AMERICAN HEALTH CONSULTANTS®

HOSPITAL PEER REVIEW®

THE HEALTH CARE PROFESSIONAL'S TOP SOURCE FOR ACCREDITATION, REGULATION, AND CREDENTIALING INFORMATION

CELEBRATING 26 YEARS OF SERVING THE HEALTH CARE QUALITY PROFESSIONAL

26

IN THIS ISSUE

Continued on next page

MARCH 2001
VOL. 26, NO. 3 (pages 29-44)
NOW AVAILABLE ON-LINE!
www.ahcpub.com/online.html

New JCAHO standards require integrated patient safety program

Standards indicate safety issues aren't going away

The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is getting mostly positive reviews on its recently approved standards focused on patient safety and medical error reduction in hospitals. But experts warn that integrating these new standards into existing safety protocols will be no easy task.

The new standards augment the nearly 50% of current Joint Commission standards related to patient safety. Requirements for establishing ongoing patient safety programs in organizations accredited under the *Comprehensive Accreditation Manual for Hospitals* will be added in the areas of leadership, management of information, and other functions. The anticipated implementation date for the standards is July 2001.

Michael Millenson, a principal with William J. Mercer, a consulting firm in Chicago, compares JCAHO's action to a politician chasing an issue. But he says that is a positive development, not a negative one. "The Joint Commission helps to validate the patient safety movement and give it stature, and for that reason, it is very important," he explains. "Nevertheless, they are validating the patient safety movement rather than leading it." In fact, Millenson argues that there is no technological reason that everything included in the new standards couldn't have been accomplished a decade ago.

"What this represents is another step in how the

IN THIS ISSUE

COMING IN FUTURE MONTHS

- Job security: Tip the odds in your favor
- Medical errors: How to set up appropriate detection and prevention systems
- How to monitor the effectiveness of cardiopulmonary resuscitation
- Choose the root-cause analysis software that's right for you
- Our quarterly supplements *Discharge Planning Advisor* and *Patient Safety Alert*

leadership of the health care field has started to react to public pressure to take meaningful steps to improve patient safety," he adds. "That should signal hospitals that this isn't going to go away, and for that reason, I think it is very important."

Sally Trombly is director of regulatory services for the Risk Management Foundation of the Harvard Medical Institutions, in Cambridge, MA, and chair of the 2001 advocacy task force for the American Society for Healthcare Risk Management of the American Hospital Association. She credits the Joint Commission with taking much of the advice of outside parties who commented on the draft standards even though JCAHO and other regulators sometimes are criticized for not listening to practitioners. "I think the Joint Commission, at least for this group of standards, tried to involve the industry."

One important change Trombly points to in the final standard is recognition that no single individual should be accountable. While the draft called for at least one individual to manage the organizationwide safety program, Trombly says JCAHO recognized in the final version that it requires a team concept or a multidisciplinary group to make this work within an organization.

According to Trombly, there must be a change in the culture of the health care environment in order for everyone to become vested in patient safety. "You have to educate the staff and providers to understand the value of this," she adds. "You can't just say, 'Tomorrow, we are going to have a safe institution.'"

According to **Ken Applebee** of the University of Michigan Health System (UMHS) in Ann Arbor, most health care systems already are doing most of what the Joint Commission has set forth in these new standards in one form or another. For example, JCAHO's leadership chapter requires an integrated patient safety program with qualified individuals and interdisciplinary groups, as well as an organizationwide patient safety program. "Many organizations are already doing that," he reports.

Applebee says different hospitals call it different things, and the membership structure may vary. But that is an important distinction, he adds. "This is a better structure or at least a more formal structure, and it may help meet some of the goals that everybody has been striving for, such as standardization of terminology."

Similarly, he says some organizations perceive an error to be a patient given the wrong medication. "We look at it on a broader scope." That

means looking at hospital-acquired infections and complications from procedures that may not be defined as an error but have an impact on the outcome to the patient, he explains.

According to Applebee, the new standards require health care organizations to have an integrated safety management program and collect and aggregate data not only from a reactive but a proactive basis. That includes not only medical errors that result in injury but also errors that don't result in injuries, such as "near misses" and "hazardous conditions," he says.

While there are many similarities in what organizations are doing already, Applebee says the differences lie in going beyond collecting and analyzing the data. "Some organizations are looking very closely at the research component of patient safety and expanding the definition of what some people perceive an error to be."

Applebee says that one of the more ambiguous standards that JCAHO established is eliminating the barriers to effective communication among caregivers, which falls under the Management of Information Standard. He reports that UMHS currently is addressing this area by surveying its nursing staff to determine what they see as the main barriers to reporting problems.

Warning of unexpected outcomes

According to Millenson, one potentially important item included in the new standards is the requirement that patients and their families be informed of the results of care, including unanticipated outcomes. "That is a fascinating statement, and it marks a significant shift," he asserts.

Millenson says this represents an extension of informed consent. "First hospitals told patients what the risks were, and now they are telling them that if something bad happens it was not just because they were sick. In a sense, this is a call on hospitals to rid themselves of the age-old attitude that the operation was a success, but the patient died."

Trombly says one important portion of the new standards that will pose a challenge to hospitals is JCAHO's intention to increase involvement of patients and their families.

She says there has been considerable discussion in the industry about how to get patients involved in the patient safety movement without creating barriers between patients and clinicians. According to Trombly, efforts to provide more education upfront can be a very positive development. "If you then have better patient expectations because patients are informed in advance about what areas can become problems, you are going to have fewer unanticipated outcomes, whether there is a good outcome or a bad outcome."

But Trombly says the issue of informing patients can represent a major challenge to hospitals because the populations served by institutions vary culturally as well as by their level of understanding of medical care. There also is variation between patients coming in for elective procedures vs. emergency situations.

"This is a huge challenge that is going to call for a lot of creative methods of getting information out to people," she asserts.

Trombly says she also was encouraged because the standards give patients not only rights but responsibilities. "I took that to mean, for example, that part of the patients' role in all of this is to understand that it is important to talk to their caregivers about what medications they take."

Involving patients in preventing errors

According to Trombly, that includes not only what they take by prescription but also what they take as over-the-counter medications. Many people do not yet consider aspirin, nutritional supplements, or herbal preparations to be medication.

"All of those things are becoming more important for the clinician treating the patient, who may not have access to that information unless the patient tells them," she warns.

In short, Trombly says the issue of how to involve patients goes beyond asking patients if they are allergic to certain medications.

"I think this is going to be the wave of the future as we go forward," she predicts. "Trying to build that bond between the patient and the caregiver is not an easy task with all the built-in impediments to good communications."

Trombly also points out that JCAHO is not the only group playing a role in this area. While the organization is approaching patient safety from an accreditation perspective, a number of states have legislative initiatives looking at these issues as well.

"You may have some state regulators who come out with their own set of standards that may or may not match what the Joint Commission has come out with," she cautions. "And who knows what may come out of Congress." ■

JCAHO gears up for patient confidentiality

A variety of approaches are being discussed

Hospitals gearing up to meet the patient privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 should bear in mind that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has no plans to abandon its role in this area. Rather, it is is attempting to merge its own standards for security of information and patient privacy with the final regulation released Dec. 28, 2000.

According to **Margaret Van Amringe**, vice president for external relations in Washington, DC, JCAHO is working aggressively now to develop a HIPAA strategy.

Standards relevant to all provider types

She says one challenge is that this strategy must include hospitals, home health agencies, ambulatory surgery, laboratories, behavioral health, community health centers, and mental health programs. That makes it difficult as JCAHO attempts to move into these areas in a "technology-neutral" fashion while maintaining standards that are relevant across all of these provider types, she explains.

She notes that the organization recently has beefed up some of its standards and has specifically reviewed the information management chapters in all of its manuals as well as the patient rights, responsibility, and ethics chapter.

Van Amringe says JCAHO now wants to make sure hospitals maintain codes and passwords as well as the ability to determine who has accessed the information and when that occurred. "We also added some statements about when consent was required and added some standards on preventing falsification."

JCAHO also is looking at how standards apply to areas such as telemedicine or telehealth, the electronic patient record, and some Web-based compliance products, she reports. But educating more than 1,000 surveyors in this area is going to be a major challenge, she says.

Van Amringe says the Joint Commission's biggest concern is how to balance the need for quality of care with HIPAA requirements. "We firmly believe quality of care needs to be able to be very timely. You need care when you need care, and sometimes the information may not get there if it is bogged down in HIPAA compliance issues."

According to Van Amringe, JCAHO's options fall into two main categories: standards and compliance. In terms of standards, she says JCAHO is looking at three different options. The first simply is to boil down the HIPAA requirements for privacy and security and incorporate them wholesale into the Joint Commission's manuals.

"That is an extreme position," Van Amringe asserts. "Our manuals are already pretty large, and this would make them very large." She says it might not be very practical in terms of JCAHO's ability to train surveyors.

A second option the organization is considering is to assess its existing standards and determine where they fall short of some of the HIPAA requirements. "The area where they may fall short is in having enough explanatory materials and direction to guide organizations on how to determine when there are professionally acceptable situations for releasing information," she explains.

A third possibility the Joint Commission is considering is basically to leave its standards alone or just tweak them in a few places and then rely on the standards it has throughout all of its programs. Those standards require that organizations comply with federal and state laws.

5 different approaches JCAHO could take

Van Amringe says that JCAHO's enforcement of HIPAA will turn to some extent on the decisions it makes regarding standards. She says five different approaches are on the table:

1. Adopt HIPAA standards on its own, but that will mean training at least a small cadre of surveyors to be HIPAA experts. She adds that even if JCAHO selects this option, a legal audit probably would not be possible, which makes this option unlikely.

2. Put more emphasis in its surveys on privacy and security, at least during the five years of HIPAA implementation. That option would also entail more weighting of JCAHO's information management and patient rights chapters in its overall accreditation decisions, Van Amringe adds.

3. Don't modify the processes but require an independent HIPAA audit. She says that raises questions about who would conduct that audit,

how often it would take place, and what it would include.

4. Certify some JCAHO-approved auditing organizations that may meet appropriate standards, she says.

5. Rely mainly on complaints or incidents to trigger a site visit in order to focus on privacy and security beyond what already is encompassed in a survey.

Those options are not mutually exclusive, Van Amringe says. "You can rest assured that we will not ignore obvious violations of HIPAA regardless of which of these particular compliance regimens we opt for. It is too important an issue, and we believe our standards are really very simpatico with the objectives of HIPAA privacy and security."

According to Van Amringe, JCAHO will be pulling together a technical advisory panel this month to begin looking at some of these issues. That will include the development of a complaint-handling process to determine how HIPAA complaints should be addressed and what to do if the organization gets flooded with HIPAA complaints far beyond the number it currently handles.

She says the Joint Commission also is trying to determine whether there is an opportunity with the Department of Health and Human Services for recognition of HIPAA requirements that are included in JCAHO's standards as a way to reduce duplication. She says that would amount to a sort of deemed status for security and privacy. ■

JCAHO takes a fresh look at staffing issues

Process will screen with performance indicators

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) last month announced its intention to revamp its approach to assessing the effectiveness of staffing in health care organizations nationwide. The new process will use performance indicators to screen for potential staffing issues and will be pilot-tested next year.

The good news for hospitals is that the new model will not include fixed staffing ratios or other mandates. Rather, JCAHO is seeking to improve upon its current practice, which requires accredited health care organizations to determine and provide the right number of qualified and competent staff to meet the needs of patients. Those needs usually are based on internal formulae that reflect numbers of patients and the severity of their illness.

Two groups of measures — one identified by the Joint Commission and the other one self-selected and defined by each health care organization based on its unique characteristics — will be used.

JCAHO spokeswoman **Janet McIntyre** says the new approach will reflect the consensus of a broad-based expert panel that was convened in September 2000. Roughly 100 participants offered their ideas on how to improve JCAHO's current approach to the assessment and made recommendations about which indicators would provide the best screening mechanism for identifying staffing issues.

McIntyre says the Joint Commission wanted to get input from people with expertise in patient care, operations management, performance measurement, and performance improvement. "The idea was to get a group of people together that came from all walks."

"We have standards that cover the management of human resources, and these new measures will complement those standards by combining the clinical outcome with the human resource measure," she explains. "It will provide a better picture."

As an example, McIntyre says a hospital might decide to look at the incidence of bedsores as a clinical outcome and staff vacancies as a human resources measurement. "It would be very useful to see how these two relate to one another."

However, McIntyre says JCAHO has no plans to develop staffing ratios or other mandates. "We are maintaining the same approach the Joint Commission has taken before that each organization must look at the patients it serves and determine the staffing necessary to meet their needs."

That does not mean that health care providers won't face mandates from other quarters, however. For example, California currently is searching for ways to implement a new law passed last year that includes rigid nurse-to-patient ratios. It is too early yet to know how many states may follow suit. But California often establishes trends, for better or worse, that are emulated across the country. ■

THE QUALITY - CO$T CONNECTION

Present comparative data effectively

Share data allowing for accurate evaluation

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

The Joint Commission on Accreditation of Healthcare Organizations' ORYX project is impacting the way hospital caregivers evaluate performance. Ten years ago, very few data from external groups could be used for comparative purposes. Today, with all the different report card initiatives, such data are easier to find.

Now quality managers are facing the challenge of sharing these data with administrative and medical staff leaders in a way that allows for accurate evaluation. Data presentation and analysis can be more effective when several preparatory steps are followed:

• **Verify the accuracy of the data.** Compare what you know happened to the data in the comparative report. Verify the numbers from your database or other input documents against the values in the reports. If you find data quality problems, be careful about presenting the data to administration and physicians. It's best to wait until the data are corrected, if possible.

• **If you are satisfied the data are accurate, look for significant variations (two standard deviations from the mean) at the global performance level.** For example, is your facility cesarean rate higher or lower than the mean for peer facilities in the state? Is your overall pulmonary or cardiac mortality rate higher or lower?

• **Look for significant variations at the DRG level.** For example, is the vaginal delivery after cesarean (VBAC) rate at your facility higher or lower than the mean for peer facilities in the state? Is your facility's acute myocardial infarction death rate higher or lower?

• **Focus on areas of interest to your organization.** Although length of stay may not be a core measure for the Joint Commission, administrative and medical staff leaders are likely to be very interested in these statistics. How do your lengths of stay for various DRGs compare to hospitals in your state?

• **If no significant variations are found by comparing your performance to other facilities in your state, look at how you fare on the national level at the global and DRG level.** If no statistically significant variations are discovered on state and national comparisons, you've got some "Don't we feel good about ourselves!" data. Share the information with administrative and physician leaders and other relevant groups. Remember, however, that every process can be improved. Even if the comparisons don't show statistically significant variations, your organization may choose to work on improving performance in select DRGs or patient categories.

If statistically significant variations are discovered, then you need to get people's attention. Present the information in a way that clearly shows where variation exists and the extent of the variation.

Prepare for the reactions

People in your organization can react to significant variation on comparative reports in many different ways. Even if the variation is statistically significant, they may choose to ignore it. Even the most competent quality manager with the best data presentation can't ensure that people will dig deeper into the cause of variations. It is important, however, to remind facility leaders that the Joint Commission expects an in-depth analysis be conducted when it is found that the facility's performance varies significantly from peers.

It's common for people to challenge the data validity when faced with unfavorable performance measurement results. If the data are proven to be accurate, then people may react by saying, "We look different because our patients are sicker!" Be prepared to respond with information about the severity-adjustment mechanisms used to risk-adjust the comparative data. If the comparison data are derived only from claims data, the risk-adjustment system will not account for every factor that impacts patient outcomes.

The outcomes of care depend on a complex combination of:

• the effectiveness of available treatments;

(Continued on page 39)

PATIENT SATISFACTION PLANNER™

Satisfied patients yield better outcomes, revenue

Scrutinize those follow-up surveys

To compete in today's health care market, hospitals and clinics need to be a cut above the competition. Therefore, administrators are placing much more emphasis on patient satisfaction to ensure patients will remain loyal customers. Many facilities hire national satisfaction measurement companies to determine how well they are doing compared to other facilities their size across the nation.

In the battle for customers, patient education plays a key role. As part of its marketing strategy, the Department of Veterans Affairs (VA) identified several customer service standards, and patient education is one. The patient-focused standard reads: "We will try to provide information and education about your health care that you will understand."

The VA conducts its own satisfaction measurement survey throughout the system and releases the results annually. "Looking at the 2000 survey scores, patient education correlates highly with overall patient satisfaction. We are really seeing the connection," says **Carol Maller**, RN, MS, CHES, patient education coordinator for the New Mexico VA Health Care System in Albuquerque.

To obtain the scores, patients randomly are given the customer satisfaction survey in both the inpatient and outpatient areas. Questions pertaining to patient education include: "Were you involved in decisions about your care as much as you wanted?" and "Did you get as much information about your condition and your treatment as you wanted from the provider?"

Patient education and patient satisfaction are integral, says **Jackie A. Smith**, PhD, project administrator and clinical associate professor at the University of Utah Health Sciences Center in Salt Lake City. Patient education compliance and customer satisfaction are based on whether patients' learning needs are met, and that can be anything from a map to the hospital to detailed information about a restrictive diet.

Also, both depend on whether health care workers are kind, courteous, and available, and treat patients with respect and dignity. When patients are treated well, their ability to absorb the learning increases dramatically, explains Smith. "When you blend patient education and patient satisfaction together, you will have better outcomes in both."

Good patient education has a great impact on patient satisfaction, says **Yvonne Brookes**, RN, patient education liaison for Baptist Health Systems of South Florida in Miami. It's not enough to give people information; they must understand it. "If patients don't have their basic questions answered because a health care worker is too busy, they will be dissatisfied," she says.

Failing to tailor education to the patient's learning preference can cause dissatisfaction, says **Pamela Moore**, MSN, RN, vice president of nursing at Citrus Memorial Hospital in Inverness, FL. Also, patients who are dissatisfied with their care or have other problems such as financial worries are not as ready to receive the education. "They may not be as satisfied with the education because they aren't as receptive at that point in time," she explains.

Discernment always is warranted due to outside factors that could influence numbers, such as dissatisfaction with the admitting clerk.

However, patterns are revealing. To make sense of the data garnered from patient satisfaction surveys, the right question must be asked, says Brookes. "We need specific questions, clearly written to illicit the kind of outcome we want, not vague questions like 'Were the admitting clerks helpful?' Open-ended questions are best because the patient can provide information that is really useful."

Although Baptist Health Systems uses a national satisfaction measurement company, a team is creating a section specific to patient education with permission from the company, which will have four or five questions about education, says Brookes. Some of the questions were too vague and others too negative. "One question asked about complications, and we didn't want the question to be negative from the beginning. We wanted people to assume there wouldn't be

complications," says Brookes. That question was changed to: "Were you told what problems to watch for after you went home?"

At the VA in Albuquerque, surveys determined that patients were dissatisfied with education about medication side effects. Yet it did not pinpoint why patients weren't satisfied. It could be because they were given too much information, the information is too sophisticated, they don't know how to individualize it for their particular situation, or they want 24-hour access to side effect information, says Maller.

To determine what strategy to take to improve patient education in this area and therefore boost satisfaction scores, Maller plans to organize focus groups to determine why patients are confused. It's best to implement one strategy at a time rather than six, so it is easy to determine whether the strategy worked, she advises.

Although written surveys frequently are used to measure patient satisfaction, follow-up telephone calls to patients after discharge to ask if they have questions often is more useful, says Brookes.

Where there is confusion, there is usually dissatisfaction with teaching, she explains. For example, a patient may not know how to take medications safely. Tracking this information might uncover patterns and areas for improvement.

To improve patient satisfaction, be proactive rather than reactive, says Smith. Rather than using data gathered after a program was implemented, gather data upfront so the program will fit patients' needs from the moment it is first implemented.

What is certain is that we are in an age where patients are bombarded with information about their health, and they often get confused. It is up to the health care industry to take the lead by making patient education an important part of patient care. "People are satisfied when they feel they are in control, and knowledge puts people in control," says Brookes.

[For more information on improving patient satisfaction with good patient education, contact:

*• **Yvonne Brookes**, RN, Patient Education Liaison, Baptist Health Systems of South Florida, 6200 S.W. 73rd St. Miami, FL 33143. Telephone: (305) 242-3530. Fax: (305) 242-3578. E-mail: YvonneB@bhssf.org.*

*• **Carol Maller**, RN, MS, CHES, Patient Education Coordinator, New Mexico VA Health Care System, 1501 San Pedro Drive S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, ext. 4656. Fax: (505) 256-2870. E-mail: carol.maller@med.va.gov.*

*• **Pamela Moore**, MSN, RN, Vice President of Nursing, Citrus Memorial Hospital, 502 Highland Blvd., Inverness, FL 34452. Telephone: (352) 344-6530.*

*• **Jackie A. Smith**, PhD, Project Administrator/Clinical Associate Professor, University of Utah Health Sciences Center, College of Nursing, 10 South 2000 E. Front, Room 332, Salt Lake City, UT 84112. Telephone: (801) 581-4804. Fax: (801) 581-4642. E-mail: Jackie.Smith@hsc.utah.edu.]* ■

Newsletter helps patients seize the day

Individualized information a hit

The idea to improve patient satisfaction came to the nurse manager at 2 a.m. one morning when she couldn't sleep. She got out of bed to check her appointment book for the day and thought that patients might like to know what tests or procedures were scheduled on any given day, as well.

Soon, a newsletter was implemented on the unit that she managed. Each newsletter was individualized with the patient's appointments for the day so he or she had some control over their time and family members knew when to visit. "The newsletter empowered patients," explains **Lisa Oldham**, BSN, RNC, CAN, nurse manager at Hackensack (NJ) University Medical Center.

It also prompted patient education. The day-shift nurse would go over the newsletter with the patient discussing the tests and procedures scheduled for the day and answer any questions the patient had. Because the nurses on night shift had distributed the newsletters at 7 a.m., the patients had time to formulate questions.

The evening staff would review the newsletter with the patient again at the end of the day to answer any questions the patient had after the test and procedures had occurred. "Within a 24-hour period, the patient would have been educated, or his or her education reviewed on every single scheduled test and procedure at least twice," says Oldham.

In addition to the patient's scheduled tests and

procedures, the newsletter had important phone numbers the patient might need, such as consumer affairs and the physician on the case. There were several different preprinted sheets that were geared to various conditions so that each newsletter could have some educational information. For example, the cardiac sheet had a heart with its various parts named.

Routinely scheduled events such as lab rounds and meal breaks were printed on the sheets. The night nurses would write the name of the test or procedure and its scheduled time on the sheet by hand. The newsletter was kept by the patient's bedside so nurses could easily make changes during the day.

Although the newsletter was pilot-tested on a new unit, patient satisfaction scores kept increasing during the month it was implemented, says Oldham. Its success prompted the medical center to conduct a pilot test on several units.

If the scores for patient satisfaction on those units are up on the third quarter report from Press, Ganey Associates, a health care satisfaction measurement company based in South Bend, IN, the newsletter will go hospitalwide. The pilot newsletter is professionally designed and printed, unlike the original, which was printed from a computer.

[For more information on creating a daily informative newsletter for patients, contact:

*• **Lisa Oldham**, BSN, RNC, CAN, Nurse Manager, Hackensack University Medical Center, 30 Prospect Ave., Hackensack, NJ 07641. Telephone: (201) 996-2425.]* ■

Ohio rehab therapists learn the 24/7 standard

Changes mean happier patients, more efficiency

Alliance (OH) Community Hospital's Center for Rehabilitation decided not to wait for the prospective payment system (PPS) before making changes that would benefit patients, payers, and clinical care quality.

Three years ago, the hospital's chief executive officer challenged the rehab director to eliminate inefficiencies and therapist shortfalls by moving from a compartmentalized approach to an integrated approach, recalls **Cyndia Schreiner**, BS, CRRN, LNHA, director of rehab services and administrator of long-term care for the hospital.

"I was given responsibility for the long-term care facility and all of the therapies across the continuum, and I was told to make it work," Schreiner says. "I had no long-term experience at all because I'm a dyed-in-the-wool rehab nurse, so it was swim or drown."

Schreiner formed a total quality service team that identified the facility's most urgent concerns and its greatest assets.

"We had a body of people committed to good patient care," Schreiner says. "That was one common thread that ran in every one of us, and we were able to weave those threads together and come up with a product called the continuum of care."

The result has been greater patient satisfaction, and the facility is building up physician referrals. "We have a patient satisfaction tool, and patients are singing our praises," she says.

The change also helped the hospital to boost its outpatient rehab volumes. Physicians who might have sent patients to other outpatient facilities could see that Alliance offered patients consistent therapy care, often with the same therapists following a patient from acute through outpatient treatment, and this resulted in more referrals.

Here are the steps the facility took:

1. Identify problems.

"What we identified first was that we had a shortage of therapists," Schreiner says. "We saw that at any given point in time the acute care hospital or outpatient or long-term care facility could have either feast or famine."

When the departments had a shortage of rehab therapists they would use contract services to fill the gap. This not only cost money unnecessarily because there likely were qualified therapists elsewhere in the hospital who had open slots that week, but it also led to less consistent patient care. Since the change, staff fill in the gaps, saving the facility money on contract services.

"We wanted to give good patient care, and that's why we got rid of all territorial barriers," Schreiner says. "If you're an outpatient therapist and your mom is on the rehab unit or in the nursing home, don't you want her to have access to the best services, and if you can be the one to provide those services because your workload is down, don't you think that would be a great thing to do?"

2. Cross-train staff.

Alliance Community Hospital had nurses do rotations through the various therapies, including physical therapy, occupational therapy, speech, and recreational therapy. "The nursing staff followed through with the same approaches that therapists were doing," Schreiner says. "This way, we had a 24/7 approach so that what patients learned in therapy was carried on with nurses working at 3 a.m."

Therapists were cross-trained and rotated to spend time in the various settings. For example, an inpatient rehab therapist would spend a day or longer in an outpatient rehab setting and then in the nursing home. This continued with the therapists who were primarily assigned to the other settings until every therapist knew how to work in any of the sites along the care continuum. The only exception was home health, where it was more cost-efficient to keep separate home health therapists. After everyone was cross-trained, any therapist could fill in at almost any point in our continuum," Schreiner says.

3. Move closer to a 24/7 philosophy.

One of the big changes rehab facilities will experience under PPS involves the workday philosophy. Therapists have grown accustomed to having evenings and weekends off. But this 8 a.m. to 5 p.m. schedule does not always work best for patients or for achieving the best quality of care.

Considering the patients' needs

Schreiner says that inpatient rehab facilities may have to change to a more flexible therapy schedule. Some long-term care facilities made that sort of change when their field was hit by PPS. "When PPS came to long-term care, we needed to identify a mechanism where we could give the patient the biggest bang for the buck," Schreiner says. "At that time in our community, for a therapist to even consider working on a Saturday was rare."

Now the hospital has Saturday therapy coverage in the acute hospital, inpatient rehab, subacute, long-term care, and outpatient rehab settings. Rehab therapists also provide some weekend coverage to a separately owned facility through a contract. "We have therapists on call on holidays, and everyone is striving for the same goal of quality outcomes," Schreiner adds.

4. Achieve staff buy-in for changes.

"Some therapists were very resistant to the changes," Schreiner says. "But once they got into it, it was a wonderful learning opportunity for them."

At rehab service meetings where all disciplines gather, Schreiner explained to the staff how PPS is changing the way rehab is done and the way its documented. Therapists were told that nurses, therapists, and other members of the rehab team needed to be speaking the same language and doing things the same way. All of these changes would result in better patient satisfaction, a goal that has since proved true.

"The greatest thing that helped us with buy-in was the fact that we wanted to see our outpatient referrals grow," Schreiner says. "So we identified that if we could streamline the inpatient length of stay by providing services on Saturdays, then we could get these patients out sooner and they'll go to outpatient care."

Also, inpatient therapists now communicate more closely and effectively with their counterparts in the outpatient setting, so patients can be assured of more consistent care. Occasionally, an inpatient therapist may fill in for an outpatient therapist and follow the same patient across the care continuum.

While all areas now have Saturday coverage, soon, because of PPS, some Sunday therapy probably will be scheduled as well, Schreiner says. "It would be so much more seamless and easier for patients, and we offer scheduled time off during the week for those working on weekends."

Schreiner sold therapists on the idea that it's not so bad to have a day off during the week every now and then. "With the volume of therapists we have, they don't have to rotate onto a weekend except for once every five or six weeks," she says.

Therapists also have grown accustomed to working on holidays, although that also required a buy-in.

"The key was to be empathetic and sensitive and listen to what they had to say," Schreiner explains. "I kept on reminding them, 'Remember, we all said we want to give the best patient care we can.'"

The final strategy to achieving staff buy-in was to give therapists flexibility. They could change days and hours with other therapists to accommodate child care, weekend family activities, and other requirements. ■

(Continued from page 34)

- the patient's characteristics and risk factors;
- quality of care;
- random chance (recognizing that biology is always somewhat unpredictable).

It is impossible to control for all risk factors. But knowing what risk factors have been accounted for in the data comparisons can help your organization interpret comparisons of outcomes across hospitals.

It may be necessary to provide data that allow the clinicians to look at other dimensions of risk that are not adequately addressed in the comparative database, e.g. age, sex, race, and ethnicity (demographics); acute clinical stability; physical functional status; cognitive and psychosocial functioning; cultural and socioeconomic attributes; or patient attitudes and preferences for outcomes.

People may react to unfavorable comparative data with the response, "So what if we look different? . . . The numbers are too small to be meaningful!" At the DRG or practitioner level, you are likely to be working with small numbers. When the N is less than 30, the data may not be statistically significant, although the variation is real. In this instance, you have three choices:

- Gather historical data to increase the sample size.
- Wait to analyze the results when more data are available in the future.
- Use advanced statistical analysis tools specifically designed to analyze data from small sample sizes. The Fisher's exact test is useful in situations where the expected frequency of an occurrence is very small (> 5). The t-test can be used to compare the arithmetic means of two small sample populations to determine whether they are identical or different.

"So what if we look different? . . . It's not affecting the overall quality of patient care," is another response often heard when people are faced with unfavorable performance results. Scatter diagrams are useful data display tools for responding to this reaction. A scatter diagram is a graphical technique used to analyze the relationship between two variables.

Two sets of data are plotted on a graph, with the Y-axis being used for the variable to be predicted and the X-axis being used for the variable to make the prediction. The graph is useful for illustrating the relationship between one variable and another and for showing the interrelationship of causes. For example, a scatter diagram could be used to show the relationship between decreased VBAC rates and patient dissatisfaction with their level of participation in treatment decisions. Additional information such as this can substantiate quality concerns that might otherwise not be evident in the comparative reports.

The quality manager cannot force people to discover the cause of performance variations found in comparative reports. However, by anticipating how people will react to the information, the quality manager can come to the meetings prepared with responses.

The questions on the worksheet **(see box, below)** can help you predict issues that might be

Quality Manager's Comparative Data Analysis Worksheet

As I reviewed the comparative data, I identified the following issues that need further investigation or appear to be improvement opportunities:	What questions might be asked when I present these data to physicians, nurses and other groups?	What information do I need to answer these questions?
1.	1.	1.
2.	2.	2.
3.	3.	3.

brought up during data presentations. Adequate premeeting preparation by the quality manager can go a long way toward increasing the chances that people will want to dig into the process to discover why performance is unfavorable. ■

Q&A

Winning physician support for your quality initiatives

Practical suggestions from a physician champion

This month, **Joel Mattison**, MD, a member of *Hospital Peer Review's* editorial board, offers tips for bringing physicians on board for hospital quality initiatives. He is the physician advisor in the department of clinical resource management and medical director at St. Joseph's Hospital in Tampa, FL. St. Joseph's is a 900-bed hospital comprising a children's hospital, a women's hospital, and a psychiatric section.

Mattison describes St. Joseph's vision of quality as processes that exceed "reasonable or useful expectations. It's a moveable target," he says. "As we reach for it, it manages to just barely exceed our grasp each time. But at the same time, we seem to be jumping higher and reaching farther. What was good yesterday is not sufficient for tomorrow, and we must be ever moving in this pursuit."

Instead of mincing around the ever-present self-interest of physicians and other health care workers, Mattison views it as a fact of institutional life. Check out his practical suggestions for using it to improve patient care:

Q. One of the challenges quality professionals continually face is that of engaging physicians in hospital-based quality initiatives. From your experience, what kinds of incentives will hook them?

A. The first thing all physicians say when you approach them with this challenge is, "Well, you're just trying to make money for the hospital." We try to get our physicians to understand what's in it for them. We try to show them how the quality processes they learn at the hospital also can help their office practices and even the face-to-face management of their patients.

An example is the use of examination and management (E/M) codes. It takes good documentation to true grade your codes. When physicians really understand documentation, they also do more accurate coding in their offices, and their personal incomes can rise — not with upcoding, but with right coding. We're trying to teach them how to do that.

We want their case mix index (CMI) to measure the true level of their patients' illnesses. That means they shouldn't have a CMI of 1, because that's a pretty well person. When their patients are really sick, we want them to have a CMI up toward 2. This reflects comorbidities, complications, and other problems. That pays the hospital more through Medicare because it's a multiplying factor.

But it's not just for us. We want them to look good by having a high case mix, around 1½ or so, to reflect that their patients really need to be in the hospital.

We want them to have a bell-shaped curve, with a small number at each end (levels 1 and 5); most of them in level 3; and a few in levels 2 and 4. To show what happens when they don't, we tell them about the one physician who said, "Well, I'm going to beat this. I'm never going to have a problem. I'll code all of mine as level 2." And so he did. And Medicare audited him for the quality of his practice because it said he couldn't tell the difference between a sick patient and one with no problems.

Q. Besides upgrading processes in their office practices, are there other incentives for physicians to participate in hospital-based improvement projects?

A. If physicians understood and properly evaluated and documented the illnesses of their patients, that would almost be enough. One consultant explained that it could mean around $15,000 a year to the average family practice or internal medicine practitioner.

The reimbursement system is set up to pay the hospital or physician for taking care of a young, uncomplicated patient with one illness. When that is increased by two or three comorbidities, such as diabetes, hypertension, and renal failure, with complications and age added on top of that, then a physician has a higher index for that patient.

That index has a factor that's used to multiply the hospital's payment from Medicare. It makes quite a difference. Also, when HMOs sign up physicians, they like to see their CMIs and other data to determine their average lengths of stay (LOS).

Physicians definitely like to be associated with a hospital that enjoys a good reputation in the media and in published scores. They'll sometimes participate in programs that save time and make them more efficient. They'll frequently buy in to attempts to get better than expected results for patients and for the institution. They also like to know that some of the money they save is spent on modalities that eliminate barriers and move patients toward an early and beneficial discharge.

Although we have to be careful not to engage in gainsharing, I think it helps, every now and then, to tell doctors, "We just bought a new CT scanner for the emergency center because you needed it, and the money you saved us helped with the purchase. The scanner will help you move your other patients through the Emergency Center more quickly. And if they need to get to the operating room, perhaps you'll be able to get them there more quickly, also."

I repeat that while you can't share your gains with the physicians, it's nice to let them see that the hospital responds to barriers by maintaining the infrastructure.

Q. What's guaranteed to turn doctors off from quality initiatives?

A. Doctors are turned off by the impression that all of our quality talk is only about increasing the bottom line for the hospital. "Doing something for the hospital" never appeals to them. If we're to have their support, they have to see that it's mutually beneficial.

Q. Let's imagine for a minute that regulatory bodies like the Joint Commission on Accreditation of Healthcare Organizations or the Health Care Financing Administration gave hospitals a one- or two-year "bye" from reporting obligations. Would hospitals refocus their measurement activities on processes that more accurately reflect the quality of inpatient service?

A. I think we'd measure the same things we measure now: Patient satisfaction, physician satisfaction, staff satisfaction, 30-day readmission rates, infection rates, morbidity and mortality rates, LOS, CMI, and charges per patient per admission.

If our LOS is short, we especially like for our 30-day readmission rates to be low. We like to look at charges per patient, patient satisfaction, low rates of incidents like falls, etc. A high LOS provides a patient more time to develop bed sores or infection, or to fall, or to encounter medication errors. I'm not saying these are common, but it's obvious that the quicker you get out of the hospital, the less likely they'll happen. So we consider LOS as a quality thing as well as cost-saving. And physicians buy into that one, too.

Q. Any other measures you would consider important enough to keep, even if they were not regulated?

A. As I mentioned earlier, I think patient satisfaction is terribly important. You want patients to be happy — to feel that your hospital is a concerned, caring, friendly place to get well. There is also that difficult-to-measure factor of employee and staff morale. Patient satisfaction always follows employee and staff morale.

Q. Are physicians and other health care workers on the same page about the definition of a "good" quality initiative?

A. I don't think that's true in most hospitals. I think it's the case in more institutions now than it was 10 years ago, but in many places, physicians and other health care workers make up different factions that go in slightly different directions. The administration is viewed with suspicion. The nonphysician staff view the physician staff with some suspicion. It's very difficult to keep everyone working together.

Keeping everybody happy

And of course, self-interest is a big key to aligning all the groups on the same page. Each one needs to feel that it's being heard and that the institution cares and has some concern about it and its responsibilities. This is extremely important.

If team members are happy, and if their satisfaction is high with the institution and with each other, then the quality of care is good, the patients are happy, and the outcomes data are confirmatory. Patient satisfaction cannot increase without these interlaced fundamentals. Patient satisfaction is somehow a subjective complement of the objective indicators of quality.

In one of our programs at St. Joseph's, we found that focusing on quality almost inevitably produced a simultaneous and untargeted reduction in cost. Doctors who practice quality medicine seem to focus on their patients, treating them one at a time, coordinating with case managers, and making rounds as often as necessary rather than the obligatory once a day.

This meticulous attention to small detail results in quality of care and, frequently, in a dramatic, simultaneous reduction in LOS that comes almost as a by-product. Furthermore, it seems that spending more does not necessarily seem to have a positive correlation with high-quality care.

[For further information about engaging physicians in quality initiatives, contact Joel Mattison, MD, physician advisor, Clinical Resource Management, St. Joseph's Hospital, 3001 W. Dr. Martin Luther King Jr. Blvd., Tampa, FL 33607-6387. Telephone: (813) 870-4933.] ■

Conference to target cost, quality for case managers

Experts will share their proven ideas for successful case management at The 6th Annual Hospital Case Management Conference: Blueprint for Case Management Success: Information, Accountability and Collaboration, to be held March 25-27, 2001 in Orlando, FL. The conference is sponsored by American Health Consultants, publisher of *Hospital Case Management*.

The timely topics offer something for every hospital-based case manager or quality professional. Various speakers will address issues including:

- New avenues for community case managers
- Knowledge-driven care coordination
- Creating a heart service line report card
- What you can teach your CEO about managed care
- Values, ethics, and legal parameters in case management
- The ABCs of the Balanced Budget Act
- Reimbursement: An ever-changing process
- Key concepts in case management
- An interdisciplinary practice model for acute-care case management
- Better case management through denial management
- Measuring the impact of case management interventions

Each session sets aside time for you and your peers to ask the experts your most burning questions. Nineteen contact hours of continuing education will be offered.

The conference fee includes a cocktail party to network with speakers and other registrants, continental breakfasts, lunches, a course manual, and a form exchange for attendees. For more information, contact American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ▼

Seniors with mild ischemia at risk for cardiac death

A noninvasive heart scan may help identify which senior adults are at the greatest risk for cardiac death, according to a study presented at the recent 73rd Scientific Sessions of the American Heart Association in New Orleans.

In addition, researchers say that their findings suggest that more aggressive treatment may be warranted in those elderly patients with only mild cardiac ischemia than is currently used in clinical practice.

Researchers evaluated the prognostic value of stress-induced ischemia in 15,081 patients referred for myocardial perfusion SPECT (single photon emission computed tomography) using Cardiolite (Kit for the Preparation of Technetium Tc99m Sestamibi for injection). Patients' risks were determined by the amount of ischemia evident on SPECT and adjusted by decade of life from less than 60 years of age to 80 years of age and older.

The statistical threshold of increased cardiac death decreased with advancing age, researchers reported. Specifically, 18-month survival rate was 99% for 70 years or younger, 98% for 71 to 80, and 94% for older than 80.

The findings demonstrate, says lead researcher **Leslee J. Shaw**, PhD, associate professor of medicine at Emory University in Atlanta, that the ability of a noninvasive heart scan to accurately detect and assess the degree of cardiac ischemia is critical to early intervention and the long-term survival of patients. "With this new clinical evidence, we are another step closer to improving the management of this often undertreated patient population," he argues.

"While physicians already know the clinical value of Cardiolite in the general population, this study further points to its ability to accurately predict risk of cardiac death and guide clinical decisions in older patients," says **Daniel Berman**, MD, a study investigator and director of nuclear cardiology at Cedars-Sinai Medical Center in Los Angeles.

"Furthermore, the findings of this study take on even greater significance when you consider that cardiac ischemia is the leading cause of death among elderly patients and that the elderly comprise an increasing percentage of the U.S. population," he explains. ▼

CM/access combination may reduce denials

In response to the need for clinical expertise at the point of service, the consulting company Cap Gemini Ernst & Young works with providers to build in a case management function at the front end, says **James Witt**, MBA, RN, a senior

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $319 per year; 10 to 20 additional copies, $239 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

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**.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Editorial Questions

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

manager who works out of the firm's Chicago office.

Typically, the access nurse is assigned to patient access or registration and reviews admissions for clinical appropriateness. Sometimes, the nurses are involved in precertification and sometimes not, Witt says. In the recent past, he notes, his advice has been to integrate regular case managers into the access area, viewing that department as "another patient area, like cardiology or orthopedics.

"The value of doing that is that it brings a broader perspective to access than if [upfront case management] is done by a separate access nurse, who sees just the access function," he explains.

"I have also recommended to clients that they rotate case managers through the access department every three to six months," Witt adds. "Usually I recommend rotating once or twice a year."

Witt says he believes it's good policy in general to rotate case managers from practice to practice. "They can certainly have a home service, but it helps to move people around occasionally," he explains.

"This is particularly good when case managers have not had direct exposure to access. Moving them in for a stint really helps them understand utilization issues [and] helps identify early if a patient is high-risk. It's getting the discharge plan on the way in the door, or sooner," he says.

Rotating case managers through access helps them see access as a piece in the continuum, not a distinct function, Witt points out.

His experience has been that case managers typically "really like or really don't like" working in access, he says. "[Access case management] is not as relational, but people who enjoy utilization management and payer contact really like it. Others, who are focused on a specific patient population, seem not to like access as well, particularly if they have a specialty such as obstetrics."

Although at present it's exemplified by a relatively small group, Witt suggests the industry trend is to focus more on the access area as part of the case management design and to begin the process at the point of entry. The result, he says, is good for the patient and the balance sheet.

"My general impression," he adds, "is that there is a measurable decrease in payer denial when case management is firmly in place in access, because of precert issues and also because it facilitates a better level of care." ■

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:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■