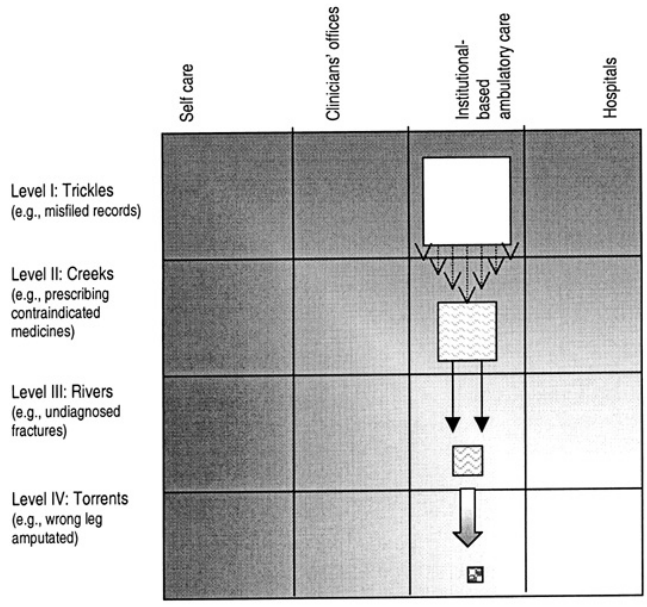
The purpose of the model is to help identify problem areas and areas where appropriate intervention can make a difference, Dovey explains. "Perhaps these minor things in primary care can build up to a torrent. We often lose opportunities to stop those from moving much further up the system. Take antihypertensive medications. Most of the patients taking them would not have a heart attack anyway, but some of them would have and didn't because they were on the appropriate medication."

A "trickle," such as a filing error, is quite common, but if that trickle involves a lab result showing a breast lump to be malignant, inaction could be fatal, she says.

"Having a misfile of an important result that should have been acted upon becomes a creek. If [it is] left without being acted upon until it's too late, it becomes a river, and if the patient dies, it's a torrent," Dovey explains.

The Patient Safety Grid was designed to researchers to "take a real 'macro' look at the whole scope of medical errors," she says. "What we currently know most about is patient deaths. If a patient dies, we say we can't let that happen again; we explore the reasons and increase our knowledge. But if they were just harmed, we don't know as much. In addition, what we currently know most about is what happens in health centers because that's where most of the research has been done." ■

Patient Safety Grid: Toxic Cascade



Source: The Robert Graham Center, Washington, DC.