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Revised disclosure standard presents new compliance challenges

Wording may mislead about what information must be disclosed

Recent changes to the Joint Commission on Accreditation of Healthcare Organizations' RI.1.2.2 standard, which is in the patient rights and organization ethics chapter, may appear to make it easier for health care providers to comply by lessening the obligation to tell patients and families of adverse events. That is not necessarily the case, however, and misinterpreting the standard could lead to serious repercussions on your next survey.

One critic suggests the change was made to appease providers grousing about the requirement to disclose adverse events, but that the change is really just window dressing. If you think the revision lets you relax your disclosure policy, you could get dinged with a Type I recommendation. Watch out if you are primarily responsible for ensuring Joint Commission

CE testing process simplified

Beginning this semester, *Hospital Peer Review* is simplifying its continuing education program by no longer requiring you to return a test form. Instead of completing a Scantron form as you have in the past, all you will need to do is complete a CE evaluation, which will be enclosed in your December issue. Upon receipt of your evaluation, your CE certificate will be mailed to you. It's that simple.

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compliance; others in your organization may want to seize this revision as an opportunity to change the way information is disclosed.

The change was scheduled to become effective July 1, 2002. Standard RI.1.2.2 states, "Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." The change was made to the "intent" section of the standard, which accredited organizations often use to help them interpret how to comply. The old intent section stated, "The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes."

But the newly revised intent section now says: "At a minimum, the patient and, when appropriate, the patient's family are informed about outcomes of care that the patient [or family] must be knowledgeable about in order to participate in current and future decisions affecting the patient's care, and unanticipated outcomes of care that relate to sentinel events considered reviewable by the Joint Commission. The responsible licensed independent practitioner [LIP] or his or her designee informs the patient [and when appropriate, the patient's family] about these outcomes of care."

While still requiring accredited providers to disclose outcomes to patients and families in many situations, especially those serious enough to be sentinel events, some see the revision as weakening the original provision.

In effect, they say, the original intent was broader and required providers to disclose information fully, while the revision only requires disclosure of information necessary for the patient to make care decisions or information related to sentinel events. Not so, says a Joint Commission surveyor who was involved with the revision.

Steve Chinn, DPM, MS, is compliance officer at Fremont (CA) Hospital, and a part-time surveyor for the Joint Commission. In addition, Chinn teaches courses for the Joint Commission and was one of many surveyors who urged the accrediting body to change RI.1.2.2.

Chinn explains that the revised standard could be confusing to providers if they interpret the new wording in the wrong way.

Rather than loosening the requirement so that fewer incidents would require disclosure, the Joint Commission actually was trying to encourage more disclosure, he says.

"We were all suggesting this change out in the field," he says. "The old intent was very flexible, subject to wide interpretation. The new intent is becoming very specific for minimal expectations, but it is important to see that they are minimal expectations. The intent does not outline all situations in which you need to disclose, but it tries to be very specific about the minimal situations that would apply."

Under the previous intent, providers were left to determine what sort of information must be disclosed, and Chinn says they often did not do a good job with making those decisions.

The Joint Commission never intended — and still doesn't intend — that providers tell patients about every single detail involving their care, but people often struggled with where to draw the line, Chinn says. In some cases, providers were creating a problem by disclosing information they did not really need to disclose, and in some cases, people were so confused that they hardly disclosed anything.

"People were paralyzed by not knowing what to include and what not to include, so they ended up not doing enough of anything," he says. "Some folks were saying that if a patient had an adverse drug reaction, but we reversed it and so there's no problem, they didn't have to disclose it. A lot of people were wondering about when a patient stayed four days and you only expected two days. Did you have to bring in a whole team to disclose that unexpected outcome?"

The adverse drug reaction should be disclosed, but the extra days probably would not be, Chinn says. The revised intent section of RI.1.2.2 is intended to help providers establish a solid minimum for what must be disclosed, while allowing

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plenty of leeway to determine that other situations require disclosure, he says.

Many hospitals are developing in-house policies on disclosure now, and the revised intent should provide some guidance, he says.

Don't relax your disclosure policies

The new wording is difficult to understand, and misinterpreting the Joint Commission revision could put you out of step with the rest of the health care community, says **Grena Porto**, RN, ARM, DFASHRM, senior director of clinical operations at VHA Inc. in Berwyn, PA. Porto is a leader in the movement to promote more disclosure and open discussion with patients, and she often works with the Joint Commission.

Porto says that, based on comments she has heard from Joint Commission officials, the accrediting body seems to be losing some of its will to promote disclosure of adverse events. That retreat was prompted by complaints in the health care industry, she says.

However, Porto agrees with Chinn that the RI.1.2.2 revision is not necessarily weaker than the previous version.

The wording may be confusing to providers and could easily suggest that the Joint Commission is backing off on disclosure, but it is in fact a convoluted definition that tries too hard to satisfy everyone, she says.

The health care industry has a terrible habit of wanting accrediting bodies to specify how to act in every possible situation, instead of expecting providers to rely on their own judgment to comply with the spirit of the standard, Porto says.

When the Joint Commission first came out with a rule promoting disclosure, providers pestered surveyors with endless questions about whether to disclose this or that, insisting that the standard should be crystal clear in every situation. In response, Porto says, the Joint Commission revised the standard in a way that only makes compliance more difficult.

"We asked so many stupid questions that now we've got a stupid answer," she says. "Instead of taking a thoughtful, common-sense approach to it, we try to paint them into a corner, forcing them to define the standard, and they come back with something worse than the original. At some point, we should be big boys and girls and look at the bigger picture and what's right for the patient."

The Joint Commission should have just left the standard alone, she says, contending that the original intent was clear enough for any provider willing to put the patient's interest first. But now that the intent section has been changed, Porto advises quality improvement and peer review professionals to be extra careful in promoting disclosure within your organization. With the confusing wording now found in RI.1.2.2, you may need to *specifically* caution providers against relying too much on the scenarios outlined in the intent. Do not let people get the idea that they must disclose only sentinel events and information necessary for care decisions. And it is particularly important that you not allow any policies to be rewritten with that misinterpretation.

Do not change any of your disclosure policies in response to this intent change, she says. Your organization's disclosure policy should continue to grow more liberal, not revert backward, she says.

"There are going to be a lot of gray areas to decide on a case-by-case basis," Porto says. "It's not a black-and-white issue, and it's stupid to expect an accrediting body to define it in very concrete terms. Do what's right for the patient, and don't look for the minimum you can get away with."

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Sentinel event leads to safety checklist

Quality project stresses input from frontline staff

A tragic sentinel event at a Michigan hospital prompted staff to develop a system to reduce the chances of it ever happening again. The result was an innovative quality improvement project that emphasized immediate results, input from the frontline staff, and ongoing refinement of the safety initiatives.

The process began in May 1999 at the Veterans

Affairs Ann Arbor (MI) Healthcare System (VAAAHS), a medical center with four campuses and more than 26,000 patients. Like many sentinel events, the 1999 incident was the result of a combination of process problems and human error. A nurse at the medical center accidentally administered a bolus of regular insulin to a nondiabetic patient through an arterial line, causing brain death, explains **Marcia Piotrowski**, RN, MS, clinical risk manager in the office of the chief of staff. The staff's root-cause analysis determined that the causative factors were improper mingling and storage of multidose vials on the top of medication carts in the intensive care units (ICUs), she says.

Devastated by the loss of life, the VAAAHS staff were eager to develop a quality improvement process that would address the problem. After some preliminary discussions with staff members involved with the root-cause analysis, **Daniel B. Hinshaw**, MD, VAAAHS chief of staff, suggested a safety checklist process that could improve the storage of medication and also proactively examine multiple safety elements in the ICUs. Hinshaw is now professor of surgery at the University of Michigan Medical School in Ann Arbor and a staff surgeon at VAAAHS.

The idea was that nurses in the ICUs could monitor compliance with safety standards established in the process improvement project, establishing a culture of safety that extends directly to the patient's bedside, Hinshaw says.

To get the project going, both Hinshaw and Piotrowski met with key staff members, including unit-level nurse managers, ICU nurses, and management. The initial meetings focused on explaining the goals of the project and gaining the support of these key staff.

Hinshaw explained to the participants that he envisioned a safety checklist that could be used similar to the way a hotel manager might conduct a "white glove" inspection. "We wanted a system where people could step back from their daily concerns and look at the bigger picture, to try to spot things that they might block out during their work routine," he says.

Input from ICU nurses would be crucial

Actually writing the safety standards proved to be difficult, Piotrowski says. The team knew from the start that the standards needed to be brief and easily understood. Consistent application of the standards was a key goal. And because of the direct relation to patient safety, the team members felt that they must implement the improvements quickly. For that reason, they decided to forgo the typical period of baseline data collection and move straight to developing a draft of the safety checklist.

"We realized that this project was not a research study," Piotrowski says. "It was a quality management tool for enhancing safety, and we didn't have the time to collect data in a leisurely way."

Everyone involved with the project agreed that the new safety standard must have input from the ICU nurses who use it. But how should they involve the nurses? Trying to work around their 24-hour schedules was too difficult and would take too long, even if the team wanted only a couple of ICU nurses to participate. So Piotrowski decided on another tactic. She camped out in an

Five questions assess quality improvement in ICU safety

The quality improvement project at the Veterans Affairs Ann Arbor (MI) Healthcare System (VAAAHS) was prompted by a serious medical error, but the process improvement team realized that the occurrence of sentinel events was not a good way to measure success. Instead, they came up with five questions that they ask regularly to determine how well the project is working.

Marcia Piotrowski, RN, MS, clinical risk manager in the office of the chief of staff, says the answers to these questions are combined with hard data about compliance with the specific safety standards on the checklist designed by the team. These are the five questions:

1. Have there been recurrences of the same type of medication error involving nonsecure medications on carts, which led to the original sentinel event?
2. Have there been similar medication errors?
3. Have patient deaths or cases of permanent morbidity linked to safety deficits occurred since the inception of the program?
4. Have staff been able to transfer their learning and experience about a specific problem to the general concept of creating a safe environment instead of solely focusing on discrete safety elements?
5. Do staff attitudes regarding the occurrence of errors differ as compared with before the program's inception? ■

ICU break room for several hours one day, chatting with nurses as they stopped by on a coffee break. Over a few hours, she was able to gain useful input from several nurses.

Two days later, the process improvement team was ready with the first draft of the safety checklist. Covering a wide array of quality measures, from control of medication carts to use of restraints, the new safety checklist was intended to address more than just the medication error that led to the sentinel event. The checklist was arranged by topic, outlining a number of standards to be met, such as "medication carts locked" and "IV pump labeled with infusion name." Two ICU nurses used the checklist for a couple of days, keeping track of how well the standards on the checklist were met.

That information was used to revise the checklist, and then it was tested on the units again. Six versions of the form were created over the next five weeks. One of the key improvements, prompted by nurse feedback, was to include respiratory therapists and unit maintenance personnel in the safety checklist.

Realizing that the safety checklist would not be useful without compliance monitoring, the team established a system in which ICU nurses periodically check for compliance with all the standards on the list. The nurses initially examined 26 safety points, divided into three separate daily data collection forms.[1] They would check off compliance with each standard for each patient room. Checking for compliance was divided among three nurses each day, checking each other's patient rooms for compliance. Each one had to spend about 10 minutes checking and filling out the forms. That proved difficult on busy days, but the nurses almost always filled out the forms, Piotrowski says.

Most of the standards had a 90% compliance rate over the first year, she says. At that point, the nurses suggested revising the safety checklist to concentrate on fewer elements and reduce the time burden.

Four items were selected for daily measurement: intravenous pumps labeled with infusion name and solution in IV bag; bioclusive dressings

Patience, flexibility are keys to quality program's success

The safety improvement process at the Veterans Affairs Ann Arbor (MI) Healthcare System (VAAAHS) depended on a great deal of flexibility and input from the staff who would implement the solutions. These are some lessons learned in the experience:

- **You can get off to a fast start, but be very patient from then on**.

The quality improvement team wanted to address the safety concerns quickly, but actually implementing the safety checklists took some time, explains **Daniel B. Hinshaw,** MD, professor of surgery at the University of Michigan Medical School in Ann Arbor and a staff surgeon at VAAAHS. Trying to bulldoze a new system into a unit can backfire. You can lose all of your buy-in from staff if they think you are trying to impose a new system from outside.

- **Empower everyone to suggest changes and take action.**

Overcoming the hierarchy of a health care system can be difficult, Hinshaw says, but it is vitally important if you are to improve safety. Anyone in the unit must be comfortable with speaking out about a condition that could threaten a patient.

- **Provide feedback and results.**

Once people are on board with the project, they will want to know how well they are doing. **Marcia Piotrowski,** RN, MS, clinical risk manager in the office of the chief of staff, says she quickly heard from irate intensive care unit (ICU) staff when she was slow in posting compliance data for the safety checklist.

- **Don't rush the project into another unit too soon.**

Hinshaw and Piotrowski are eager to implement the safety project in other areas of the VAAAHS, but they found out the hard way that you can't rush the process. Soon after starting the project in the ICU and seeing some initial results, they tried to introduce it to another clinical unit.

"We thought we had laid the groundwork with the leadership in that department, but some unofficial leaders in the department complained to their superiors that it would take too much work," Piotrowski says. "Because of that, the administration had us back off and we haven't gotten back to that unit since."

- **Don't wait for every staff member to sign on.**

Once you have the support of the leaders in the department, go ahead and approach the rest of the unit. Don't wait for every single person to agree it's a great idea, Hinshaw says. You'll never get 100% support from the beginning, and waiting too long will just give naysayers time to complain.

"You need to listen well and promote the idea that this will be *their* project," he says. "That's what will determine whether you'll succeed, and that's why it will never be the same project from one unit to another." ■

dated and timed on arterial, central, and peripheral IV insertion sites, and each dressing changed within the past 72 hours; gauze dressings, dated and timed on arterial, central, and peripheral IV insertion sites, and each dressing changed within the past 24 hours; and an identification band on each patient's wrist.

Those items would be checked daily for every patient, but another five points were labeled "intermittent" and checked only if they applied to a particular patient. They dealt with isolation and restraint protocols. The rest of the items on the original checklist were divided into four groups, and the ICU nurses checked a different group each quarter. This change significantly reduced the daily time burden on the nurses, Piotrowski says.

Program streamlined after two years

After about two years of success with the program, the system was refined further. Instead of daily forms, the nurses now use a weekly data collection tool posted in each patient room. At each shift change, twice daily, the incoming and outgoing nurses jointly document compliance with each standard.

This change has improved quality of care by reducing the chance of "confirmation bias" in which one nurse "sees what she expects to see," Piotrowski says. With two nurses checking at the same time, at least one is likely to spot any deviation from the standard. The procedure also reduces the time burden on the nurses because they can incorporate the checklist into their change of shift reports.

In addition to the standards that are to be checked for all patients, the intermittent standards are rotated onto the weekly checklists periodically to keep the nurses' attention and to facilitate data collection.

Data management proved to be a challenge in the project, mostly because the team wanted it done quickly so patient safety could be improved without waiting for analysis. VAAAHS hired students from a nearby university to set up spreadsheets and transfer data from the forms. The results were compiled into bar charts that are posted in the ICUs to show compliance rates.

While the rapid evolution of the safety checklist kept it useful and encouraged nurses to use it, the many changes made data analysis difficult, Piotrowski says. The best measure of the program's effectiveness can be found in patient safety outcomes, she says.

Piotrowski and Hinshaw decided that the project's success could best be measured through a series of questions addressing safety concerns. **(See box, p. 92.)**

Since the program was begun in 1999, no adverse events have been traced to improper storage of medications on top of carts, but there have been two near-misses that led to improvements in procedure. The biggest improvement, Piotrowski says, is the way nurses and other staff now are actively involved in improving processes and ensuring patient safety. Even when compliance with a particular safety standard falters, posting the rates in the ICU results in more attention from nurses, she says.

"Major adverse events with morbidity happen so seldom that it's not a good benchmark of whether you're successful," she says.

"That's not to say that errors don't happen in the ICU and we couldn't have another sentinel event, but their investment in looking at their environment makes us think that the likelihood is less on those ICU units than in other places in the institution," Piotrowski says.

Program may be expanded to other areas

The success of the program has prompted Hinshaw and Piotrowski to look at expanding the quality improvement project to other departments. **(For some lessons learned in the first phase of the project, see article, p. 93.)**

Likely candidates include inpatient psychiatry and the emergency department. Both are good candidates, Hinshaw says, because the clinicians use a team approach and are with patients for long periods. Physicians do not participate much in the ICU safety project because they tend to come and go quickly, unlike the nurses and other staff who are on the unit for long stretches.

"Besides, working with physicians is like herding cats," he says. "We thought it would be too ambitious to include them in the initial implementation of the project. We're hoping to see more physician involvement when we take the idea to other areas."

Physician involvement may bring up other problems, however. The safety checklists are completed by peers in the ICU, and Hinshaw suspects "it will create war" in the emergency department if physicians use the checklists to critique a nurse's work.

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Discharge Planning Advisor®

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DP, CM skills may stem bed-capacity problems

Crowded EDs said to be draining resources

The nation's beleaguered emergency departments (ED) may be just the most visible evidence of a complicated web of problems that is pushing to the limit hospitals' ability to meet the demands of patient care and presenting new challenges for discharge planners and case managers.

Solutions to those problems may be found in a stronger discharge planning and case management presence in the ED and a more proactive approach to community-based case management, leaders in the field tell *Discharge Planning Advisor*.

Bed capacity is "higher than anybody anticipated," observes **Jackie Birmingham**, RN, MS, a longtime case manager who is now managing director of professional services for Curaspan Inc. Because there is no room for patients, they must remain in the ED longer, she adds.

> *"The ED physician just doesn't know how to deal with the psychosocial and chronic illness care dimensions. If patients seem to lack resources and it doesn't appear safe for them to go home, they end up getting admitted and it has an impact on bed capacity."*

ED diversions — where ambulances are redirected from one hospital to another — are now a year-round problem rather than a product of winter flu season, according to a report by the Washington, DC-based Center for Studying Health System Change (CSHSC). These ED overflows, the report notes, are one symptom of the high-capacity rates in acute-care hospitals.

Contributing to this ED convergence are several factors, Birmingham adds. "Medicare is decreasing payments to physicians, who, as a result, are refusing to take new Medicare patients. Patients who cannot get appointments with primary care physicians, in turn, are increasingly going to the ED for primary care, she says.

HMO disenrollments result in increased ED use

At the same time, elderly patients are disenrolling from managed care plans, or those plans are loosening their control over health care usage patterns, she notes. As a result of these less-restrictive HMO management practices — a response to the consumer backlash against managed care — ED use is increasing, according to the CSHSC report.

Hospitals, meanwhile, have reduced inpatient capacity over the past several years in anticipation of lower utilization under managed care and declining reimbursement from private payers and Medicare, Birmingham adds. Contributing to the problem, she points out, is the nation's nursing shortage.

What should hospitals do to calm this ED tempest? "The advice is to put more resources into the ED and see what it can do for bed-capacity issues and denials for appropriateness of care," Birmingham suggests. When it comes to discharge planning, in many cases, the players are in the nursing units when they should be in the ED, she says.

With the ED emerging as the center of a "very complex wheel" of patient care events, the question for discharge planners becomes, "Why aren't you covering the ED 24/7?" Birmingham asks. "Any on-site liaison from an insurance company should sit in the ED, stop by the ED."

Post-acute affected

Actions taken, or not taken, in the ED affect not only the inpatient side of care but the post-acute side, she says.

"I did some consulting at one hospital where there was a bad problem with inappropriate admissions," Birmingham says. After looking at a week's worth of admissions to observation status, she noticed that most of those admissions happened at 11 p.m.

The bed manager worked until 10 p.m., and the ED physicians — employees of a private company, as is often the case — wanted to clear out the ED for the next shift, she explains. "The ED physicians would admit the patients under observation status, since they don't have to meet the criteria for true inpatient admission."

The hospital's discharge planners — as they tried to place these patients in nursing homes or rehabilitation facilities — would find that because they hadn't met the payer requirement of three inpatient days, the patients were financially responsible for their care at the post-acute institutions, she notes.

"I was at one hospital where the discharge planners weren't aware that 'three days' meant three *inpatient* days." Hospitals need to have nurses who do case management and discharge planning in the ED, Birmingham advises, if not 24 hours a day, "certainly 12."

Start planning in the ED

Although a great percentage of admissions come through the ED, the focus should not just be on bed placement, she says, but on "how not to admit the patient in the first place."

If patients are admitted to observation status, there should be extremely tight follow-up on their status, Birmingham says.

"They shouldn't be put into a general population of discharge planning patients." It's not enough anymore to begin looking at discharge planning on the day of admission, she says.

"You need to start it before, particularly in an ED situation. "A Medicare patient who comes in for primary care may look like he can't make it at home, but he can't meet the criteria for admission. You need to refer him from the ED to home care."

It's an access issue

When looking at the reasons why patients end up in the ED, it's important to ask the question, "What is their access to health care in general?" suggests **Lynne S. Nemeth**, RN, MS, director for outcomes management, research, and development at the Medical University of South Carolina in Charleston. "Do they have resources? Do they have established relationships with primary care physicians? Are they being served effectively?"

What Nemeth terms "frequent flyers" — those who regularly come to the ED for treatment — tend to be people with chronic conditions, most often a "cluster" of chronic conditions, she says.

"These are patients with, for example, diabetes with heart disease, high blood pressure, and maybe renal disease. They have multiple comorbidities and are frequently seen in the ED for medical care not being provided through traditional channels," Nemeth explains.

These are people who need community-based case management but don't get it because the payer system "is not truly converted to support case management in the community," she says.

"For example, in case management in home care or for insurance companies, everybody is protecting resources or limiting access to health care," she points out. "On the other hand, if you take a look at the needs of these patients, they are on complex medications that they may not be able to afford, and they may be scrimping in certain places — taking one pill every other day, for example. As a result, their medical care is often fragmented."

The patients may or may not be homebound, Nemeth notes, but in either case, they tend to be lacking in home care or other community-based resources. "That becomes a part of the component of why they end up in the ED in the first place."

She says the first step in providing a solution is to proactively identify these patients who are "falling through the cracks," who for whatever reasons are not hooked up with community resources.

Although she agrees that case management in the ED is necessary, Nemeth says there may be more proactive remedies. "I supervise a group

of case managers who are overseeing hospital patients. If they get involved with all the callbacks they need to make, there is not enough time to take care of those patients who are here today. Even an ED case manager would have that problem."

Looking at a coordinated-care model

What Nemeth suggests is a "coordinated-care model." The Centers for Medicare & Medicaid Services (CMS), she notes, is considering a coordinated care benefit. "CMS has put out an RFP [request for proposal] for a research project and is looking at the idea of making a recommendation for a coordinated-care benefit at the national level."

Eligibility for the benefit would be based upon having five chronic conditions, Nemeth explains, quoting from a report developed at the conference, "to be determined taking into consideration multiple providers, high costs, and high use of services, or a combination of clinically complex chronic conditions amenable to coordinated care, or two or more chronic conditions and functional impairments, which limit the ability of the individual to manage those chronic conditions."

The idea of a coordinated-care benefit, developed by CMS in March at a national conference, indicates that "it is being recognized that chronically ill patients use services more," Nemeth says. "My premise is that's what happening in the ED, where the case manager might get caught up in episodic Band-Aid work, taking care of a system that's broken."

While the focus is on setting up a visit with the primary care physician and putting in an order for medications and home care, she adds, these patients need much more.

"They have chronic conditions that limit functional ability, and that hasn't been recognized and supported well enough through the Medicare program."

"[Medicare] needs to put in that coordinated care benefit so we can decompress the ED as being the hub of care," Nemeth notes. Until that happens, she says, there will continue to be frequent denials for appropriateness of care.

"The ED physician just doesn't know how to deal with the psychosocial and chronic illness care dimensions," she says.

"If patients seem to lack resources and it doesn't appear safe for them to go home, they end up getting admitted and it has an impact on bed capacity," Nemeth adds.

For discharge planners and case managers who must deal with the effects of ED overcrowding, Nemeth says, her suggestion is to "analyze your pattern of readmissions to evaluate who is being seen frequently. That gives you an idea of who to focus on."

At her facility, she adds, the reasons for readmission are coded so that case managers can understand the patterns. "The purpose of analysis is to identify the social and system issues that are amenable to being dealt with."

Medical issues are legitimate reasons for ED visits, Nemeth notes, so the question regarding each admission is, "Is it appropriate or because of unmet social or external system needs?"

Once the needs are identified, she suggests, hospitals should develop case management resources to meet them, whether it be follow-up telephone calls or working with primary care physicians to design disease management clinics.

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For more information on the CMS idea for a coordinated care benefit, go to www.medicareadvocacy.org/CoordinatedCare.htm.

To read the Center for Studying Health System Change Issue Brief No. 38 on ED diversions, go to www.hschange.com/CONTENT/312/.] ■

Health care seeks causes for discharge delays

Lack of resources, communication cited

What is the No. 1 reason for patient discharge delays? *Discharge Planning Advisor* posed that question to several leaders in the fields of discharge planning and case management. Their responses are below.

Kathleen Moreo, RN, Cm, CCM, CDMS, CEAC, co-owner of PRIME Inc. in Miramar, FL:

"I think the No. 1 barrier continues to be written / verbal communication. Discharge can't occur because the doctor's order isn't in the chart . . .

the written permission is not obtained . . . if the patient is going from one facility to another, the approval from the receiving physician hasn't been received . . . or the approval from the payer hasn't been received.

"From my training and consulting experience, this seems to occur more often than the fact that community resources don't exist.

"Communication remains one of the most powerful tools — or barriers — to effective health care delivery. Delivery systems spend exorbitant time and funds on developing clinical guidelines and algorithms and revamping information systems while the fundamentals are often ignored.

"There is no doubt that one of the best tools in the discharge planner's or case manager's toolbox is skilled communication, coupled with effective relationships."

Psychosocial concerns cause major delays

Sandra Lowery, RN, CRRN, CCM, president of CCMI Associates in Francestown, NH, and immediate past president of the Case Management Society of America in Little Rock, AR:

"In my experience, psychosocial concerns are the No. 1 reason for serious delays. Under that category would be financing issues, decisions related to the environment they would be discharged to, and decisions related to the support services they would need, whether informal or formal. All of these pertain to the psychosocial needs of the individual more than the medical, although certainly both are affected."

Tina Davis, RN, MS, CMAC, senior director, continuum of care, Arnot Ogden Medical Center in Elmira, NY:

"The difficulty comes when there is an identified need and no resources to provide for it. It depends on the community you're in and what services are available in the post-acute continuum. In our county, we have a shortage of nursing home beds so the wait for transfer to a nursing home can be quite long. We also struggle with the Medicare prospective payment system because it becomes difficult to provide home care for those who need it when Medicare won't cover, and these people very often don't have the resources to pay for it on their own."

Maria Hill, RN, MS, CMAC, senior consultant with the Center for Case Management in South Natick, MA.

"[The No. 1 reason] is lack of bed availability for Medicare/Medicaid-funded clients in a care facility in the patient's community of residence."

Jackie Birmingham, RN, MS, managing director, professional services, for Curaspan Inc., in Needham, MA:

"Here are my top four reasons for delay in discharge from a continuum perspective:

- lack of knowledge of bed availability in the post-acute setting;
- locating the appropriate facility for the patient in relation to payer, and geography;
- communication between hospital and post-acute intake;
- transfer of medical information that can be used for post-acute care."

Marne Bonomo, PhD, regional director for patient access, Aurora Health Care in Milwaukee:

"One of our bigger discharge issues is getting a ride home. We are currently evaluating transportation options, 'meals to home,' and 'medication to home' to help expedite emptying rooms sooner whenever the patient's condition permits.

"On our new bed management eBoard, one of the indicators is 'patients with discharge orders,' so that social services and utilization [management] can easily see where they need to direct their resources. Also, in addition to length-of-stay teams for each individual hospital, we have oversight length-of-stay teams for our regions. Reduction in length of stay is one of our key strategic goals."

Lisa Zerull, RN, MS, program director, Valley Health System in Winchester, VA:

"The first thing to consider is the environment, whether it's metropolitan or rural. With [our hospital] being rural, patients can live up to 200 miles away, so transportation is a big reason for discharge delays. We can discharge the patient at 9 a.m., but if the family can't get here until 4 p.m., that person remains in our system. Another reason is physicians waiting until later in the day to discharge patients.

Physicians need incentives to discharge

"We work in an environment where managed care has not penetrated the market, so there is no incentive for physicians to get patients out faster. Something that has greatly impacted our length of stay is that we now have a hospitalist on board, so we don't have to wait for a busy family practitioner to make rounds [to discharge patients]. The trend is for family practice offices that are very busy to contract with a hospitalist to care for patients when they are hospitalized." ■

(Continued from page 94)

"Those are the kinds [of things] we'll have to consider every time we take it to another department," he says. "It is absolutely critical that the system be owned and accepted by the people who will use it."

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Reference

1. Piotrowski M, Hinshaw D. The Safety Checklist Program: Creating a Culture of Safety in Intensive Care Units. *Journal on Quality Improvement* 2002; 28:306-315. ■

Paperless records will improve quality

Predicted to be standard of care in 5 years

Paperless records will have a tremendous impact on health care quality and physician efficiency, according to an expert who says they will become the standard of care within five years. Act now to take advantage of the coming revolution, he says.

Jerome Carter, MD, FACP, is director of informatics at the University of Alabama-Birmingham and an expert on the topic of electronic records. He tells *Hospital Peer Review* that, after years of talk, the move to paperless records is picking up steam. The next five years will see a rapid adoption of the technology, he predicts, and that's good news for health care quality.

The recent emphasis on reducing medical errors and the Institute of Medicine's report *To Err is Human* all point to the need for improvement over the traditional paper record system, Carter says.

Electronic records greatly improve the clinical staff's ability to provide better care and avoid systemic errors, he says. Many of the benefits come from the electronic record's greater capabilities for spotting trends and clinical interventions that have not been utilized.

"Along with improved screening and monitoring of known useful preventive interventions, avoidance of medication-related errors is likely to be the next area of health care to see a significant impact," he says. "All electronic medical records [EMR] systems provide features that support drug interaction checking, prescription writing, and drug-related patient education. As greater numbers of clinicians gain access to these features, it is very likely that patients will benefit in a very obvious and direct manner."

The Leapfrog Group, a Washington, DC-based consortium of health care buyers who have banded together to leverage improvements in health care safety, is promoting the adoption of electronic records because of their potential for improving quality. The Health Insurance Portability and Accountability Act (HIPAA) also emphasizes the need for a paperless record.

"Given the rise of HIPAA, the recent emphasis on medical errors and patient safety, and the acknowledgment that EMRs provide the most means for addressing these issues, I expect that electronic medical records will be the standard of care within four to five years," Carter says.

"All of these things are forcing physicians and quality professionals to look at the way they do these everyday processes of care. The only way to improve these processes in a reasonable amount of time is a paperless record," he adds.

Discussions of electronic records often focus on the patient-encounter note, but Carter says that is the least promising aspect of paperless record systems. The encounter note usually is used only by the physician who wrote it, but a good electronic records system can make information available to both that physician and the rest of the staff that they otherwise might not have.

"The preventive medicine capabilities can tell the system to spot all women over 50 who need a mammogram, or it can do a drug recall by finding all the patients taking that drug. You can set up the system to prompt interventions based on certain inputs," he says.

"The system can provide information that significantly adds to the quality of care, rather than just being a different way to store data. It's going to be difficult in five years to say why you're not doing that when you know the capabilities," Carter explains.

One paperless communication system is being

tested by the Patient Safety Institute (PSI), a nonprofit, voluntary, collaborative initiative in Washington, DC, formed to establish a technology-based patient safety and health care information solution. PSI has selected hospital sites based on their community leadership and patient-centric focus to demonstrate a communications network the group devised to improve patient care.

The PSI system, which will provide real-time, secure, patient-centric clinical information access to participating physicians, was installed recently at Deaconess Medical Center and Valley Hospital and Medial Center in Spokane, WA; and Swedish First Hill, Swedish Providence, and Swedish Ballard, in Seattle. **Jack Lewin**, MD, CEO of the California Medical Association and chair of PSI's board of directors, says the system is intended to improve patient safety by providing clinicians with more and better information.

"Both hospital systems selected are ahead of the learning curve in terms of patient-centric technology," he says.

"The PSI demonstration program has received outstanding support from both hospital systems. Their in-depth expertise and input will help ensure the PSI network is optimally structured to achieve our goal of improved health care safety and quality nationwide," Lewin adds.

Suzanne Delbanco, executive director of The Leapfrog Group, endorses the idea of preventing errors through better use of electronic records.

Emphasizing quality improvement rewards

"Preventing medical mistakes involves improved communications between patients, physicians, providers, and purchasers," Delbanco says. "PSI's breakthrough real-time clinical information service, coupled with the computerized physician order-entry systems Leapfrog promotes, will further reduce the risk of errors."

Peer review professionals can spearhead the adoption of electronic records in a health care organization by showing the effects on quality improvement. The biggest impediment to rapid adoption of the electronic record is the lack of reliable information on different electronic systems, Carter says.

There still is not a reliable source of information for comparing products from different vendors, so Carter cautions that you have to take a chance now when you buy a paperless records system.

"The cost of the actual software is not that great, and the cost of the hardware is not an issue whatsoever. Even hand-held units are extremely affordable," he says. "It's also very hard to find a good consultant to make these decisions for you, because most of them are resellers associated with vendors. The infrastructure for making this change is not there yet."

Other than pushing for the adoption of an electronic records system, Carter says quality improvement professionals should use their expertise to help select a paperless record system that will be most useful in improving quality of care. That means focusing on features like referral management, prescription management, monitoring of lab results, and preventive medicine systems.

"Going paperless is not the issue," Carter says. "That's just the way you're doing it. Getting more information about your patients and managing their care better is your goal."

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VA hospitals score high in JCAHO quality measures

In one of the health care industry's top measurements of quality, the hospitals of the Department of Veterans Affairs (VA) scored slightly higher than their non-VA counterparts.

The scores were based on triennial surveys of VA health care facilities by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). VA's mean score was 93, nearly two points higher than the average for non-VA hospitals nationwide.

Secretary of Veterans Affairs **Anthony J. Principi** announced the scores recently. Each of the 58 VA hospitals surveyed in 2001 received a full three-year accreditation.

All of VA's hospitals are fully accredited by JCAHO. VA's Consolidated Mail Outpatient Pharmacies (CMOP), which dispense more than 65 million prescriptions a year to VA facilities and veterans, were accredited by JCAHO for the first time in 1999 and are scheduled for resurvey in 2002. Six of the seven CMOPs achieved Accreditation with Commendation. VA was the first mail prescription service to be accredited by the Joint Commission. ■

AHA chief criticizes National Quality Form plan

"Public accountability" should not be the primary goal of any data collection program aimed at quality improvement in health care, says **Rick Pollack**, executive vice president of the American Hospital Association (AHA). A plan proposed by the National Quality Forum (NQF) is off-base for that reason, he says.

Pollack recently wrote Kenneth W. Kizer, MD, MPH, president and chief executive officer of the NQF with his concerns and made the letter public. Pollack's comments represent the AHA's official response to the National Quality Forum's report, *An Initial Measure Set for Hospital Performance Evaluation*.

The AHA strongly supports the project's aim to create a core set of quality measures for hospitals that will be used to assess and improve care, Pollack says.

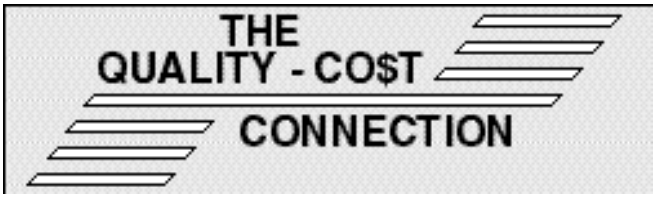
"We firmly believe that a core set of measures should be used to provide valuable information for benchmarking and that a core measurement set should reduce the redundant and resource-consuming requests for data hospitals are currently subject to from external organizations, including government, accreditors, managed care plans, and employers," he says.

But Pollack goes on to say that "we strongly believe that quality data should first and foremost be used to promote learning and improvement. We disagree with the NQF's assertion that the primary purpose should be for 'public accountability.' Further, while ideally a core set of measures should help ease the burden associated with data collection, the report gives scanty attention to this important issue. The report should be more specific about the need to reduce this burden and the discordant messages sent to hospitals and other providers when different measurement sets are used."

Pollack also cautions that it will also be critical for the NQF to utilize its consensus process to secure an understanding and commitment among private and public entities about what and how much "core data" are important to collect.

"Part of the NQF's mission was to reduce the hodgepodge of information and resources expended in meeting the demands of disparate measurement efforts. Creating a core set of measures is only half the battle; now we must agree on an over-arching measurement strategy and framework," he explains.

The NQF did not immediately issue a response to the AHA's letter but indicated that all comments will be considered when finalizing the plan. ■



How quality managers can stop information overload

Screen out nonessential information

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

It seems that the biggest problem facing health care quality professionals is not that there is too little progress, but rather too much of it. A typical quality manager in the late 1970s probably felt overwhelmed just processing the latest Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and newest requirements from Medicare.

Today's manager must address not only these issues, but also must deal with a full set of additional information arriving from professional associations, consumer-advocacy groups, business coalitions, patient safety organizations, and other

state and national groups involved in health care quality initiatives.

It is difficult to cope with the rate of change and growing demands. Quality managers must contend with a large volume of seemingly high priority requirements.

Information technology tools such as the networked desktop workstation, e-mail, and the Internet combined with telephonic means such as the fax, wireless phone, and pager all compete for the quality manager's attention.

These tools are attaining a greater presence throughout the workplace, increasing not only the amount of information, but also the number of potential correspondents.

It is clear that quality managers face a huge challenge in assimilating all the information coming from various sources. Sorting through, interpreting and distributing the most valuable information to appropriate individuals and groups are never-ending struggles.

It is quite likely that the amount of information will continue to overtake the quality manager's ability to process it. It may be unrealistic to expect that you'll ever catch up. Advances in information technology will continue to make information more accessible. That's why it is important for quality managers to develop efficient habits and techniques for managing all of this information.

Strive for an immediate response

A primary cause of information overload is the lack of a system for handling data as it comes into your office. It is easy to get backlogged if you don't have a routine method for responding to new information. It's not the volume of information that's the problem; it's our failure to make decisions about what to do with it. Plus, in the back of our minds, there is always a fear that we'll throw something out and need it later.

This fear paralyzes our ability to effectively manage information. To become more productive, next time you receive information from any source, ask yourself these four questions:

- Do I need to keep it?
- Where do I keep it?
- How long do I keep it?
- How can I find it again?

Try to screen out the nonessential information. Focus on keeping information that helps you or your organization deal with high priority quality issues.

Be ruthless about what you allow yourself to keep. Deal with the information that's left by determining what each item refers or relates to. This will tell you what file it should go in. To keep the information from getting lost in your files, place a reminder note on your "to do" list, your "projects" list, or on your calendar.

Learn to put paper where it belongs the first time you touch it. Never read something without making a decision or taking action.

If it's an e-mail that needs responding to, take the time to do it immediately or place the e-mail in a "pending action" folder in your e-mail system. Tear out interesting articles and toss the remainder of the publication.

Once you've finished reading, decide where

Paper-Based Log for Tracking Quality-Related Information Referrals and Actions

Document	Date Issued	Source	Date Rec'd by Quality Department	Reviewing Individuals and/or Groups (Record each one on a separate line.)	Date Reviewed	Decisions and Actions Taken (Entry required for each individual and/or group that reviewed document.)

the information goes next. Set aside time in your schedule to read or respond to information (twice a week for 30 minutes, if you can).

Track knowledge-based information

Some of the information that comes across the quality manager's desk must be shared with other individuals or groups in the organization. Keeping track of these referrals and actions taken can be time-consuming.

With the focus on patient safety, it is important to develop a system to document dissemination of safety related information, including JCAHO sentinel event alerts. Include in your documentation the recipient of the information, the individuals / groups that reviewed the information and all decisions or actions that were taken in response to the information.

The log shown on p. 102 is an example of a paper-based tool for managing the dissemination of quality-related information.

The title of the document is entered in column one. The date issued or published and the source (e.g., JCAHO, American Hospital Association, Institute for Safe Medication Practices, American Medical Association, etc.) are documented in the next two columns. The remaining columns are used to record the names of each individual or group to whom the information is sent, date the information was reviewed, and what decisions or actions were taken as a result of the information. In some instances, the information may not be found to be relevant to your organization, and no further action is necessary.

In other instances, the information may be used for improvement purposes, e.g. initiate a process improvement project or conduct a failure mode and effects analysis on a high-risk process. Any and all actions should be documented. Use a paper tracking system such as the paper-based tracking log or design an electronic tracking system with spreadsheet or database software.

Be sure you've got a workable strategy for documenting the dissemination and use of patient safety information as well as other quality-related information. At the time of a JCAHO survey, your organization will need to confirm that knowledge-based information is being used to design new processes or modify existing processes.

The quality department receives a lot of information that is important to the success of the organization. In whatever form the information arrives, the department must have a systematic way of processing it and tracking responses. Do you have scores of e-mail messages to read, piles of mail and papers to sort, a six-month-old stack of journals that you haven't even opened? If so, you are probably suffering from information overload.

It's time to develop methods for responding to what is most important and discarding information that won't be needed within the next three months or so. Backlogs are caused not by the volume of information but by not knowing what to do with everything when it is received.

Quality managers must have effective systems for managing this overload as the information age matures. ■

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CE questions

The CE testing procedures have been changed. For more information, see box on cover.

1. The revised intent section of Joint Commission standard RI.1.2.2 states: "The responsible licensed independent practitioner or his or her designee clearly explains the outcomes of any treatment or procedure to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes."
   A. true
   B. false

2. A sentinel event at Veterans Affairs Ann Arbor Healthcare System in Michigan led to a quality improvement process involving a safety checklist in what hospital department?
   A. emergency department
   B. intensive care unit
   C. case management department
   D. cardiology department

3. Which of the following lessons were learned during the safety improvement process at the VA Ann Arbor Healthcare System in Michigan?
   A. Empower everyone to suggest changes and take action.
   B. Don't rush the project into another unit too soon.
   C. Provide feedback and results.
   D. all of the above

4. For Joint Commission surveys conducted in 2001, what was the mean score for Department of Veterans Affairs hospitals?
   A. 89
   B. 91
   C. 93
   D. 95

Answers: 1. B; 2. B; 3. D; 4. C

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.

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