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ORYX data collection valuable but difficult and labor-intensive, some say

System calls for more personnel, more time than you might think

The ORYX core measurement pilot project is yielding two conclusions from the participating hospitals. The good news: The data look valuable and should help improve health care. The bad news: It takes a lot of work to get those data, according to some participants. Many health care providers probably won't be ready when the time comes to start collecting the data nationwide, says **Karen Reeves**, vice president of professional services with the South Carolina Hospital Association in West Columbia. The association is one of several helping the Joint Commission on Accreditation of Healthcare Organizations to conduct a trial run.

"I don't think administrators are ready for how people are going to come to them and say 'we need more people; we need more resources,'" Reeves says. "We've gotten used to using automated systems to do reviews, and now we're going back to in-depth chart reviews. I'm afraid it's going to take a lot more work than people are anticipating right now."

(Editor's note: The August 2001 Hospital Peer Review *erroneously reported that data collection started this year. As savvy* HPR *readers know, only those centers participating in the pilot project are collecting data now. Other accredited facilities will begin collecting the data in July 2002.)*

Officials with the Joint Commission offer reassuring words and stress that the final ORYX system may not be identical to the pilot project. They say the reports of such labor-intensive experiences are just anecdotal so far, and even if the system does take a lot of work, there could be changes in the coming year that would ease the burden.

Jarod Logue, PhD, the Joint Commission's vice president for research and performance measurement, confirms that pilot project participants are reporting it takes a lot of work to collect the data, but he cautions peer review professionals not to assume that means their own work in 2002 will be unreasonably hard.

"Are these measures labor-intensive? The answer is absolutely," Logue

says. "But this is a work in progress. What the pilot project participants are doing today is not necessarily what everyone else will do in 2002. These are groundbreakers, and they're doing yeomen's work to shape the process."

Hospitals find out the going is tough

The core measure pilot project is a collaborative effort among the Joint Commission, five state hospitals associations, five listed measurement systems, and 83 hospitals in nine states. The project is intended to give the Joint Commission, health care organizations, and performance measurement systems an early base of experience in implementing a limited number of core performance measures, which have been grouped into these five sets: acute myocardial infarction (AMI, nine measures), heart failure (HF, six measures), community acquired pneumonia (CAP, nine measures), pregnancy and related conditions (PRC, three measures), and surgical procedures and complications (SPC, two measures).

The project began September 1999 when **Dennis O'Leary**, MD, Joint Commission president, sent a letter to all of the state hospital associations, soliciting interest in a pilot project that would assess the implementation of core measures by hospitals. Of the eleven qualified state hospital associations that expressed an interest, five were randomly selected to participate. Each was asked to identify a performance measurement system and 10 to 25 hospitals that also were interested in testing the implementation of core measures.

For the pilot project, participating hospitals have begun the data collection process for AMI, HF, and CAP measures, and the first transmission of data to the Joint Commission was received mid-April 2001. Throughout 2001, the Joint Commission, state hospital associations, measurement systems, and hospitals participating in the core measure pilot project have been working together to meet the objectives of the project and prepare for the national implementation of hospital core measures in 2002.

Hospitals will begin collecting core measure data for patient discharges beginning July 1, 2002. That date will come all too soon for some providers, Reeves says.

"This is another case of the Joint Commission developing something that is, in its opinion, the reasonable, rational thing to do, but [the organization] underestimates how executing [the project] will have a major effect on hospitals as far as cost and staffing," Reeves says.

The Joint Commission explains that each accredited organization will be required to select core measure sets based on the health care services the organization provides. Surveyors will assess a health care organization's use of its selected core measure sets in its performance improvement activities during the on-site survey process. Over time, core measure data will be used by the Joint Commission to assist it in focusing on-site survey evaluation activities.

The total number of measure sets an organization will be required to use will be relatively small. Individual organizations to which the core measure sets identified for their type are not applicable will continue to use their noncore measures to meet ORYX requirements until applicable core measure sets are identified.

Other types of accredited organizations will continue using noncore measures to meet ORYX requirements until core measures are identified for them. Home care core measure identification will focus on adopting Outcome and Assessment Information Set-derived measures for home health agencies, while long-term care core measure identification will focus on the adoption of Minimum Data Set-derived measures. Core measures for home care and long-term care organizations are expected to be consistent with Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) requirements in order to reduce duplication in performance measurement activities.

For long-term care, home care, hospital, and behavioral health care organizations that are becoming accredited for the first time, the requirements to participate in a measurement system and transmit data to the Joint Commission have been abated for two years or until core measures for

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these programs are implemented, whichever comes first. These organizations will satisfy performance measurement requirements by selecting and using six measures from the universe of relevant measures.

For these organizations, Joint Commission surveyors will evaluate their use of performance measurement data for quality improvement during the on-site survey activities.

One peer review administrator in the pilot project tells *HPR* that it will yield "great, super data," but that it is "very labor-intensive." **Indun Whetsell**, RN, BSN, is quality management coordinator at The Regional Medical Center of Orangeburg (SC) and Calhoun County. Her facility is one of three participating in South Carolina. Staff at that facility are collecting data on the congestive heart failure and myocardial infarction measures.

"They're very specific data, which makes them really useful, but it's all manual extraction," she says. "It literally means pulling a chart and sitting down to go through it and finding the right information. The data are at a much higher level

Prepare now by studying data sets, enlisting support from top

Some critics say the Joint Commission on Accreditation of Healthcare Organizations is trying to implement the ORYX data collection project too fast. But the machinery is in motion now, and there appears to be no stopping it, so what can you do?

Start by trying to pinpoint the costs of this whole endeavor, says **Karen Reeves**, vice president of professional services with the South Carolina Hospital Association in West Columbia. Take that into consideration when you select the two data sets that your facility will gather next year, and remember that they are not all equally difficult to collect. At the Regional Medical Center of Orangeburg (SC) and Calhoun County, **Indun Whetsell**, RN, BSN, quality management coordinator, says she started working with the congestive heart failure and myocardial infarction data sets because clinicians there already had an interest in those subjects and wanted to make use of the information. They are getting good, usable data, but she suspects some other data sets might have been easier to tackle.

Remember that the data sets are not created equal — far from it, actually. Acute myocardial infarction (AMI) has nine measures, heart failure (HF) has six, community acquired pneumonia (CAP) has nine, pregnancy and related conditions (PRC) has three, and surgical procedures and complications (SPC) has two measures. Health care providers will want to consider the value of the data for their own use, but you also should consider the amount of work involved, Whetsell says. If you know you're really going to tax your resources, it might be wiser to choose PRC or SPC instead of a data set that requires more work.

"What you choose will determine how labor intensive the work will be," she says. "Go into it with your eyes open."

Scott Williams, PsyD, the Joint Commission's associate project director in the division of research, is managing the pilot project. Williams says feedback from the pilot project participants indicates that the level of support from upper administration makes a huge difference.

"What seems to be pretty consistent is that for those hospitals with a tremendous amount of CEO buy-in, performance measurement is important, a lot of resources are available to them, and it's not that much of a burden," he says. "For those without a lot of buy-in, they have to make do with resources they already have and that were set aside for other activities. They have more difficulty with the project."

Logue and Williams offer this advice for how to prepare for the July 2002 deadline and make the data collection less burdensome:

- Study the data collection sets and get familiar with the specific requirements of each one. Determine how your particular organization would respond to each.
- Look for opportunities to streamline your medical records and make finding the data elements more efficient.
- Make sure you are documenting all the required data effectively.

"We've found that with some measures, hospitals do them very well but don't document them very well," Williams says. "Smoking cessation programs are a good example. If hospitals improve their documentation, they not only get the benefit of being credited with that work but also they reduce the time required to find that information and pull it together."

Automation will lessen the workload with some data collection, but the work certainly can be done by hand, Logue says. By the time the ORYX program is finalized for the July 2002 deadline, the Joint Commission will be able to offer more specific advice gleaned from the pilot project, he says.

"There are things you can do now to prepare so you're not blindsided and wake up in July 2002 and suddenly have this incredible job in front of you," Logue says. "And by that time, we will have streamlined the process in some ways and heard some helpful advice that we can pass on." ■

than when we were just pulling it off the bills, but that [quality of information] comes at a price."

Staff members in the medical records department pull the chart and record the appropriate data. The chart review can take between 60 and 90 minutes of combined staff time, which includes everything from initially pulling the chart to abstracting the data and entering the information into the computer. That time-per-chart adds up quickly, she says.

AMI data collection calls for 9 items to be extracted

The Joint Commission on Accreditation of Healthcare Organizations' core measurement data requirements vary among the five sets, but acute myocardial infarction (AMI) is one of the most labor intensive. These are the specific sets of data that must collected from each AMI chart:

- **Smoking cessation advice/counseling** — AMI patients with a history of smoking, who are given smoking cessation advice or counseling during hospitalization.
- **Aspirin at arrival** — AMI patients who are given aspirin within 24 hours of arrival or within 24 hours prior to arrival at the hospital.
- **Reperfusion therapy** — Timely reperfusion (opening blocked arteries) of eligible AMI patients; time from arrival to initiation of thrombolysis medication administration.
- **Reperfusion therapy** — Time from arrival to initiation of primary percutaneous transluminal coronary angioplasty.
- **Aspirin at discharge** — AMI patients who are prescribed aspirin at discharge from the hospital.
- **Beta-blocker at arrival** — AMI patients who receive beta-blocker medication within the first 24 hours of arrival to the hospital.
- **Patients with left ventricular ejection fraction (LVEF) less than 40% prescribed angiotensin converting enzyme inhibitors (ACEI) at discharge** — Ensuring that appropriate patients are given an effective treatment for AMI. The rate of patients with AMI and LVEF less than 40% discharged on ACE inhibitors.
- **Beta-blocker at discharge** — AMI patients who are ideal candidates for beta-blocker medication who are given a prescription for beta-blockers at discharge.
- **Inpatient mortality** — Patients with a primary diagnosis of AMI who expire during hospitalization. ■

To improve the process and make it faster, Regional Medical Center developed a form that nurses can use when providing patient education for congestive heart failure and myocardial infarction. The form lists all the education steps that are supposed to take place. The nurse checks off each step on the form, which is added to the patient's chart. That puts all the patient education information in one place so the chart reviewer can find it more easily.

"The extraction is a lot simpler when they use that form," Whetsell says. All the information is centrally located. That's the only tool we've put in place so far, but I think we'll end up doing more, and I'd recommend that hospitals look for ways like that to make the process easier."

The process also requires physicians to check for things such as contraindications, information systems staff to pull demographic data, and clerical staff to input data. The resulting data are immediately useful, she says, but the pilot project has put a strain on the hospital.

"It takes a lot of people to get good data," Whetsell says. "I think it's going to be a shock for people next year. You know it's coming, but until you do it, I don't think you realize how much work you have to do and what's involved."

Price tag still unknown

According to Reeves, the other two South Carolina hospitals in the pilot project are reporting the same difficulty. When full-scale reporting starts in July 2002, many health care providers will find that they did not adequately budget for the increased labor, she predicts.

"Hospitals will have to find a way to accommodate the labor requirements, and there is no vendor out there who can do it in an automated format," she says. "This is not the kind of data that can be captured on billing or automated data sets."

Aside from the staffing issues and the costs related to that problem, Reeves says hospitals are likely to find additional expenses that will blow their budgets. "We still don't know how much it's going to cost and that's extremely frustrating," she says. "No vendor can tell you the exact price for transition to the core measures, and hospitals are well into their budget planning. You can't go to the administration at the last minute and say you need a lot more money. Hospitals are going to have to make last-minute decisions, and administrators will be surprised at the money they're asking for."

Logue disputes Reeves' assessment of how much time is required and says other hospitals have reported satisfaction with the process. He notes that a hospital's experience could depend on what information processing systems already are in place, as well as other variables such as the hospital's size and the level of support from the administration. **(For recommendations on how to prepare for the July 2002 implementation, see box, p. 135.)**

"Remember also that there is a learning curve in every hospital," Logue says. "It will not take as long to do it next month as it did this month, and it will take even less time the following month."

Whatever additional work is required, Logue says, it's worth the effort. "Remarkably, the imposition of core measurement activities doesn't seem to result in a significant difference in the work these hospitals are doing already to meet Joint Commission requirements," he says.

"That doesn't mean there hasn't been an increase in full-time equivalents, but the key question is whether the juice is worth the squeeze," Logue adds. "The answer we're hearing is 'Yes. It is.'" ■

Safety profiles delayed by JCAHO but coming soon

The "patient safety management profile" proposed by the Joint Commission on Accreditation of Healthcare Organizations is under fire from health care providers who say it will create unfair comparisons and increase liability exposure, but a lead player in the plan says you will be subject to some sort of safety rating before long.

When the plan was reviewed by the Joint Commission's board of directors recently, health care providers flooded the board with objections and concerns, says **Ken Shull,** FACHE, president of the South Carolina Hospital Association in West Columbia.

The board was considering whether to go forward with a plan that would score hospitals and other providers according to how well they complied with certain standards and best practices considered key to providing a safe environment for patients.

Shull tells *Hospital Peer Review* that the board felt the heat from providers and decided to send the plan back for another look. The Joint Commission staff then sent the plan to the Accreditation Process Improvement Implementation Task Force, which Shull chairs. The committee has met once to consider the plan and is likely to meet once more on the same topic.

"They wanted field input to make the plan worthwhile, meaningful, doable, and not have it lead into more liability than necessary," Shull says. "It's considered a very important issue, and it's on a fast time frame."

Shull says his committee hopes to present its recommendations to the Joint Commission board in November and the plan might be implemented soon after.

According to Shull, even though the proposal has generated criticism, the Joint Commission is determined to enact some version of it without delay. He acknowledges that much of the concern is legitimate and says he hopes his committee's work will overcome some of the problems.

"Disclosure of anything is a touchy issue for health care," he says. "Concern about liability is a top priority. I think the general feeling is that we need some release of data, but we have to be careful . . . and make sure they're accurate, fair, and presented in a way that people can understand — a way that is relevant to how people obtain health care."

What data to gather and how to report them

The committee is considering two main issues: what information should be included in the profile and how to report that information publicly. As proposed, the patient safety management profile would be part of the Joint Commission survey process, with each organization getting a report card on how it manages hospital safety. Each hospital would receive a score, with quantitative numbers that theoretically could be used to compare providers. That is one of the biggest concerns.

"The information would be live and in color on the web, accessible to anyone. There's no easy way to display data like that and make sure people understand them in the way you intended," Shull says.

"I don't care how many disclaimers you have on something; if there is a graph, chart, or picture, people are going to look at that and forget all the words. They will make assumptions that you may not have intended and that may not be an accurate assumption," he adds.

The committee is reassessing one of the original proposals to use the Joint Commission's *Sentinel Event Alerts* as a way to calculate the hospital's patient safety management score. The *Sentinel Event Alerts* are published periodically by the Joint Commission as a way of highlighting sentinel events and bringing attention to the types of dangers involved, plus the lessons learned by health care providers.

The original idea was for the alerts to be used as criteria for determining how well a hospital has addressed patient safety, in effect considering each one a lesson and then seeing how accredited hospitals have put those lessons to use, Shull explains. But there has been criticism that the plan to use the alerts is too complex.

Karen Reeves, vice president of professional services with the South Carolina Hospital Association, has been monitoring the situation since the Joint Commission first proposed the plan. Though Shull is her boss, Reeves says she is not shy about voicing her opinion of the project he's trying to improve.

"Thank God that didn't fly," she says. "The Joint Commission wants to develop a methodology for a grid that would show a numerical score like 90%, with that number used as an indicator of patient safety. But it's a black box methodology. It's not been disclosed how you would calculate that numerical score, so there's no reason to think it's valid or reliable."

Alerts could be a lot to comply with

The plan to use the *Sentinel Event Alerts* as a measure of patient safety causes particular concern for Reeves. She is concerned that the Joint Commission would throw too many of the alerts at hospitals and not realize how much work is required to comply with them.

"They wanted to tell hospitals in October of each year that you have to show compliance with these 10 alerts for next year. But if you tell me in October that you're focusing on these 10 things, there is no way that in January I can have a good process in place for doing that," she says. "It would be much better for them to say, 'Here are 20 alerts, and you need to pick a couple that involved concerns at your hospital, implement them, and then explain to the surveyor why you chose those.'"

Shull has heard similar concerns from many other health care providers and observers.

He says that, despite some serious misgivings by different parties, the patient safety management profile will be a reality within a matter of months.

The actual implementation date may come after the grace period built into most new Joint Commission standards and procedures.

"We're going to have to click this together pretty quickly," Shull says. "It's on a fast track because it's important. The public, employers, and insurers are all looking for information like this. It's all part of the increased awareness and emphasis on medical errors and patient safety."

Standards Review Task Force making progress

Shull also chairs the Joint Commission's Standards Review Task Force, which is conducting a sweeping review of nearly all the Joint Commission standards and requirements for demonstrating compliance with standards, with the goal of making them less burdensome and more realistic for health care providers.

The 18-member task force will pinpoint which accreditation standards are most relevant to the safety and quality of patient care, and target for elimination or modification those standards that do not contribute to good patient outcomes. In addition, the task force will identify "redundant and overly burdensome" documentation requirements with an eye toward streamlining and identifying areas that need more attention. Only a few recently established standards, such as new requirements regarding pain management, patient safety, and restraint and seclusion are exempt from scrutiny.

Shull tells *HPR* that the process is going well. The committee has met twice and gone through three chapters, he says. It will be a yearlong process through the end of June 2002. Shull says the specifics of the committee recommendations cannot be released yet, but he is pleased with its progress.

"So far we've pointed out some redundancies and that seems to be well-received by the senior [Joint Commission] staff," he says. "We've said others were not necessary, and that also was well received. And we've confirmed that some were good, that they needed to be there."

Shull says he is most pleased by the reaction of the Joint Commission staff, who he says seem serious about the plans to cull the standards of unnecessary and unreasonable requirements.

"The book ought to be thinner when we're done," he says. ■

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Combined roles: Balance clinical, financial responsibilities

Streamlining systems can work — support crucial

Increasingly, hospital-based case managers have had to take on a conglomeration of duties, serving as utilization manager, discharge planner, and clinical case manager, among other things.

When the caseload is reasonable, the case manager's skill set well rounded, and the department empowered, the integration of functions is highly successful, says **Maria Hill,** RN, MS, CMAC, senior consultant with the Center for Case Management in South Natick, MA. If those pieces aren't in place, Hill cautions, the results can be less than desirable.

Weighing the pros and cons

"There is good and bad [to combining the three roles]," she explains. "The good part is that you are streamlining systems so that when the case manager is looking at the medical record and patient/family, that individual can ask, 'What is the primary diagnosis? What are the comorbidities that may complicate the case? Do the treatments, tests, and medications being administered meet the criteria for a hospital stay? What resources will be used during the hospitalization?'"

Understanding the severity of illness, the intensity of service, and the complexity of the plan of care helps the case manager craft the clinical outcomes to be achieved and the discharge plan to be put in place, Hill says.

The overriding challenge is to balance clinical and financial considerations, she points out. This can be accomplished if the case manager has a manageable caseload, is not required to cover too many inpatient units, and has administrative support, she adds.

Difficulty arises when case managers are asked to see too many patients and to cover too much geography, she notes, as when one case manager is given responsibility for the emergency department (ED), the intensive care unit, and the general care units. The challenge becomes even more overwhelming, when case managers also are expected to address such issues as length of stay, denied days, and costs of care without data and administrative support, Hill notes.

> *"The on-top-of-it case manager will have the ability to place a person in a skilled nursing facility or a rehab setting within 24 hours."*

The proper ratio is one case manager to between 20 and 25 patients, she says, as long as no extraneous duties are added to the workload. If the case manager also is charged with doing infectious disease reports or collecting quality measurement data, that person won't have sufficient time to perform well the three central functions, Hill points out.

Developing the skill set

Besides adequate time to do the job well, she suggests, the case manager who successfully does utilization review (UR), discharge planning, and

clinical resource management must have a well-developed skill set that includes the following:

• **Knowing the utilization review criteria that the hospital uses internally, as well as those used by the higher-volume payers.**

"The goal is to ensure the right level of care at the right place at the right time within the typical clinical trajectory for the diagnosis," Hill says. "By having a detailed knowledge of the UR criteria, the case manager can negotiate — through conversation with the payers — the appropriate place for the patient."

Without this knowledge, she adds, the case manager won't have the ability to properly articulate the reasons the patient whose condition is borderline when compared to the standard criteria should be in the acute care setting.

• **Ensuring, as part of the clinical case management function, that daily outcomes are achieved and the patient is making progress in line with the care plan for the hospital stay.**

It is essential, Hill says, that the case manager establish procedures to manage care on a daily basis and against a standardized plan of care for the stay. "A targeted length of stay by diagnosis is essential," she adds.

Evaluate family's caregiving skills

The case manager also is charged with reviewing the care of both the individual patient and the aggregate population — all the hospital's stroke patients, for example — against this plan of care for the stay, Hill says.

With stroke patients, for example, the case manager should be looking at a four- or five-day expected length of stay, she notes, and should make sure that within an hour of presentation to the ED, the patient who meets criteria is given an antithrombic agent.

Within 12 to 24 hours, the case manager should ensure that:

— the patient is evaluated by a speech pathologist;

— a plan for communication and nutrition is established;

— the patient's blood pressure parameters are set and blood pressure is managed within this range;

— the patient is evaluated by a physical therapist and an occupational therapist, and the resulting plan is written in the chart and acted on;

— immediate communication is established with the physician to review complications and exceptions to the stroke clinical plan of care for the stay.

• **Understanding all aspects of discharge planning.**

What's key here, Hill suggests, is crafting "Plan A" and "Plan B" for the high-risk patient so that if Plan A fails, Plan B may succeed. It's also crucial that the case manager know enough about the patient to measure the effectiveness of Plan A, and know the proper time to put Plan B into place.

Plan A for a stroke patient, for example, might be to send the patient home after discharge from the hospital. Part of the skill set required here, Hill says, involves working with the therapy staff to know what the predicted functionality of the patient will be at the end of the four- or five-day acute care stay.

"That should be judged within the first 24 hours of admittance to an inpatient setting," she notes.

Another crucial component is evaluating family members' ability to assist the patient in the home, and also evaluating their willingness to change their schedules in order to do so, Hill points out. "Once you know they're able, [determine if they're] willing to provide the assistance and surveillance necessary for the patient to function in the home."

In approximately 25% of cases, family members either get home and are overwhelmed at the prospect of caring for their loved one — in which case the person is readmitted — or they realize at the last minute that they can't do it, she says. That's why Plan B, the backup plan, must be highly viable, Hill explains.

"The on-top-of-it case manager will have the ability to place a person in a skilled nursing facility or a rehab setting within 24 hours," she says. Knowledge of community resources is important, she adds, including good programs available for "special interest" patients, such as those with significant brain injuries, significant functional motor loss, or dependence on a ventilator.

Look out for 'red flags'

Ideally, the case manager will have taken steps to avoid this last-minute regrouping, Hill explains. A "big red flag" to look out for, she adds, is family members who insist they can take the stroke patient home but haven't spent any time in the hospital.

Something Hill recommends, but which she says isn't done enough, is for the case manager to

have family members come to the hospital and then observe them taking care of the patient.

"[The case manager should] instruct them on how to care for the patient — helping mobilize, feed, give medication — and then observe them as they do these tasks," she notes. "I have had case managers do it, and [the family members] get a better picture of what the workload is, what their knowledge base needs to be, and whether they can actually manage their family member at home."

Another red flag, Hill adds, is discord within the family. "One person really wants to take mom home but can't provide all the care, but another sibling is not interested in assisting."

In those cases, she suggests, the case manager should try to arrange a family meeting and present the different views he or she is hearing from the members.

"The key in these situations is to have an excellent relationship with a clinical social worker who can help a family adjust to the new diagnosis and change in the person's functional ability," Hill says.

"This helps the family know realistically what they can and can't provide."

She suggests that all stroke patients be assessed by a social worker within 24 hours of admittance to the hospital.

It's important to have the family look at placement options, even when they're thinking of taking the patient home after discharge, Hill says. "If you think Plan A might fail, encourage the family to visit facilities within their community. Let them know that you're looking to the future, when they may need to put their family member in this setting for a short time."

If there's too much, prioritize

In situations that are less than ideal, where the case manager is responsible for more than a reasonable number of patients, he or she will have to prioritize, she points out.

"You have to perform utilization review on all patients every day or every other day, but you may do a good job with care planning and discharge planning only on the higher-risk patients," Hill says.

"You would have to delegate to the unit manager or bedside clinicians the cases for which they would create a care plan and a discharge plan," she explains.

Role negotiations, she adds, should be at the administrative level, with oversight provided by a steering committee that helps establish policies and procedures.

That committee, Hill suggests, would include such participants as the director of case management, the vice president of patient care services, and the vice president of medical management. ■

CCMC task force looks at review process

A task force of the Commission for Case Manager Certification (CCMC) is taking a look at its eligibility review process, with regard to who is allowed to sit for the certified case manager (CCM) exam and the criteria for what makes a case manager.

"This is a process that is always ongoing," says **Susan Gilpin,** JD, chief executive officer (CEO) of CCMC, based in Rolling Meadows, IL. The organization does research every five years, she says, and will do a "role and function study" next year.

The present task force, however, represents CCMC's efforts to keep current between those five-year studies and "to take a look at changes in the field," Gilpin says. "Does it make sense to review eligibility criteria? Has there been that much change?"

"What is the continuum of care?" is a key question that is being addressed, she notes. "How do you define the continuum of care across multiple environments? The task force will be looking at issues like that, [and] will try to be open to examining the criteria we have set, at how that has been defined."

Commissioners serving on the task force are case managers who practice in a variety of settings, Gilpin says. Charged with its mission in June, following the organization's annual meeting, the task force will give a preliminary report on its findings to the entire commission at the midyear meeting in January, she adds.

The task force will be looking for opportunities to identify research projects that might be undertaken by CCMC's exam and research committee, Gilpin notes.

On a related subject, she adds, the commission has found that the job descriptions submitted by people applying for CCM certification have gotten much more specific.

"This might be an industrywide trend," Gilpin suggests, "that human resources departments are doing a good job of updating descriptions and making sure they reflect what case managers are doing."

In the case of some applications, however, there is a need for more illustration of how the job fits case management criteria, she says. "We urge people to make sure when they submit an application that they take a look at the job description and make sure it accurately reflects what they do."

CCMC receives some applications, Gilpin explains, that include a single-page bullet-point job description, with a very limited list of duties. "Unless you're able to show in the job description what you really do, it may look like you only perform clerical functions."

To make the package more complete, she advises, applicants might submit a case study, and say, "Here's a case I worked on, this was my role, and this was my involvement level."

Applications that are rejected, Gilpin notes, go to a different committee for consideration during the appeals process.

[Editor's note: For more information on attaining the certified case manager (CCM) credential, contact the Commission for Case Manager Certification, 1835 Rohlwing Road, Suite D, Rolling Meadows, IL 60008. Telephone: (847) 818-0292. E-mail: info@ccmcertification.org.] ■

New book aims to fill case management void

Looking for a manual that consistently addresses the case management process regardless of practice setting, pay system, professional affiliation, or patients served?

Case Manager Review Course: The Essence of Case Management, published in May 2001 by American Nurses Credentialing Center (ANCC) and the Institute for Research, is "the first published case management book to be inclusive of all health care disciplines in the practice of case management," according to the publishers.

The book is intended to "embrace the essence of case management across the continuum of care," says **Anne Llewellyn,** RN, C, BPSHSA, CCM, CRRN, CEAC, who co-wrote it with **Kathleen Moreo,** RN, Cm, BSN, BPSHSA, CCM, CDMS, CEAC. Llewellyn and Moreo are business partners who own PRIME Inc. in Miramar, FL.

"This is for people coming into practice to understand the whole scope of practice, as well as for the experienced case manager who may have worked in only one setting, such as the hospital or in managed care," Llewellyn adds.

The book includes several case studies focusing on nursing, social work, respiratory therapy, nutrition, rehabilitation, and other specialty practice arenas, she notes.

Each chapter includes review questions and answers, with rationale, to assist in studying for national examinations, and to allow the reader to learn in a user-friendly manner, she notes.

[Editor's note: Case Manager Review Course *can be purchased by calling the ANCC at (800) 924-9053. For more information, contact Anne Llewellyn at allewellyn@primeinc.cc.]* ■

Medicare hikes pay for outpatient services

Hospitals will get a 2.3% payment hike, effective Jan. 1, 2002, under the proposed rule for the outpatient prospective payment system (OPPS) released in late August by the Centers for Medicare and Medicaid Services (CMS).

The rule would achieve the goal of making appropriate reimbursement payments given the ongoing shift of services from inpatient to outpatient setting, according to **Tom Scully**, CMS administrator.

While the rule outlines possible approaches for CMS in estimating payments for hospitals' use of "pass-through" devices, drugs, and biological products in outpatient services, it makes no actual estimate.

Congress required Medicare to make such payments temporarily, and capped them at 2.5% of the estimated overall amount paid under OPPS.

Currently, should the estimate exceed the cap, an across-the-board cut on all pass-through payments would be required. The proposed rule can be viewed at www.hcfa.gov/regs/propcy2002.htm. ■

Guidelines should improve cardiac data collection

A new set of standard terms and guidelines for data collection developed by the American College of Cardiology (ACC) in Bethesda, MD, is intended to improve the quality of care for cardiac patients.

The Acute Coronary Syndromes (ACS) Clinical Data Standards provide a common terminology for describing the care and outcomes of patients with acute heart conditions, including heart attack and unstable angina. Lack of standardization in terminology and data collection has posed a major obstacle to efforts aimed at improving cardiac care and comparing results of studies, says **Ralph Brindis**, MD, chief of cardiac services at Kaiser-Permanente in San Francisco.

Uniform standards, definitions

"The document provides tools and guidance for collecting data in a standardized manner and for comparing different data sets," says Brindis, who also chairs the ACC Task Force on Clinical Data Standards.

"At times, medicine seems to operate in a Tower of Babel, where different terms mean different things to different people. By having standard language tools, we will be able to make logical and accurate comparisons in our assessment of the care provided to patients who have ACS," he says.

The standards provide a single definition of a heart attack, for example, which can be used in all clinical trials, Cannon says. Such standardization will permit more accurate and useful comparisons of different studies and data registries. Comparison of cardiac care provided at different hospitals also will become more precise and meaningful.

Uniform standards will permit more accurate evaluation of the type and quality of cardiac care provided to patients and more accurate comparison of findings from studies of treatments for ACS, says **Christopher Cannon**, MD, a cardiologist at Brigham and Women's Hospital and Harvard Medical School in Boston and chair of the panel of experts that wrote the ACS standards.

"Standardization will help facilitate efforts to improve the quality of cardiac care," Cannon says. "Quality improvement is a major focus of individual hospitals and states as well as on a national level. Collecting accurate data is a major factor in monitoring and improving care. Clear definitions and guidance about how to monitor care should help improve quality."

The ACS standards evolved from an extensive review and discussion of the terminology and methods used in clinical studies, registries of clinical data, and published articles related to the care of patients with ACS. As a primary objective, members of the writing committee sought to identify the best definitions and standards for clinical care and research.

More standards in the works

"We have tried to make the definitions as clear as possible and as useful as possible," Cannon says. "We want people to be able to begin using the standards in the development of quality-improvement efforts and new clinical trials and data registries as soon as they are finalized."

The ACS standards are the first in a series of documents the ACC is developing. Brindis says two other writing groups from his task force have begun work on standards for heart failure and atrial fibrillation.

The standards are posted on the ACC web site at www.acc.org.

After comments are received, a final draft of the standards will be posted on the ACC web site and published in the *Journal of the American College of Cardiology*. ■

Diabetes guidelines call for earlier screening

Diabetes guidelines released recently by the American College of Endocrinology (ACE) and the American Association of Clinical Endocrinologists (AACE) in Jacksonville, FL, call for more aggressive treatment and earlier screening.

The guidelines say diabetes screening should begin at age 30 in high-risk groups, whereas current standards call for screening to begin at 45. The federal Centers for Disease Control and Prevention reports that the prevalence of diabetes has increased 76% among those ages 30 to 39.

In addition, the guidelines lower the target

on the glycosylated hemoglobin A (HbA_{1c}) test to 6.5% from the previously recommended 8%. The ACE / AACE consensus panel recommends that the HbA_{1c} test be universally adopted as the primary method of assessment of glycemic control.

The panel says it should be performed at least twice a year in patients whose levels are on target and more often in patients whose levels are above target and in those who are changing therapies.

Claresa Levetan, MD, director of diabetes education at Medstar Clinical Research Center in Washington, DC, and a member of the panel, explains that the HbA_{1c} test should be called simply the A_{1C} test.

"It is critical that patients know their A_{1C} level and their goals," she says.

The guidelines also set targets for plasma glucose: Fasting and preprandial levels should be <110 mg / dL and two-hour postprandial levels should be <140 mg / dL. ■

THE QUALITY - CO$T CONNECTION

Don't overlook CEO performance evaluations

How to design an effective evaluation process

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

An essential factor for a successful health care organization is a good relationship between the governing board and chief executive officer (CEO).

The CEO is the primary agent of the board and is the single most influential person in creating an outstanding health care institution. Selection, evaluation, and support for the CEO are among the board's most important responsibilities. The CEO and board must function as a team.

The CEO is charged with carrying out board policies, while the board members look to the CEO for guidance and leadership. Mutually agreed-upon and clear descriptions of roles and responsibilities help to ensure open communication, confidence, and trust.

The governing board is responsible for defining CEO expectations in written policy, the job description, and in annual goals.

Most health care organizations have very comprehensive programs for evaluating their employees. Surprisingly, many of these same facilities do not conduct performance reviews of the senior leaders, or if they do, the evaluations are irregular and extremely subjective.

The governing board provides important support for the chief executive by performing regular evaluations and giving constructive feedback. Formal evaluations may be scheduled annually, although ongoing communication is important to prevent problems from festering.

The primary purpose of a formal evaluation is to bring the CEO and the board together to discuss how their performance and priorities contribute to the safety and effectiveness of health care services for patients and the community. The emphasis should be on identifying what works well and what needs improvement.

Objectives of the CEO evaluation process include:

- Assess how well the organization is fulfilling its mission.
- Examine and re-define, if necessary, goals for the organization and the CEO.
- Support the CEO by providing constructive feedback on performance.
- Develop plans to address issues that arose during the evaluation process.
- Provide an opportunity for the board to learn how its performance affects the board / CEO partnership.
- Foster communication between the board and CEO.

The evaluation process

There is no single right way to assess CEO performance. Differences in style, temperament, organizational complexity, and culture will lead to different methods and procedures. Whatever evaluation process is used, it should be developed jointly by the CEO and the board and mutually agreed to.

The following questions need to be answered

(Continued on page 146)

CEO Annual Evaluation Survey

Please rate according to the following scale: 1 = remarkable; 2 = satisfactory; 3 = unsatisfactory; 4 = unknown

Organizationwide Program Development and Delivery

A.	Ensures that the organization has a long-range strategy that achieves its mission, and toward which it makes consistent and timely progress	1	2	3	4
B.	Provides leadership in developing program and organizational plans with the board of directors, physicians, and staff	1	2	3	4
C.	Meets or exceeds financial and quality goals	1	2	3	4
D.	Evaluates how well goals and objectives have been met				
E.	Demonstrates quality of analysis and judgment in program planning, implementation, and evaluation	1	2	3	4
F.	Shows creativity and initiative in creating new services and programs	1	2	3	4
G.	Maintains and utilizes a working knowledge of significant developments and trends in the health care field (such as patient rights, safety improvement, managed care, etc.)	1	2	3	4

Comments: _____

Administration and Human Resource Management

A.	Divides/assigns work effectively, delegating appropriate levels of freedom and authority	1	2	3	4
B.	Establishes and makes use of an effective management team	1	2	3	4
C.	Ensures that job descriptions are developed and regular performance evaluations are held and documented	1	2	3	4
D.	Ensures compliance with personnel policies and state and federal regulations on workplaces and employment	1	2	3	4
E.	Ensures that physicians and employees are licensed/credentialed as required, and that appropriate background checks are conducted	1	2	3	4
F.	Recruits and retains a diverse staff	1	2	3	4
G.	Ensures that policies and procedures are in place to maximize physician involvement in organizational activities	1	2	3	4
H.	Encourages staff development and education, and assists staff in relating their work to the goals of the organization	1	2	3	4
I.	Maintains a climate that attracts, keeps, and motivates a diverse group of top-quality physicians and staff	1	2	3	4

Comments: _____

Community Relations

A.	Serves as an effective spokesperson for the organization; represents the services and point of view of the organization to outside agencies, organizations, and the general public	1	2	3	4
B.	Establishes sound working relationships and cooperative arrangements with community groups and other organizations	1	2	3	4

Comments: _____

Financial Management

A.	Assures adequate control and accounting of all funds, including developing and maintaining sound financial practices	1	2	3	4
B.	Works with the physicians, staff, finance committee, and the board in preparing a budget; sees that the organization operates within budget guidelines	1	2	3	4
C.	Maintains official records and documents, and ensures compliance with federal, state and local regulations and reporting requirements (such as Medicare cost reports, payroll withholding and reporting, etc.)	1	2	3	4
D.	Supports an effective corporate compliance program	1	2	3	4
E.	Assures that funds are received and disbursed in accordance with contract requirements	1	2	3	4

Comments: _____

Quality and Safety

A.	Develops realistic and ambitious quality and patient safety improvement goals	1	2	3	4
B.	Meets or exceeds quality and patient safety improvement goals	1	2	3	4
C.	Establishes positive relationships with physicians, managers, and staff to ensure adequate grass-roots support of performance improvement activities	1	2	3	4
D.	Successfully involves physicians, managers, and staff in quality and patient safety improvement initiatives	1	2	3	4

Comments: _____

in designing the evaluation process:

- When should the CEO be evaluated?
- What should the criteria be?
- What types of instruments, if any, should be used?
- Who should conduct the evaluation?
- Who should participate in the evaluation?
- How should the results be communicated?
- Should the evaluation be tied to compensation or contract extensions?

While ongoing evaluation occurs naturally as the CEO and board members discuss issues, it is important to schedule a formal evaluation session at least annually.

This evaluation helps the chief executive understand areas for improvement. The formal evaluation also helps the CEO know where the board may not be receiving a sufficient amount of information.

Typically, the board officers or a committee of the board leads the evaluation process and reports on the evaluation to the entire board. Because the CEO acts both directly and indirectly through others to manage the organization, evaluating this person's performance is inevitably linked to evaluating the organization's performance as a whole.

Developing the criteria

Many boards incorporate the CEO evaluation into the annual review of organizational performance and goal setting for the coming year.

The criteria used to evaluate the CEO must be defined well before the actual evaluation takes place so that expectations are clear. Issues of governance and accountability are very important in today's health care environment, and the board should evaluate all aspects of the CEO's job.

Evaluation criteria can be derived from the following:

- Progress toward the mission, vision, and institutional goals (financial and quality goals).
- Adherence to organizational policies and operational procedures.
- The CEO's job description and/or the policy statement on his or her roles and responsibilities.
- The CEO's annual goals and objectives (established each year in consultation with the board).

The board also may gauge how well the CEO develops, attracts, and retains an effective top management team and how the CEO relates to the medical staff and other clinical staff, the media, and community leaders.

Many hospitals involve only other board members directly in the CEO evaluation process. Because a failing executive can hide problems from the board more readily than direct caregivers, some boards of directors involve physicians and staff in the review process.

Use wide range of sources for feedback

Still others go outside the organization to gather information regarding the performance of the CEO from community leaders, collaborating

13. How many measures are included in the acute myocardial infarction set of ORYX core performance measures?
    A. two
    B. three
    C. six
    D. nine

14. On what date will hospitals begin collecting ORYX core measure data for patient discharges?
    A. Dec. 1, 2001
    B. July 1, 2002
    C. Sept. 1, 2002
    D. Dec. 1, 2002

15. Which of the following items is not included in the acute myocardial infarction set of ORYX core measures?
    A. smoking cessation advice/counseling
    B. aspirin at arrival
    C. length of stay
    D. aspirin at discharge

16. According to Patrice Spath, RHIT, criteria used to evaluate a health care organization's CEO can be derived from which of the following?
    A. progress toward the mission, vision, and institutional goals
    B. adherence to organizational policies and operational procedures
    C. the CEO's job description and/or the policy statement on CEO's roles and responsibilities
    D. all of the above

organizations, volunteers, or former patients.

Feedback from board members, physicians, staff, and external groups can be gathered through survey-type assessments. **(An example of a CEO evaluation survey tool is shown in the box on p. 145.)**

How useful is your instrument?

It is important to understand the shortcomings of survey instruments such as this. First, they are based on people's perceptions, and frequently these people have very limited views of the executive director's performance.

A second shortcoming is the quantitative nature of the questionnaire. It tends to attribute

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Editorial Questions

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the same level of importance to all activities, and success with smaller tasks can inappropriately compensate for a big failure.

For example, if the CEO does wonderful work with community leaders, but has allowed patient safety issues to remain unresolved, the problem will only show up as one or two negative "grades" and won't affect the overall score. Because of these shortcomings, it's important to see the CEO performance assessment as the starting point for discussion, not the end result. Evaluation instruments and checklists can be very helpful tools to help people clarify their thoughts.

However, the discussion of what the results mean and what can be improved generally is more valuable and important to the board than the specific numbers or ratings obtained from surveys.

Confidentiality is vital

The CEO evaluation should be confidential with the evaluation session taking place in closed sessions of the board. Discussions between board members and the CEO generally are the most valuable portion of the evaluation process and provide insights into ratings or written comments. Discussion will include a review of the evaluation results as well as general questions such as:

- What is your assessment of the past year, both successes and things that didn't go well?
- What is the organization's most significant achievement for the year?
- What difficulties were encountered?
- What aspects of the CEO job are most interesting and rewarding?
- What aspects of the CEO job are most frustrating and least interesting?
- What do you, as the CEO, need from the board to ensure further success for the organization?

Regardless of the evaluation process used, don't forget that executive directors need feedback all year round. Like any employee, CEOs need praise and acknowledgment for work well done and immediate feedback when problems arise.

In the best situations, the board president and trustees have a good working relationship with the executive director and constant feedback flows in both directions. The annual formal evaluation is an important component of, not a substitute for, that relationship. ■

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