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On the march toward value-based purchasing: How far does OPPS go?

Does final OPPS rule measure quality or utilization?

On Oct. 30, 2008, the Centers for Medicare & Medicaid Services (CMS) issued the final 2009 rule for the Hospital Outpatient Prospective Payment System (OPPS). For the first time, beginning in calendar year 2009, hospitals that did not meet the outpatient quality reporting requirements or that elected not to report quality indicators in calendar year 2008 will see a payment reduction.

Jugna Shah, president of Nimitt Consulting in Washington, DC, says, this is the "first time hospitals will face a payment implication in the outpatient setting as CMS kicks off its hospital outpatient quality program, an indicator of the move toward value-based purchasing [VBP] in the outpatient setting."

But how far does the rule go toward VBP? Though CMS sought comments on 18 additional quality measures, only four new measures on imaging services were added to the seven measures adopted in 2008. **(See box, page 155, for the 11 quality measures for 2009.)** In general, Shah says the 2009 OPPS final rule reflects most of what CMS proposed, despite commenters' concerns. "For example, providers will see new composite APCs [ambulatory payment classifications] in the area of multiple imaging services and further reductions in drug reimbursement, despite industry concerns."

Four new quality measures

What's interesting, Shah points out, is that the four new quality measures being adopted for 2009 will not require hospitals to do anything extra from an administrative or data collection perspective, unlike the initial seven measures implemented in 2008. "All hospitals have to do is basically operate as they always have and submit their claims to CMS. Hospitals will not have to expend any additional resources to abstract the new indicators from their data to report on the new measures. Medicare will do it on its end by using the claims data."

Just what Medicare will do with these data is still unclear, Shah says. While CMS stands behind the new measures on imaging, contending that they speak directly to patient safety, Shah and many commenters, question

whether the new indicators really get at measuring quality or whether they are simply focused on utilization patterns. She points to the measure on mammography follow-up rates. "In the final rule, Medicare says it's not measuring how or when follow up occurs but the degree to which the facility must repeat the mammography imaging. So that sounds like CMS is interested in counting frequency... and that's a volume or utilization issue," she says — a sentiment many commenters echoed.

And while CMS says the imaging measures address unnecessary exposure of patients to contrast and radiation, Shah says, the agency has not set any particular performance scores, and how it will determine payment implications for 2010 reimbursement remains unclear. She notes that many commenters questioned CMS' intent by releasing these new measures. For example, are we going to see CMS tie these new measures to diagnoses? In mining the claims data, what will CMS determine about hospital quality? Answers remain elusive, Shah says.

Composite APCs

Shah says a report by MedPAC a few years ago showed that imaging services "exploded in terms of volume so Medicare may be thinking, providers are 'doing more,' but is the volume increase in imaging services directly related to improved patient outcomes or higher quality of health care?"

In addition to the four imaging measures, CMS adopted four new composite APCs for multiple imaging services provided in the same session for families of services in the area of ultrasounds, CTs, and MRIs. CMS initially proposed payment reductions for these types of services in 2006 but deferred implementation pending further study. In 2009, providers will see CMS' movement forward in reducing separate payments when multiple services are rendered on the same date of service.

"If you provide multiple imaging services today, you will receive multiple APC payments," Shah explains. "In 2009, if you provide two or more services from the same imaging family on the same date of service, you will receive a single new composite APC payment." If a hospital performs two services, she says, their reimbursement might be better than it is today. But, "if three or more services are provided on the same date of service, then providers are likely to lose financially pretty much every time," she adds.

Shah believes the new composite APCs and the new quality measures speak more to CMS wanting to create efficiency incentives for providers to control utilization, rather than directly aiming to measure quality. CMS indicates that its new initiatives are aimed at creating "efficiency incentives" so that only what's neces-

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sary is provided and what's unnecessary is cut. One way CMS is doing this is by reducing the number of items or services it will generate separate payment for. "Some of that is all well and good," she says "though some people might argue that CMS is going too far with some of its policies."

Truly measuring quality, in terms of patient outcomes, etc., is tough to quantify and that is not what CMS is doing right now, says Shah. "What I think CMS is doing is measuring whether hospitals report certain measures, but perhaps this will eventually be linked to true patient quality and outcomes data. Perhaps that's the next step."

Voluntary validation program

With the 2008 rule, Shah says hospitals "pretty much met the reporting requirements if they signed up to be in the program and reported their data." Though validation criteria were expected to be part of the 2009 rule, CMS postponed implementing them in the final version. In the meantime, it will go forward with a voluntary validation program. The agency in 2009 will randomly select 800 hospitals from which to review 50 records.

Though participation by selected hospitals is voluntary, Shah says, "if your hospital is selected, you should consider participating since it would be useful for hospitals to learn something about their data abstraction accuracy before there are any formal repercussions."

The next step: VBP

While CMS proposed adding elements of the inpatient rule's value-based purchasing statutes, including present on admission and hospital-acquired conditions, it did not finalize the implementation of such measures for the outpatient setting for 2009, Shah says. But much discussion was generated from commenters. Characterizing the comments, Shah says many questioned how to create equivalent measures for the outpatient setting, especially considering the differences between the two settings' payment systems. We're just not there yet for the outpatient setting and much still needs to be sorted out, she says, and CMS recognized this.

However, "I think it's just a matter of time before we see CMS move forward with measures that are similar to the inpatient present on admission and hospital-acquired conditions as these are additional elements of VBP that CMS is interested in," she says. "I think it's simply a question of when CMS is able to sort out the current data and payment system issues, but at least providers will not see this for 2009 and probably not even 2010. I think it's going to take them some amount of time to actually get some of that stuff sorted out."

But the transition to a value-based purchasing system is moving "full steam ahead," Shah says. "I would say CMS has certainly started the march down that road," with payment policies that encourage providers to think carefully about what and how many services it is providing.

(Editor's note: The final rule in the Federal Register *is open for comment through Dec. 29.)* ■

11 Quality Measures

- Median time to fibrinolysis
- Fibrinolytic therapy received within 30 minutes
- Median time to transfer to another facility for acute coronary intervention
- Aspirin at arrival
- Median time to ECG
- Timing of antibiotic prophylaxis
- Prophylactic antibiotic selection for surgical patients
- MRI lumbar spine for low back pain
- Mammography follow-up rates
- Abdomen CT — Use of contrast material
- Thorax CT — Use of contrast material

What to expect from a DNV Healthcare survey

Focus on outcomes, document control, CoPs

In preparation for its unannounced survey with DNV Healthcare, Citizens Medical Center personnel readied their survey preparation box. Last minute documents were pulled when surveyors arrived for the unannounced survey — a patient census, the surgery schedule, a list of patients in restraints.

"Kind of the same things you would pull for The Joint Commission," says **Caren Adamson**,

assistant administrator for the Victoria, TX-based hospital.

Then they assembled a team to accompany the surveyors — including Adamson, director of quality **Cherie Brzozowski**, the director of engineering, the assistant administrator for nursing, hospital educators — with whom they shared the survey schedule.

DNV's accreditation program, NIAHO, hinges on Medicare's conditions of participation (CoPs) and the ISO 9001 methodology. The process secures participation in the Medicare/Medicaid program and signals an introduction to working within ISO and optional certification. But prior knowledge of the ISO system is not required to go through the NIAHO process, says **Patrick Horine**, executive vice president of accreditation for DNV.

Horine says when DNV surveyors arrive, they will deliver the schedule outlining the documents for review. "Then we just start laying out the meetings for the survey activity. So first activities would involve things like the quality management review, starting to look at patient units," he says.

Initial interviews would usually include infection control, medical staff, HR, and offsite clinics, with a primary survey team comprising a generalist, someone with an administrative or quality-related background; a clinician, either a nurse or physician; and a physical environment life safety specialist.

Adamson says in many ways the survey was similar to the tracer methodology used by The Joint Commission. With the hospitals' policies in hand, surveyors "looked for evidence that we were practicing what we said we were going to do. They followed that pretty closely," she says.

"They focused on all the standards within the conditions of participation, and they followed that to a tee. They evaluated our compliance with those standards. They visited all of our patient care units. They visited with our staff. They looked at open records; they looked at closed records. They were very thorough," Brzozowski says.

Process, document control

The difference in working with DNV, according to Brzozowski, was the emphasis on processes — how they are followed and how they affect outcomes. She suggests that hospitals going through the NIAHO program "focus on outcomes, looking at the end results of your efforts and how that had an impact on patient safety and quality."

"We don't have patient safety goals," says Horine. "We're very focused on hospitals being innovative, identifying best practices." Prescriptive, cookie-cutter approaches don't allow for the differences between, for instance, a 25-30 bed hospital and a Cleveland Clinic, he says. "You need to be cognizant of that when you're surveying. There can be effective ways of doing things without us prescribing every aspect of it."

A big challenge for Brzozowski and Adamson in preparing for their survey was document management. "With ISO, under this document control, we were challenged to find a process that allows us to present to our employees the most recent form, the most recent policy so they don't get confused in the work we're asking them to do," says Adamson.

Horine says surveyors are finding that hospitals, for instance, might have three different ways of obtaining informed consent or multiple versions of a procedure in place. He recommends hospitals look at how they handle forms and documents. "Documentation completeness seems to be a problem," he says, such as deficiencies in updating care plans or the processes for authenticating orders.

"What we're doing is after the initial survey, we're looking for hospitals to streamline some of that."

Focus on CoPs

In working with DNV, Adamson recommends "focusing on the CoPs where it states a policy is required." Seems simple enough, but Horine says in working with hospitals, DNV has seen that many have "gotten away from knowing the conditions of participation. Although they still remain accountable for those, they look at their one source for accreditation and lose sight of the CoPs. So it's kind of getting hospitals back to the basics.

"The focus right now is on the National Patient Safety Goals, and they lose sight of some of the important aspects of the hospital just so they can focus on those. But I think that hurts in many ways, looking at the overall scheme of things in patient care."

He says CMS recently updated the state

operations manual, which hospitals need to be familiar with. Two areas he says DNV sees hospitals struggling with on CoPs: the time frames and requirements on patient grievances and how to respond to those and updating H&Ps prior to surgical procedures.

(Editor's note: You can download NIAHO requirements at http://www.dnv.com/focus/hospital_accreditation/.) ■

What P4P could mean for safety net hospitals

Are these hospitals in peril?

For the sake of her study, **Rachel Werner**, MD, PhD, assistant professor of medicine at the University of Pennsylvania school of medicine and researcher with the Philadelphia VA Medical Center, defined safety-net hospitals predominately by the rate of Medicaid patients seen by the facility. But she acknowledges that the term encompasses much more — in general, those hospitals that treat primarily uninsured, vulnerable patient populations.

And the thesis of her study, *Comparison of Change in Quality of Care Between Safety-Net and Non-Safety-Net Hospitals*, is how these hospitals would fare in a pay-for-performance environment and the unintended consequences that could result from such a system.

Werner tells *Hospital Peer Review* her concerns for safety-net hospitals with the advent of P4P and value-based purchasing is that these resource-poor facilities won't be able to afford to invest in quality improvement to receive incentives. That, in turn, could further erode their financial standing, adversely affecting their quality.

"Safety-net hospitals sometimes have lower quality at baseline and so for them to improve enough to get an incentive in a rank-based system may be unrealistic," she says.

One area that sets these hospitals at a disadvantage is the disparity between their patients' conditions and those requiring measurement. While safety-net hospitals deal with heart failure and heart attacks, for instance, they also contend with patients presenting "other medical problems that aren't being measured" — mental health, pregnancy, substance abuse.

If you look at CMS' Hospital Compare web site, Werner says, the measures reported on — heart attack, heart failure, and pneumonia — are areas where safety-net hospitals might lag. While one answer might be for these facilities to invest in these specific areas, they risk harming care in other areas — conditions that they treat more frequently.

The three conditions highlighted on Hospital Compare, she adds, are, of course, important ones, but for safety-net hospitals "those represent a smaller portion of that quality," not reflecting true quality across the hospital.

Vice president of the National Rural Health Association **Brock Slabach** agrees that those measures do not accurately capture what's going on inside a safety-net hospital, in which he includes rural and critical access facilities.

"Our rural critical access hospitals do an outstanding job providing high-quality care to their patients, but I do see what has happened in rural hospitals because of the environmental demands from all types of backgrounds. A lot of these small rural hospitals are unable to keep up with the stated demands because a lot of them have one person who is responsible for performance improvement within the facility and that's not usually the only hats they wear," he says.

What he'd like to see is "rural-relevant metrics" — "a common data set for metrics that everyone could agree on for all critical access hospitals... in the same transformative way that Hospital Compare and the Leapfrog Group and all those other data sources have done for urban hospitals."

Slabach says NRHA is assembling a workgroup next year to promote establishment of such measures. The American Hospital Association has expressed interest, he says, and his association is also working on this effort with the American Health Quality Association.

Performance improvement managers in rural hospitals "are extremely valuable," he says, and encourages them to develop good communications with their CEOs. "Using data as a tool for improvement is another thing that can be powerful, especially in a small facility because things travel so fast. Data can be a real antidote."

As far as the future of safety-net hospitals, Werner says it's difficult to predict. She's

concerned the P4P movement will result in an even greater disparity between high-quality and low-quality care and questions whether resource-poor hospitals will make it in the end.

"We need to give safety-net hospitals a tool to improve quality rather than letting them figure it out," she says. ■

Interim guidance leads to first list of approved PSOs

Common formats for reporting established

As final guidance is hammered out on the Patient Safety and Quality Improvement Act of 2005, interim guidance from the Department of Health and Human Services (HHS) on the criteria for becoming a patient safety organization (PSO) has allowed the The Agency for Healthcare Research and Quality (AHRQ) to officially designate PSOs.

As of press time, 15 official PSOs were listed on AHRQ's web site. **(See box, this page, for full list.)**

Listed Patient Safety Organizations

- California Hospital Patient Safety Organization (CHPSO) — Sacramento, CA
- Clarity PSO — Chicago
- ECRI Institute PSO — Plymouth Meeting, PA
- Florida Patient Safety Corp. — Tallahassee, FL
- Health Watch Inc. — Easton, MD
- Human Performance Technology Group — Collierville, TN
- Institute for Safe Medication Practices (ISMP) — Horsham, PA
- Missouri Center for Patient Safety — Jefferson City, MO
- ORQA LLC — Peoria, IL
- Peminic Inc. — Fort Washington, PA
- Quantros Patient Safety Center — Milpitas, CA
- Sprixx — Santa Barbara, CA
- Texas Patient Safety Organization Inc. — Bellaire, TX
- The Patient Safety Group LLC — Boston
- University Healthsystem Consortium — Oak Brook, IL

Thinking about becoming a PSO?

Who can apply to be a PSO?

William B Munier, MD, director for the AHRQ's Center for Quality Improvement and Patient Safety, says, "very simply stated, it's pretty broad."

The guidance allows for-profit, not-for-profit, government, and non-government entities to apply for status as a PSO, but excludes insurance companies or components of insurance companies. The proposed rule, Munier says, added that accrediting bodies also would not be applicable for much of the same reason as insurance companies compromise the culture of safety and open disclosure intended with the PSO legislation.

"There's a couple of things to think about" in deciding whether to apply for PSO status, Munier says. "There is a requirement that the primary mission of the entity be improving patient safety and quality." The main mission of a hospital, he adds, should be treating patients "and that's a little different than providing care so that's one thing to keep in mind."

Another is that an entity interested in applying to be a PSO can establish a unit or component with the primary mission of safety. Such a unit would not have to be separately incorporated, Munier explains.

Among the newly approved PSOs, there is the Plymouth Meeting, PA-based ECRI Institute, "which is really a prototype of a PSO if you will," Munier says; the Horsham, PA-based Institute for Safe Medication Practices, "which has been doing medication safety as its principal function for a long time"; and the Oak Brook, IL-based University Healthsystem Consortium, which "has a very sophisticated paper safety reporting system that it uses and makes available to a bunch of other people."

Common formats issued

As the legislation begins to take tangible form with official PSOs, HHS Secretary Mike Leavitt instructed AHRQ to issue common formats for reporting "so that the information being collected would be interoperable, both electronically and clinically" across PSOs, Munier says.

Called Version 0.1 Beta, the common formats

Continued on page 163

PATIENT SATISFACTION PLANNER™

Public reporting boosts patient satisfaction

Experts say internal changes behind improvement

Press Ganey Associates Inc., the South Bend, IN-based patient satisfaction and quality firm, reports that "patient satisfaction leaped" after the launch of public reporting. The company cites an "unprecedented" jump in hospital patient satisfaction since March 2008, when hospitals began publicly reporting data on patients' experience of care. The company analyzed its proprietary patient satisfaction data for hospitals that in March began reporting data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures.

These improvements were specifically cited in three areas:

- likelihood to recommend "definitely yes";
- coordination of care "very good";
- overall rating of hospital nine or 10.

The analysis included data representing more than 1.5 million patients and 1,158 hospitals from January 2007 through June 2008, and indicated year-to-year comparisons for each month. **(The graphs of these Press Ganey data points are available at http://www.pressganey.com/galleries/default-file/HCAHPS_Graphs.pdf.)**

"Our clients have seen slow and steady improvement over the years, but the comparison of one month this year over the same month last year is statistically significant — and we have not seen that before," notes **Deirdre Mylod**, PhD, vice president of acute services at Press Ganey.

What is the link?

The first question begged by this new data is this: Just what is the link between patient satisfaction and public reporting? "The link is mostly a push for transparency within the organizations," says Mylod. "Consumers don't use most of the public data yet, but even if they are not looking at them and make decisions about them, if hospital leadership and boards see they are being publicly reported, we see tremendous attention to and seriousness with which these [patient satisfaction processes] are taken."

In addition, she says, "What we have found in our clients is that those who have been modeling transparency within the organization and giving nurse managers access to their own data are those that are improving more on the patient satisfaction front."

Traditionally, she notes, hospitals were required to report on patient satisfaction quality measures, which had a lot to do with processes. "But now they also have to report how patients evaluate their care," says Mylod. "So much of being patient centered is the culture; it adds a piece to not just drive the numbers, but also getting people tapped into their mission."

"Researchers have shown there's a linkage between quality improvement and public reporting, so it does not surprise me that the same thing is going on with patient satisfaction rates," adds **Patrice L. Spath,** of Brown Spath Associates in Forest Grove, OR.

"These same researchers who identified the link between increased quality improvement and the reporting of quality outcome data found that when that same data were only reported internally there were still quality management activities that occurred, but not necessarily at the same rate as in those hospitals where they were reported publicly."

Hospitals participating in HCAHPS, she continues, know their data will be publicly reported and, therefore, are making a more concerted effort to raise their patient satisfaction scores. "Those things being publicly reported are those things hospitals focus on," she notes.

Most patients don't know that these data are being shared publicly, she continues, adding that recent studies confirm this. "So, it's not the fact that hospitals say they are being transparent, but there are different levels of transparency," Spath notes. "What increases satisfaction is one-on-one transparency, like disclosing adverse events when they occur. That's more important."

Nevertheless, she says, "Satisfaction is a subset of quality and it is probably a more meaningful measure of quality to consumers than some of the

clinical measures. If consumers are looking at this data, it would seem they would be likely to use those hospitals [that score higher]."

One system's response

Paul Convery, MD, senior vice president and chief medical officer, Baylor Health Care System in Dallas, agrees that most consumers are not yet paying attention to the publicly reported data. He can also testify to how HCAHPS has impacted his system's patient satisfaction efforts.

"Public reporting has a bigger impact internally than externally at this time, and this has been true for a number of years," he notes. "Our internal managers, executives, board members, doctors, and nurses pay more attention to patient satisfaction because we circulate data internally and report them internally. When they know they're being made public they are more concerned about it than the public is."

Right now, says Convery, "the public is not paying a lot of attention to the public web sites, but the knowledge that it was going to be public in March caused us, and a lot of other systems, to begin working on satisfaction and understanding the drivers for the last couple of years. Once we knew the data were going to become public we talked about it internally, and the two years we have been working on it has really made a difference."

What exactly has Baylor learned? "We learned we have to be very focused on specific behaviors that must be done, and that it varies from department to department," says Convery. "So in the ED, for example, it may be greeting people and introducing who you are, telling the patient what you are going to do, and giving people information about how long they are going to wait. You may do regular rounds on inpatients and ED outpatients, and give that information back to the staff on a regular basis and work with them to let them know how important these things are."

He says that Baylor has undertaken "a whole series of activities in a systematic fashion," and that is what is driving its improvement. "We measure our satisfaction scores on a monthly basis, and we have broken the responses down by what the key satisfiers and dissatisfiers are," says Convery. "And we employ internal coaches who are trained to work with the staff on these line items that are dissatisfiers." Those dissatisfiers, he explains, "may be a nurse who is not communicating with the patient, or a doctor who is not explaining the medicine or the wait time."

In addition to the internal coaches, he says, "we communicate with the staff to help them understand how to perform important system activities."

Patient focus critical

Mylod says that patient-centered care is the key to improving satisfaction and, thus, looking good on those public reports. "The organizations that are listening to patients and sharing what patients say in a transparent way, those are the ones that are improving," she notes. "What improves patient satisfaction is that focus on the patient — how you communicate with them and build trust. This can be different than a process improvement, because it's both process and culture."

For quality managers, she continues, public reporting should be an impetus to galvanize and "move the needle." "They must ask themselves how they can improve," she advises. "Hospitals are less comfortable with driving behavior change and holding people accountable. What we say is you already hold them accountable on the clinical side."

Quality managers, she says, know that staff have to be accountable for behavior as well as clinical performance; they know what the staff need to do, and what will happen if it's not done.

"It's not any different when it comes to serving patients; there needs to be behavioral standards defined, they need to be noticed and tracked, and people need to know what will happen if they do not do it since it is part of the performance standards of working at the facility," she explains. "Patients need to know they can trust you, they need to share in their care, and this needs to be defined. You guys are already experts in this; you just need to define those quality standards to a different type of behavior."

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Study: Patient satisfaction not what it could be

Yet programs have positive impact on outcomes

There's good news and bad news in a new study just released by the Health Research & Educational Trust, an affiliate of the American Hospital Association, and the Boston University Health Policy Institute: Of 470 hospital chief quality officers surveyed, 97% reported that QI activities had a positive effect on patient care outcomes. However, when that same group was asked about patient satisfaction, only 28% agreed it was at the level it should be.

In addition, they found, hospitals in which the chief quality officers perceived high levels of patient care quality were more likely than others to have embraced QI as a strategic priority, fostered staff training and involvement in QI methods, and engaged in an array of QI activities and clinical QI strategies.

"The overall picture is that there is a lot of progress being made, but we still have a long way to go as far as moving in the direction of high-performing organizations and a high-performing national health system," says **Alan B. Cohen**, ScD, professor of health policy and management and executive director of the Boston University Health Policy Institute, and one of the study's principal authors, who noted that the respondents came from hospitals of all sizes and types. "We have a long way to go, and a lot of work to do."

While more than 80% of the respondents said they had seen important gains in quality in the three years prior to the survey, he continues, they did believe their hospitals were "falling down in the area of increasing patient satisfaction."

In this particular study, he adds, the respondents we not asked to identify potential causes. "We hope to do that this fall with a small set of institutions," Cohen says. "We'll go into some high-performing organizations to see what it is they do to improve patient satisfaction and quality of care in general."

Hospitals still 'falling short'

Although hospitals have continued to improve in terms of complying with certain recognized quality and safety strategies, says Cohen, there are other areas where the results are still disappointing.

"We found a number of clinical QI strategies that are being used, many of which follow on the recommendations of the IHI [Institute for Healthcare Improvement] — such as preventing surgical site infections, central line infections, and ventilator-associated pneumonia," Cohen notes. "They really have gotten hospitals focused on preventing these things. But a sizable majority of the institutions surveyed show there is not the desired level of diffusion of other things that IHI, the IOM [Institute of Medicine], and the Leapfrog Group have been talking about for a long time." For example, he says, the survey indicated that:

- Only 47% of the respondents reported that they use evidence-based practice guidelines widely;
- Only 52% said they use standing orders widely;
- Only 62% said they use medication reconciliation widely.

"If left to their own devices, many hospitals will likely fall short," says Cohen. "The IHI has been pushing the notion that there really is some value to using reminders and setting up systems with prompts and alerts and reinforcing the notion that these are things you have to do."

Compliance, he continues, also comes down to checklists. "These are busy professionals, and they constantly have to be reminded of certain routines that are important in terms of reducing medication errors, wrong-site surgeries, and so forth," Cohen says. "We constantly have to stay vigilant."

One key problem, he acknowledges, is that such vigilance can be costly. "The question is, how do we define optimal levels and when do they become too burdensome from a cost standpoint?" he poses. "Some will say we can never do enough, while others will say there are limits to what institutions can afford to spend."

Some surprises

Cohen says that not all the survey results were what he and his colleagues anticipated. "We were surprised that almost half of the hospitals did not monitor wait times for outpatient services," he says. "There is much evidence that if people do not have access to good outpatient or primary care it will most likely lead to serious illnesses and conditions that result in avoidable hospitalization. It makes sense from a QI and cost

perspective to prevent this from occurring."

The bottom line, he says, is that hospitals "Should be vigilant about how long it takes to get a patient a clinic appointment because delays can lead to adverse outcomes."

Another survey finding, he says, is that the jury is still out on the issue of rapid response teams. Noting conflicting evidence in the medical literature, Cohen reports the following: "We found that two-fifths of all the hospitals said they were using rapid response teams widely, and another two-fifths said they were using them minimally or not at all.

"We surmise that some hospitals might have been convinced by the weight of evidence that [rapid response teams] made sense, and they had the necessary resources to use them widely, while the others probably adopted a 'wait and see' attitude concerning whether they proved to be both clinically effective and cost-effective. If more positive evidence is produced, these hospitals will be more likely adopt rapid response teams and make them part of their QI plans."

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'Most wired' hospitals have higher patient satisfaction

Interactivity is most appreciated by patients

Patient satisfaction is higher at hospitals that embrace technology, according to the 10th Annual Most Wired Survey and Benchmarking Study of *Hospitals & Health Networks* magazine, which is published by the American Hospital Association. These hospitals scored significantly higher in patient satisfaction in a number of areas, including: admission process, room, nurses, tests and treatments, visitor and family interactions, and services.

"That doesn't surprise me at all," says **Brent James**, MD, vice president of medical research at Intermountain Healthcare in Salt Lake City, which has been on the "Most Wired" list for 10 years.

There is "most definitely" a correlation between a hospital's use of technology and patient satisfaction, adds **Penny Smith-Horton**, patient and family satisfaction coordinator for Memorial University Medical Center in Savannah, GA, which has been on the list for nine years.

"We use Press Ganey for patient satisfaction surveys, and we've found it was one of the areas that patients rate higher and made them more likely to recommend us," she continues. In the data Memorial reported for publication on the HospitalCompare web site, 71% of its patients said they would "definitely recommend" Memorial. "This is higher than both the state and national averages," says Horton. "We think there's a connection [with technology] to the high score; our patient satisfaction is steadily increasing on the inpatient side."

"I think it does improve satisfaction, as well as quality," notes **David Erickson**, MD, chief medical officer for Avera Health, a Sioux Falls, IA-based system that has been on the "Most Wired" list for 10 years. "We have been very pleased."

What the 'most wired' use

The "most wired" facilities use a variety of technology to provide services and interact with patients. All three of the aforementioned organizations, for example, say they have an EMR (electronic medical record) system.

"On our web site we have transparent data on quality measures from a clinical standpoint," notes **Deanna Larson**, RN, Avera's vice president of quality. "When patients come in they are given a brochure on how they can connect. And in one facility, we have a system that looks like a hotel TV connect monitor; if a patient has concerns, they can click and someone will come to see them."

"We have a Meditech EMR at various stages of implementation, depending on the facility," adds Erickson. "At one of our clinics, you can go online and schedule an appointment, which I think has been very successful."

In addition, Larson says, "some patients are in the initial stages of e-prescribing — and that helps a lot." She adds that all nurses have pagers and phones on their belts, which enable them to respond to patient calls more quickly. And, most of the facilities' ICUs are linked to outside intensivists 24/7 through an e-ICU system. "The patients actually hear that voice come into the room," she notes. ■

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AHRQ has created address acute care hospitals and are open for comment and review — a process that Munier expects to be an ongoing one "so there's never a final set." **(To see the common formats, go to www.psoppc.org/web/patientsafety.)** Other settings will be addressed as more formats are created.

Long-term expectations

While the legislation continues to be hammered out and definitions continue to be refined, Munier says, the agency "hopes, over time, that we will be able to get to some kind of comparative benchmarking [with the data collected by the PSOs]." But, he says, challenges with that are twofold.

One, because it is a voluntary reporting system, the level of reporting and the completeness of reporting could vary, and there is no authority to demand otherwise. Second, surveillance systems vary by hospital so "denominators are fairly difficult to come by," Munier says. "And you need denominators if you're going to establish rates or compare providers. I think in the early days of PSOs, we're talking about a learning system where we learn from what happens."

But he refers back to the intent of the law — to encourage disclosure in a confidential, non-punitive system, and he encourages hospitals "to do what they've always said they wanted to do" — to find a local PSO and begin a reporting relationship. Though there is a lot left to be seen about how PSOs will work, to Munier, this move forward signals a great thing — finally, "uniform national protections for peer review," he says.

(Editor's note: The final rule is expected by the end of the year.) ■

IHI shares results of 5 Million Lives Campaign

Campaign scheduled to wrap up in December

If you're getting tired of bad news these days, the Institute for Healthcare Improvement has some positive news. As it nears the end of its 5 Million Lives Campaign this month, it celebrates this year's successes, and according to IHI Vice President **Joe McCannon**, those have been plentiful.

McCannon talked with *Hospital Peer Review* in advance of this month's annual IHI conference, where further results and data will be revealed. Of the campaign, he says, the organization has been quite pleased and excited about the level of activity and the level of involvement on a national scale.

"Then there's really some promising signs in terms of organizations demonstrating breakthrough performance and, in some instances, whole systems or whole states demonstrating breakthrough performance."

All of this is inching the health care industry closer to what he calls a "critical mass of organizations that are showing what's possible, and in so doing, changing expectations I would hope permanently about what we can do to get better care to patients and families."

Nationwide involvement

McCannon says more than 4,000 hospitals are now enrolled in the program, representing about 80% of hospitals nationwide. And he says IHI is "especially excited" by the "significant increase" in involvement of rural hospitals. Of about 2,000 rural hospitals, more than 85% are part of the campaign, he says.

12 Interventions from the 5 Million Lives Campaign

1. Prevent pressure ulcers
2. Reduce methicillin-resistant *Staphylococcus aureus* (MRSA) infection
3. Prevent harm from high-alert medications
4. Reduce surgical complications
5. Deliver reliable, evidence-based care for congestive heart failure
6. Get boards on board
7. Deploy rapid response teams
8. Prevent adverse drug events (medication reconciliation)
9. Improve care for acute myocardial infarction
10. Prevent surgical site infections
11. Prevent central line-associated bloodstream infections
12. Prevent ventilator-associated pneumonia

Of 200 hospitals that are serving as mentors or coaches in the campaign, 60 of those are rural or critical access hospitals. "So we are seeing these pockets of success, which will hopefully raise energy and excitement and create higher expectations about what's possible," he says.

As part of the campaign, affinity groups including facilities such as rural hospitals and pediatric and teaching hospitals have been formed as networks for sharing successes and lessons learned. At the state level, "field offices" or "nodes" have been created to act in the same way on the state level.

As part of the 100,000 and 5 million lives campaigns, IHI has created 12 interventions, priorities hospitals can focus on to improve quality and safety **(see box, pg. 163)** and areas where the campaign has seen many successes, McCannon says:

- More than 65 hospitals in the campaign have reported going more than a year with no ventilator-associated pneumonia.
- More than 35 hospitals report no cases in one year of central line infections.
- Hospitals in Rhode Island report a 42% decrease in central line infections across the state.
- New Jersey hospitals report a 72% reduction in pressure ulcer incidents.

What's next for IHI?

"We need to finish the job," McCannon says, referring to the future of the campaign after its conclusion in December. That is, he says, to get people thinking about moving successes in discreet areas to reducing harm and mortalities across facilities.

"We need to move from pockets of success to ubiquity when it comes to introducing the interventions that have already been in the campaign and helping them move success from one unit to other units and sustain the work," he says.

The next frontier for IHI, he says, is moving hospitals to "more complete performance," to making these distinct success stories commonplace ones. IHI is working on consolidating priorities, suggestions, and practices learned as part of this campaign to move health care to the next level.

(Editor's note: IHI will host its 20th annual national forum Dec. 8-11 in Nashville, TN.) ■

New IP guidelines on track to become standards

'A powerful expectation' that hospitals reduce HAIs

The Joint Commission has strongly endorsed recently issued compendium infection prevention guidelines, announcing that the condensed, actionable recommendations may become required as accreditation standards by 2010.

"In 2009, we will expect all hospitals to review their current practices and their risks and consider which of these [compendium] strategies they need to add," **Robert Wise**, MD, vice president for standards at The Joint Commission, said at an Oct. 8, 2008, press conference in Washington, DC. "Also in 2009, we will convene stakeholders, hospitals, experts in the field, consumers, and government officials to review the entire collection in the compendium to help determine which strategies should be immediately required as part of accreditation. In 2010, we will add these requirements to our accreditation standards. The Joint Commission will continue to create a powerful expectation to take on the problem of hospital infections."

Along with The Joint Commission, *The Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* represents a two-year collaborative effort by the Society for Healthcare Epidemiology of America (SHEA); the Infectious Diseases Society of America; the American Hospital Association (AHA); and the Association for Professionals in Infection Control and Epidemiology (APIC). The compendium was published as a supplement to the October 2008 issue of the SHEA journal, *Infection Control and Hospital Epidemiology*.

The compendium is essentially a synthesis of established prevention guidelines to prevent *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus*, central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CA-UTIs), surgical-site infections, and ventilator-associated pneumonia.

In that regard, many of the infections already have been targeted for prevention in the Joint Commission's recently finalized 2009 National Patient Safety Goals. Asked whether the compendium essentially mirrors the patient safety goals, Wise said the goals actually were based on

the compendium. "The best strategies have never been in one place in an easy-to-use format as they are now," he said. "Immediately, we will join with our partners to rapidly disseminate these practices throughout the country."

Many hospitals already are following the measures recommended by the compendium but there are wide variations in practice even within institutions, he added. "The same hospital that does great at inserting central lines might do poorly at handling urinary catheters, not keeping track of who has them in and [whether] they are being checked daily to see whether they should be withdrawn," Wise said.

'A common playbook'

A key player in the process is the AHA, which can get the attention of hospital administrators and executives. "As of today, the nation's infection control team has a common playbook," said **Rich Umbdenstock**, AHA president and CEO. "As a partner to this group, the AHA is excited to offer these strategies to the field and will share this important work with our national hospitals through our multiple communications vehicles."

Indeed, having the AHA onboard is seen as a favorable sign that the guidelines actually will be clinically implemented.

"It has to start at the top," said **Marsha Patrick**, RN, MSN, CIC, an infection preventionist representing APIC at the press conference. "The C-suite sets the tone and I have certainly seen that during my career. We know the best practices, but we have to get them down to the bedside to each and every individual practitioner. Infection prevention efforts must be adequately resourced for us to make these kinds of changes and to be successful in our organizations. Our patients are counting on us."

Another driver in all this is the Centers for Medicare & Medicaid Services (CMS), which has reduced reimbursement for complications associated with two of the infections included in the compendium: CLABSI and CA-UTIs. "It's unfortunate that is has taken CMS threatening the withdrawal of reimbursement for some of these activities to get the attention at the C-suite level," Patrick said. "But, you know, it takes what it takes."

While there was reference to "federal partners" in the panel discussion, joining CMS on the conspicuously absent list was the Centers for Disease Control and Prevention. That immediately raised the question about possible confusion about standards of care, particularly if any CDC recommendations were at odds with those in the compendium. However, **Patrick Brennan**, MD, SHEA president and chair of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) — the gold standard for infection prevention recommendations — said that would not be a problem. "I don't have concerns about confusion about the standards given the collaborative nature of the process," he noted.

Indeed, an editorial accompanying the compendium publication was co-authored by **Michael Bell**, MD, a medical epidemiologist in the CDC division of health care quality promotion and the CDC's principal liaison with HICPAC.[1] For all practical purposes, the editorial states that the compendium can be used as shorthand for the CDC's recommendations. "Although there is potential for variability among reviewers in their assessment of recommendation strength or evidence quality, this compendium represents an important tool that facilitates implementation of practices and procedures to prevent HAIs, complementing official Centers for Disease and Prevention guidelines," the editorial states.

Moreover, with CDC guidelines often stuck in the limbo of protracted government review, the compendium was actually used to provide updated CDC recommendations. "[T]he compendium delivers updated guidance in areas where official guidelines have revisions pending (e.g., surgical-site infection prevention and urinary tract infection prevention guidelines currently in preparation)," the editorial states. "The compendium published here is a concise, easily applied distillation of current guidelines for the prevention of HAIs that brings together recommendations from respected sources in a format suited to implementation in the clinical setting. . .

"As the CDC continues to produce official

guidelines in collaboration with professional societies and academic partners, implementation tools such as this compendium will serve as a means to ensure that the best practices for infection prevention are successfully brought to the bedside."

Strong out of the gate

With a clear stamp of approval from the CDC and the promise of future enforcement by The Joint Commission, the compendium comes out of the gate about as strongly as any infection prevention initiative in recent memory. A new age of transparency, regulation, and consumer involvement is certainly pushing such action. Likewise, the ante has been upped by a new wave of clinicians who are showing that tools like simple checklists dramatically can reduce infections once considered inevitable. However, there is another factor that can scarcely be underestimated, the rise of multidrug-resistant and highly virulent strains of pathogens both in the hospital and community. Brennan recalled that he first saw the power of such bugs a decade ago when he lost a patient after a combination of infection and drug contraindications ruled out all available antibiotics.

"An attempt was made to drain the collection of infected fluid from the chest, but the patient died a few days later," he said. "For me this was an alarming and sentinel event. But imagine the feeling for the patient's family. A patient had acquired an infection in the hospital, and through a confluence of events had died without effective treatment as his doctors and nurses stood by helplessly. I didn't encounter such a situation again for a number of years, but now this scenario has become more commonplace. Extremely ill patients, limited therapeutic options, poor outcomes. Prevention is essential."

Given such consequences, the infection prevention community could ill afford to be seen as lost in a maze of its own making. However, a recent government report seemed to be suggesting just that in repeatedly noting that there are a staggering 1,200 individual infection prevention recommendations by the CDC to guide clinicians in protecting patients.[2] "The report mentions that fact so often that it suggests disbelief that so many recommendations should be necessary to accomplish the task of prevention," Brennan said. "The number does not surprise us who deliver hospital care. The processes that simultaneously support patients and pose a hazard of infection

CNE *questions*

21. How many new APC composite payments were added in the 2009 final OPPS rule?
A. two
B. three
C. four
D. five

22. DNV Healthcare has equivalents to The Joint Commission's National Patient Safety Goals as part of its NIAHO accreditation program?
A. True
B. False

23. According to **William B. Munier**, can insurance companies apply as patient safety organizations?
A. Yes
B. No

24. What percent of U.S. hospitals have participated in the Institute for Healthcare Improvement's 5 Million Lives Campaign?
A. 40%
B. 60%
C. 80%
D. 90%

Answer Key: 21. C; 22. B; 23. B; 24. C

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

are intricate and must be executed carefully. "

However, given the rising expectations by the public and even within the health care epidemiology community, it was time to err on the side of plain guidance rather than academic equivocation.

"We are now at an important intersection: the translation of public policy into health care reform," he said. "Our health care organizations need additional guidance, not about the knowledge but about the execution of HAI prevention measures. Too often where we fail is not in the knowledge, but in the execution. The compendium is intended to help organizations prioritize the myriad recommendations in order to focus their efforts to safely conduct these processes of care."

Patient advocate Victoria Nahum — who founded the Safe Care Campaign after the death of her son Josh due to an HAI — concurred. "We know the right way to proceed," she said. "It's going to take all of us together."

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1. Singh N, Brennan PJ, Bell M. Supplement Article: Editorial. Primum non nocere. *Infect Control Hosp Epidemiol* 2008; 29:S1-S2

2. Government Accountability Office. Health care-associated infections in hospitals: Leadership needed from HHS to prioritize prevention practices and improve data on these infections. Report to the chairman, Committee on Oversight Government Reform, House of Representatives; March 2008. GAO-08-2839. ■

CMS shifts claim reviews from QIOs to FIs, MACs

Change will mean efficiency, consistency, it says

Citing improved efficiency and consistency, the Centers for Medicare & Medicaid Services (CMS) has begun transitioning the handling of hospital claim reviews from quality improvement organizations (QIOs) to fiscal intermediaries (FIs) and Medicare administrative contractors (MACs).

FIs and MACs are tasked with preventing improper payments, while improper payments will be measured by CMS' Comprehensive Error Rate Testing program (CERT).

According to CMS, the transition will also free up QIOs to focus on quality of care improvement

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- 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 or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- Incentive programs that build on your quality improvement initiatives
- Core measure missed opportunity notices and how to use them
- Story from the field: A newly accredited hospital shares with us
- NPSGs update: How are we doing?

issues and provider assistance efforts.

CERT began reviewing acute care hospital claims for improper payment measurement in April 2008, and will review claims submitted from April 1, 2008, and beyond. FIs and MACs began shortly afterward reviewing acute care inpatient hospital claims for improper payment prevention and reduction, and will review claims submitted from Jan. 1, 2008, and beyond.

"This is significant in that hospitals will now need to call their FI rather than their QIO for some specific topics," according to **Jackie Birmingham**, RN, MS, CMAC, VP Professional Services for eDischarge, Curaspan Health Group Inc., in Newton, MA.

FIs and MACs began education efforts along with the reviews that commenced in the summer. Experts warn that the shift will mean that statistics generated after the transition won't be accurately comparable to previous sets of statistics.

QIO responsibilities changed

Until recently, QIOs were responsible for Hospital Payment Monitoring Program (HPMP) reviews, including utilization reviews for payment purposes and accuracy measures of Medicare payments for short- and long-term acute care hospitals; quality of care reviews for Medicare beneficiaries; provider-requested, higher-weighted diagnosis-related group (DRG) reviews; and EMTALA reviews.

Prior to the transition, FIs and MACs had no acute care hospital claim review duties, and the CERT program wasn't responsible for measuring improper payments involving acute care inpatient claims.

Under the new system, QIO focus shifts to quality improvement. QIOs will continue to conduct quality reviews, some utilization reviews, and expedited determinations. FIs and MACs will perform most utilization reviews in the new process.

CMS cites three main benefits to the change in review-handling:

- Consistency in having all Medicare fee-for-service (FFS) settings reviewed by FIs and MACs (Acute long- and short-term hospitals were the only FFS sites not reviewed by FIs and MACs.)
- Efficiency in having the same entities that process claims responsible for preventing improper payment. CMS believes the new designation of responsibility will also be a cost-saving measure.
- Lessened perception of conflict of interest raised when QIOs measured the payment error rate for claims on which they themselves made payment determinations. ■

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