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One big step toward value-based with CMS issuance of proposed rule

Experts pose many potential problems in proposed version

Value-based purchasing has been a much-used term, and the evolution to such a system has been long held as a reality for the future. It's closer than ever now, as the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule Jan. 7 for the establishment of the value-based purchasing (VBP) system in health care.

However, the road is still unclear, experts say. And their concerns with the proposed rule may signal a very busy comment period, which ends March 8. *(See story, page 28.)*

What we know now

As part of the Patient Protection and Affordable Care Act of 2010, CMS is required to provide hospitals value-based incentive payments by fiscal year 2013. The payments are to correspond with both a hospital's achievement of selected measures and its improvement over a specific time period on those same measures.

For the FY 2013 VBP program, CMS has chosen 17 clinical measures, as well as eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey *(see box page 27)*. In FY 2014, CMS proposes to add three mortality measures, eight hospital-acquired condition measures, and nine Agency for Healthcare Research and Quality (AHRQ) Indicator outcome measures. The change in hospital payments will take effect in fiscal year 2013 beginning with discharges on Oct. 1, 2012.

CMS is required to keep the program budget-neutral and within the proposed rule laid out a reduction in base operating DRG payments at 1% in FY 2013, to increase to 2% by FY 2017. CMS proposes to calculate hospitals' achievement score from 0 to 10 points for each measure when during the performance period the hospital's achievement falls in the median of aggregate hospitals' performance and a national benchmark. The improvement score, from 0 to 10 points, would be based on how much a hospital's performance improves on a measure during a performance period versus the performance in the base period. A hospital would then receive the higher score from the achievement or

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improvement finding. For FY 2013 measures, CMS has set a baseline period of July 1, 2009, to March 31, 2010, and a performance period of July 11, 2011, through March 31, 2012.

For the HCAHPS, or patient care experience, measures, hospitals would receive scores based on achievement, improvement, and consistency, and can receive 0 to 80 points. For improvement scores, a hospital could get 0 to nine points, and for consistency 0 to 20. A total performance score then would be determined by combining the scores for process measures and patient care experience measures. CMS proposes to assign a weight of 70% to the clinical measures and 30% to the HCAHPS measures.

In choosing clinical measures for inclusion, CMS said it would exclude those quality measures that are "'topped out,' meaning that all but a few hospitals have achieved a similarly high level of performance on them. We believe that measuring hospital performance on topped-out measures will have no meaningful effect on a hospital's total performance score." The agency identified seven measures as "topped out":

- AMI–1: aspirin at arrival;
- AMI–5: beta-blocker at discharge;
- AMI–3: ACEI or ARB at discharge;
- AMI–4: smoking cessation;
- HF–4: smoking cessation;
- PN–4: smoking cessation;
- SCIP–Inf-6: surgery patients with appropriate hair removal.

What it means to you

The proposed rule "just underscores something that's already been in place, and that is the importance of having some kind of process in place for ensuring that things get documented while patients are in the hospital," says **Patrice Spath**, of Brown-Spath & Associates in Forest Grove, OR.

Of the measures proposed for inclusion, Spath says hospitals have been reporting on these for some time now, so none of it is new in that regard.

As far as the financial effects the rule could have, Spath says, "Since it has to be budget-neutral, it's really just moving money around. So there won't necessarily be a bigger pot of money available, but it may be that the hospital down the road gets a little bigger piece of the pie and you get a little bit less because of this.

"But it's hard to calculate what the financial incentive is. And studies of the demonstration projects that were done with Premier found that without a significant financial incentive, that hospitals just didn't spend the dollars that were necessary to get their scores up," she says.

She also says it is difficult to see the financial effect of the improvement portion of the scoring methodology. "What happens when you're at 100% all the time?" she asks.

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Editorial Questions

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Matthew Vogelien, director at Huron Consulting Group in Chicago, agrees that the financial impact, at this point, is hard to forecast. "We field a lot of questions about, 'What's the real financial impact, or financial benefit, if you will, of this?' And I think, unfortunately, it's a little bit of wait and see... I think there is still just a lot of gray area there."

Spath says the impact of the 1% reduction "depends on the percent of patients that you have who are Medicare patients." She notes, too, that presently there's no adjustment for the size of hospital. Critical access hospitals are excluded from the program.

She says she would expect that adjustment to be included. "If they're using percent of improvement, they give you certain numbers. If you have 10,000 patients versus 1,000 patients, that percentage is obviously going to be impacted by that denominator."

Documentation and data integrity will continue to become more and more integral to the quality improvement director's job, Spath says. Make sure your data are high-quality, she adds. The question quality managers should be asking, she says, is: Do we have a system in place to ensure that the data we're sending to CMS are accurate?

"You were getting paid for reporting before. Now the quality of the data will actually impact your reimbursement. Do you have a system in place for clinical documentation improvement?" she says.

Vogelien says, too, he is hearing questions from clients about what happens if there are glitches in your reporting processes. For the quality measures themselves, hospitals are used to reporting on them as part of the Hospital Inpatient Quality Reporting Program. So, many of his clients are looking at the VBP program as a positive thing. But they question what will happen if after self-reporting they find problems in measurements, for example. What kind of oversight model is out there? he says.

Beyond sorting those things out for the VBP program, "one of the things that's going to happen in the midst of all of this is the transition to ICD-10," Spath says. "And in order to accurately code things in ICD-10, especially on the procedure side, things have to be very clearly documented. So there's already under way in organizations a push to improve the clinical documentation in patient records." Ratcheting up documentation, not only for Medicare patients in terms of VBP, but for all patients in terms of ICD-10 is more

Proposed measures for FY 2013 VBP program

Acute Myocardial Infarction
- AMI–2 Aspirin prescribed at discharge
- AMI–7a Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI–8a Primary percutaneous coronary intervention within 90 minutes of hospital arrival

Heart Failure
- HF–1 Discharge instructions
- HF–2 Evaluation of left ventrical systolic function
- HF–3 ACE inhibitor or angiotensen receptor blocker for left ventrical systolic dysfunction

Pneumonia
- PN–2 Pneumoccal vaccination
- PN–3b Blood cultures performed in ED prior to initial antibiotic received in hospital
- PN–6 Initial antibiotic selection for community-acquired pneumonia in immunocompetent patient
- PN–7 Influenza vaccine

Healthcare-Associated Infections
- SCIP–Inf-1 Prophylactic antibiotic received within one hour prior to surgical incision
- SCIP–Inf-2 Prophylactic antibiotic selection for surgical patients
- SCIP–Inf-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
- SCIP–Inf-4 Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose

Surgeries
- SCIP–Card-2 Surgery patients on a beta-blocker prior to arrival that received a beta-blocker during the perioperative period
- SCIP–VTE–1 Surgery patients with recommended venous thromboembolism prophylaxis ordered
- SCIP–VTE–2 Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery.

Patient Experience of Care Measures
- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Cleanliness and quietness of hospital environment
- Discharge information
- Overall rating of hospital

Source: Centers for Medicare & Medicaid Services.

important than ever.

Another area for hospitals to look at is HCAHPS scores. "The problem you run into," Spath says, is that patients' "perception is impacted by things that oftentimes are outside of your control."

Referring to the possibly variable impact the rule would have on hospitals of differing sizes and populations, **Regan E. Tankersley**, attorney with Hall Render, says, "Any time there is going to be anything new to the payment system, it's always a wait and see. How practical is it going to be? How burdensome is it going to be?" Echoing what most experts told *Hospital Peer Review*, she says the end result for hospitals is yet to be seen, especially as there could be many iterations before a final rule. She asks: "[Is CMS] going to take into account providers of the same size? Is it going to be just completely based on the number of procedures and quality?..."

"It could be difficult for smaller providers that don't have this type of infrastructure that may have had difficulty reporting the quality data," she says. "Depending on what their systems are, they're going to have to get up to speed. I think it's always the smaller hospitals who struggle when things like this come across because it might not be cost-effective for them initially to a put a lot of money into an infrastructure, especially when you don't know how the calculations are going to come out in the end," she says. ■

Proposed rule leaves many questions

Concerns in field on many fronts

It's a proposed rule. So it's up for comment. And that's a good thing, because there are many in the field. Though experts agreed there were not many surprises in terms of quality measures laid out for fiscal year 2013 in the Centers for Medicare & Medicaid Services' proposed rule on value-based purchasing (VBP), they are concerned with other things.

"Most of what is included in the value-based purchasing proposal is driven off the MedPAC report from several years ago," says **Kathleen Ciccone**, RN, MBA, executive director of the Healthcare Association of New York State (HANYS) Quality Institute.

"The major concepts are the same, the themes are the same. I think what's new and different is the details," she says. While CMS historically talked about building a VBP program from the pay-for-reporting or Hospital Inpatient Quality Reporting programs, she says, the information still up in the air was which measures, time frames, and reimbursement formula would be used.

These details are what we're seeing now, says **Stephen Harwell**, vice president, economics, finance, and information for HANYS. Echoing the concerns of others in the field, he says the financial impact is still to be seen.

"What one individual hospital does depends on how its score, starting in July 2011, measures up against every other hospital. So you really can't know ahead of time. In fact, in this proposed rule, CMS lays out the whole thing conceptually; the mechanism is laid out, but they don't give you the scales and exactly how to calculate [a score] because they won't know until they actually see every hospital's performance beginning in July," he says.

What this means for hospitals, Ciccone says, is that they will, in essence, always be chasing a moving target. "For hospitals, pace matters because they can be improving, but if others are improving at a faster rate, then they're losing ground."

Hospital-acquired conditions

One of the biggest concerns is the inclusion of eight hospital-acquired conditions as quality measures for FY 2014. "We are very strongly opposed to the inclusion of those measures in two places in hospital regulations," says **Beth Feldpush**, DrPH, senior associate director for policy at the American Hospital Association (AHA).

First, as part of the Affordable Care Act, Feldpush says, beginning in 2015, hospitals with high rates of hospital-acquired conditions are to be penalized. With CMS' proposal to also add those conditions to the VBP program, that "really puts hospitals at risk for double jeopardy and potentially being dinged twice on exactly the same measures. And that, we are strongly opposed to."

There also is the policy already in place dictating that for patients who have no present-on-admission indicators and then get a hospital-acquired condition, hospitals don't receive

a higher DRG payment as part of the inpatient prospective payment system. Reminded of this, Feldpush says, "so in a sense this shows up three times... That's really triple jeopardy, so to speak."

"That seems inherently unfair," Ciccone says.

Feldpush says the AHA will definitely be commenting to CMS "that we strongly oppose the inclusion of these HACs in two different places in regulation related to the health care reform delivery changes." Ciccone agrees.

Mortality measures

Another contentious element of the proposed rule is the inclusion of mortality measures, also on tap for FY 2014, specifically 30-day mortality rates related to AMI, heart failure, and pneumonia.

"Measuring mortality is certainly a very important component of looking at quality metrics. I think we would like to see from CMS more information on the proposed rule about how they would exactly incorporate those measures into the scoring," Feldpush says.

With the clinical measures, such as administering aspirin, it's a simple yes or no — the hospital complied or it didn't. But with the mortality measures, CMS would have to account for risk adjustment for hospitals with differing sizes and patient populations, Feldpush says, as well as accounting for patients near end of life and those who elected not to receive life-sustaining treatment.

"I think there's still some outstanding questions around these mortality measures as to whether or not we've gotten the risk-adjustment methodology down."

Risk adjustment in general is a concern many experts have. **Jessica Roth**, assistant director of legislation and health policy at McDermott Will & Emery, says: "One of the things that we're thinking about here is that maybe what CMS should do is utilize that reporting structure for determining points related to outcome. So, perhaps hospitals that are better than the national average would get 10 points on that measure. Hospitals that are at the national average would get five points. Hospitals that are worse would get none.

"So, rather than looking at raw mortality data because of the issues around risk adjustment [make] sure that the measure is actually reflecting care that's within the hospital's control. I think that's one of the issues with the outcomes measure is, are you measuring something that is within the hospital's control? And, if it isn't, then is it fair to be measuring them on it? And, I think most people would say no, even CMS," Roth says.

"So, if that is, in fact, a concern because of these issues around the risk-assessment methodology, then we understand that outcomes are important and that CMS wants to look at those and consider those in this program; maybe a way to do it is, again, utilizing these more general categories rather than raw mortality rates."

HCAHPS scores

Another concern is the way the rule, specifically the scoring methodology, includes the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measures. A hospital's total score in the proposed rule would be calculated with 70% going to the process measures and 30% to the HCAHPS measures. "As we talk to hospitals, it seems that the general sense in the field is that that 30% weight for HCAHPS is too high," Feldpush says.

Ciccone also questions the 70-30 weighting.

Not only are HCAHPS scores subjective, but "I think the jury is still out on our understanding of what really impacts patients' responses, and we're beginning to learn more about [the fact that] patients who have more serious medical conditions tend to be more depressed, not surprisingly," Feldpush says. "And people who are depressed tend not to view their hospital experience so positively. Again, not necessarily surprising. But that's an example of the kind of relationship that's not captured in the current measures, so we have no way of risk-adjusting for sicker or depressed patients in HCAHPS."

Ciccone says in looking at HCAHPS scores, "one of the things that's clear to us is that there is a regional distribution of HCAHPS scores that varies by hospital size, even geography. The larger urban centers tend to have lower HCAHPS scores. People in some of the Northeastern states tend to have lower HCAHPS scores, and we are uncertain if there is any inherent bias in the survey."

Elimination of topped-out measures

In the proposed rule, CMS decided to exclude what it referred to as topped-out measures, "meaning that all but a few hospitals have achieved a similarly high level of performance on them. We believe that measuring hospital performance on topped-out measures will have no meaningful effect on a hospital's total performance score," the

agency wrote.

But if they are important and hospitals should be doing them, why not include them, asks Roth. "I would say, on the whole, that CMS shouldn't deny hospitals the opportunity to gain points. And if these measures are, in fact, providing hospitals that opportunity, they should not be excluded."

In a November letter from the AHA and other stakeholders, says "the selection of measures for the VBP program should be based on the measures' ability to improve patient care and patient outcomes."

Regan E. Tankersley, attorney with Hall Render, also questions the possibility for appeals. "So, I think it's really going to drive home for hospitals the importance of tracking and reporting the data, especially now that this data is going to be taken, and it's going to be put into a formula, and you're going to get a value-based purchasing based on your performance and how that's weighted.

Now, what that says to me is, it's almost similar to what hospitals go through, let's say, for a wage data correction. You give the contractor a lot of information, they have to review it, and who knows how that calculation is going to come out in the end. And, you would think that providers would have some opportunity to either appeal it, adjust it, make sure errors were not reported, because of the way these calculations are going to work," she says.

"So, I'm curious to see if that is going to be brought up in commentary, if that is going to be addressed; is there going to be a mechanism for hospitals to see how their data are being reported and calculated, is there going to be an opportunity to correct, is there an opportunity to appeal a determination of what their payment is?" ■

Suicide assessment team in the ED

Understanding those at risk

Michelle Buckman, RN, MSN, is a psychiatric clinical nurse specialist working as a consultant to the Loma Linda University Medical Center emergency department. Since The Joint Commission issued its Sentinel Event Alert on preventing suicide, Loma Linda has created a suicide assessment team, with Buckman as a consultant.

"We're looking at best practices, and we're just wanting to make sure we have not missed a single dot on the 'i' or a cross on the 't', and that there's just nothing anywhere we couldn't improve on within the behavioral medicine center [BMC] and emergency room," she says.

The team began with everyone bringing in what they were doing on their specific unit, with Buckman organizing the ED standards and policies, the best practices in place. "We're all going to look through that and see if there's anything we should add or change or take. We're looking at cases. We're looking at the near suicide cases we've had. Thank goodness, we've never in the BMC or in the ED, that we know of, had a completed suicide."

Not that patients haven't tried. "We've found people with shoestrings around their neck, and we've found people in the act of trying to hurt themselves," she says.

She says the team will review those cases and see what could have been done differently; they're also looking at job descriptions, shift duties, and the environment of care for any risks. "We are really working on awareness, awareness, awareness. And going through with a fine-tooth comb everything we do at all times to make sure that we can't be better at finding any missing pieces where a patient could slip through and hurt themselves or kill themselves," Buckman says.

Who's at risk

"You want to look at the general demographics that have been standardized by researchers, and that is men over 65, adolescents. The third leading cause of death for people age 15 to 25 in this country is suicide. So those people. When you add that with things like a romantic breakup, loss of a job, mental illness, traumatic events, they're at very high risk," she says.

Other high-risk triggers: homelessness, low socioeconomic status, and drugs and alcohol. Elderly people also are high risk. "When they talk about suicide, don't take that lightly. Take it seriously because the means of suicide that they use are very violent. They shoot themselves in the head, they takes overdoses, and wrap their faces in plastic," she says. Elderly men who have lost many friends, independence, and good health use serious means to end their lives, so being aware of this is important, Buckman says.

American Indians are at higher risk, as well as homosexuals, she says. And those addicted to

drugs or alcohol, who also suffer from chronic pain should also be watched. "Another group of people are those with chronic medical or terminal illness. [People with cancer or end-stage diseases.] Somebody who has been in a lot of pain or suddenly just can't take a new diagnosis," she says. Another group is people who have been in accidents and are left with disfigurements.

She says to first look at demographics and those groups automatically at high risk. "And then on top of that, are they getting a bad diagnosis? Or are they somebody who has a history of mental illness? Are they somebody who you've noticed is not having any visitors at all, they have no family come, they have no friends come, they're wrapped up in a blanket and they don't care what pills the doctor prescribes for them, they just do what they're told without any participation in their treatment," she says.

A person who is 40, has a supportive family, and strong faith is not at a high risk for suicide, Buckman says.

It's important staff also understand what patients' behavior may be signalling. "Do they look depressed? Do they have a flat affect, no interest in treatment, have they stopped eating? Have they stopped grooming? If family was coming to visit, have they now refused that?"

As far as keeping the environment of care safe, that, too, took a lot of awareness and education, she says, from kitchen workers to engineers. She says often items such as nails or pieces of wire will fall from engineers' tool belts. Cleansers should be kept inconspicuously in carts. Watch for breakaway bars in showers and check on patients in the shower, she suggests. Don't let them bring in long pants or gowns that they could use to hang themselves. Watch IV poles, IV needles. She says med/surg physicians and nurses might not be used to thinking this way, but they have to. ■

ANA awards five hospitals for nursing quality

Poudre Valley gets fourth consecutive award

According to **Craig Luzinski**, MSN, RN, NEA-BC, FACHE, chief nursing officer at Poudre Valley Hospital in Fort Collins, CO, the hospital received the American Nurses Association (ANA) NDNQI (National Database of Nursing Quality Indicators) Award for Outstanding Nursing Quality for the fourth consecutive year. "We were the first hospital to receive the award in 2007, and that year, NDNQI gave out just one award. So, at that time, they didn't fragment it by facility type like they do now," he says. Since then, the hospital has won three consecutive awards in the teaching hospital category.

What sets Poudre Valley Hospital (PVH) apart? "I think part of it is that PVH has been an organization that has embraced the Magnet model. And then, we've also been immersed in the Malcolm Baldrige quality model. And so, by merging those two things, the organization as a whole has a focus on outcomes. And that can be outcomes related to quality, finances, customer satisfaction, HR metrics," he says. By knowing current baselines for all major indicators and setting goals, the vision for top-class care is set, Luzinski says.

"What we do is we establish a process or an issue such as patient falls, or urinary tract infections. We measure to find out what our baseline is. We then go outside of our hospital to benchmark against other facilities trying to look at that top 10%. And, the nice thing about NDNQI is, a couple of years ago, they started reporting back to us the top decile. It used to be just the top quartile. And so they segmented it out a little more bit for us," he says.

So what does one do with all the data? He says the hospital has had a system of balanced scorecards for several years in which it identifies key measures to keep track of, the goals, and then measuring how it's doing on those goals. "Specifically for nursing, we have a pretty robust nursing quality dashboard, which includes many of the nursing-sensitive indicators that NDNQI has on their database," he says.

The key to the nursing quality dashboard "is involving staff identifying and developing action plans to improve our current status," he says. "And, I think that's where we have made a lot of progress — using benchmarking, using dashboards, and then making them very transparent so that everyone gets to see everyone else's data. And then, expecting action plans to be developed if we're not at the level that we would like to have."

Some of those the hospital has prioritized are patient falls, pressure ulcers, and hospital-acquired infections. The measures are unit-specific. So, for example, patient falls wouldn't be an issue in the neonatal unit. And in the med/surg floors, you wouldn't be concerned with ventilator-associated

pneumonia, he says. But in the ICU, VAPs and catheter-associated urinary tract infections would be important indicators.

"We do measure, from a financial and productivity standard, our nursing productivity measures, which are usually measured in hours-per-patient data; it's sort of a standard benchmarkable number. We look at our nurses' education levels. So, the percentage of two-year degree nurses, bachelor's degree, masters-prepared, and then doctorate or PhD. We look at and monitor the number of nurses who are certified — have national certifications — and that can be clinical certifications in their area of specialty or administrative certifications like in my job," he says.

He says Poudre has nurses in roles outside direct patient care. For instance, the director of the quality resource department is a nurse, and under him is a group of nurses who work through the "data manipulation and collection process," he says. "And they also work with the physicians, too, on their data to help organize it and then help us understand how we can better use the data rather than just reacting to things when numbers go up and down. You know, understanding control charts, and variability, and common cause..."

For its work on pressure ulcers, the hospital emphasizes a physical assessment every day so staff can be proactive in identifying redness or bony areas, as well as getting patients walking to promote circulation. The hospital has a clinical nurse specialist focused on skin integrity. Beyond other responsibilities, she works in the wound care clinic. "She's a resource so that if we find a patient that either has a pressure ulcer or looks like it's developing, we have the ability to call her up as a consult and she can come up and help nurses walk through the variety of therapy options," he says.

Falls are another priority for staff. "We've got a pretty robust program of doing an assessment of an individual and then placing them into a risk division or category, and it's based on a variety of different observed assessments or what people tell us," he says. If a patient is labeled a high risk for falls, the electronic health record system helps remind and alert staff to initiatives to reduce the likelihood of a fall. If an at-risk patient tries to get out of his or her bed or chair, an alarm goes off. High-risk patients are also escorted by staff to the bathroom. Staff "try to educate the patients and the family members as to why we're there; we're there for their safety. And we try to educate them that the bathroom is a very dangerous place if they try to get up, and they get dizzy, and they'll fall. And, so we try to say that it's not to embarrass them, but it's to keep them from hurting themselves," he says.

In the neuro unit, a video monitor technician sits at a desk to monitor everyone. The staff also have started something he says has been helpful for other hospitals — hourly rounding. Either a nursing assistant or RN is responsible for checking on patients each hour. "What you check are the three Ps: potty, positioning, and pain. And so, when you check every hour, you say, 'Do you have to use the restroom?' 'Are you positioned appropriately?', which is going to help with pressure ulcers and just general comfort. And then, 'Are you having pain that we need to address?'" he says.

(The ANA also awarded: University of Kansas Hospital, Kansas City, KS/Academic Medical Center; Medical Center of the Rockies, Loveland, CO/Community Hospital; Children's Hospital & Medical Center, Omaha, NE/Pediatric Hospital; Craig Hospital, Englewood, CO/Rehabilitation Hospital.) ■

Credentialing & Privileging

FPPE/OPPE: Monitoring practitioners' privileges

In the first three articles of this series, Vicki Searcy, president, consulting services at Morrisey Associates Inc. in Chicago, introduced the four basic components of clinical privileging. She examined establishing criteria for privileges as well as accepting applications for privileges and applying criteria.

1. Determining the scope of services that an organization will provide.

2. Determine the criteria (training, experience, behavior, skills) necessary in order to provide a specific service (or grouping of services) or procedures. Establish how exceptions will be handled.

3. Allow applicants to apply for privileges and

determine if they meet criteria. Make a decision and communicate it.

4. Monitor the individuals who are granted privileges to ensure their competence and practice within the scope of privileges granted.

In monitoring individuals who are granted privileges, **Vicki Searcy**, president, consulting services at Morrisey Associates Inc. in Chicago, says there are two components. The first component is to obtain data that show that practitioners are practicing within the scope of the privileges granted.

Several processes must be established to do this, she says. Patient care staff:

- "must be aware of their responsibility to monitor that practitioners practice within the scope of their granted privileges;
- must have a mechanism to find out what privileges have been granted to each practitioner;
- must know what to do if they identify that a practitioner is and/or plans to practice outside the scope of granted privileges (for example, a surgery scheduler should know what action to take if a surgeon wants to schedule a case for a procedure that he/she has not been granted privileges to perform)."

There are multiple ways this could be checked during an accreditation survey, she says.

A surveyor could:

- review a patient record and ask to see the credentials file of the practitioner caring for the patient to confirm that the practitioner has the requisite privileges.
- review the surgery schedule and ask a scheduler how he or she is aware of what privileges each surgeon has been granted. "If the scheduler stumbles and is unaware of how privileges can be accessed (either through electronic 'look-up' or accessing a privilege book), an adverse finding is likely," Search says.

Monitoring also requires that the compentency for practitioners who have been given new privileges be validated. This includes practitioners who are new to the organization as well as existing practitioners who apply for and are granted new privileges. "This requirement is called focused professional practice evaluation [FPPE] by The Joint Commission," Searcy says.

During a Joint Commission survey, a surveyor might ask to see the credentials file of a practitioner who was granted privileges within a year of the survey. "The documentation in the credentials file should identify how the competency of the practitioner was confirmed after he/she was granted privileges," Searcy says. This can be done by: proctoring, retrospective chart review, monitoring clinical practice patterns, etc. "It would be necessary to show that the full scope of privileges was included in the monitoring. For example, an OB/GYN with comprehensive obstetrics and gynecologic privileges should have been monitored on both obstetrics and gynecologic privileges," she says. "A file that shows that the practitioners' 'first six cases' were reviewed (which might have consisted of three D&Cs and three normal vaginal deliveries) would not validate competency for the full range of privileges granted."

Monitoring for practitioners who have been on staff for a period of time is called ongoing professional practice evaluation, or OPPE, she says. "The data collected for OPPE monitoring should cover the full scope of privileges granted," she says. Reports must be created and evaluated at regular intervals; every six to eight months is recommended, she says.

"The entire focus of OPPE is to continuously assess data to assure ongoing competency in the privileges which have been granted," she says. In order to do a full assessment, an organization has to know which privileges have been granted, those that have been denied, which privileges have been exercised, those that have not, as well as outcomes data from the exercise of those privileges. "An organization should have in place mechanisms to conduct these reviews and take action when necessary in order to assure that patients are treated only by those practitioners whose competency can continuously be documented," Searcy says. ■

NQF endorses new mental health measures

The National Quality Forum (NQF) has endorsed four outcome-based mental health measures looking at depression and patient satisfaction in an inpatient psychiatric hospital stay. The new measures are:

- depression remission at six months (from Minnesota Community Measurement);
- depression remission at 12 months (from Minnesota Community Measurement);
- depression utilization of the Patient Health Questionnaire (PHQ-9) tool (from Minnesota

Community Measurement);

• Inpatient Consumer Survey (ICS) (from National Association of State Mental Health Program Directors Research Institute, Inc.).

Hospital Peer Review spoke with the president of Minnesota Community Measurement, **Jim Chase**, about the three measures adopted from the group. "What's new and exciting about this is that these are measures that aren't just about a process of — our depression measures in the past have been medicine-compliance, which is important. But, what patients really want is, are they getting better over time? And, we think that by measuring that, we can also help providers to improve the care because that's what their goal is as well," Chase says.

Three measures, he says, relate to a "standardized patient assessment tool" — the PHQ-9. One measure is merely using it.

"The second two measures are then what we call remission," he says. Have patients' conditions improved significantly over time? He says clinicians actually check this now at the six- and 12-month mark. They also check if the patient is continuing to be treated, and did his or her score improve. "This is a really challenging measure, obviously, because depression is a really difficult condition; not everybody comes back. But we know that it's important for them to do and to stress that end," he says.

As the move for standardized measures in mental health increases, Chase agrees it's a new territory. With psychiatry, so much is based on patient perception. There are no X-rays, definitive blood tests, yes or no results. But, he says, the tool has been validated and "while, for any given patient, you may get variation around that, when you're talking about larger populations, which this is really about, you're going to get some very good indication of how you're doing compared to peers," he says.

Another important change with the adoption of the measures is addressing not only things you can control but "what I want the outcome to be for the patient. Could this be used in the ED? "I think there's a future for that. This particular measure was really meant to be used around when you have a patient in a practice setting where you're going to see them again. And in the ED, they're probably trying to screen them and refer them to someplace else. So, yeah, you could see how we're trying to do this a step at a time, but there's certainly going to be a call for other settings of care where it's more about screening and we're going to use patient-

CNE QUESTIONS

9. In its proposed rule on value-based purchasing, how many clinical measures did the Centers for Medicare & Medicaid Services include for FY 2013?

A. 10
B. 13
C. 17
D. 20

10. In the same rule, how many measures were excluded because they were "topped out"?

A. 7
B. 8
C. 9
D. 10

11. FPPE, according to The Joint Commission, stands for focused professional practice evaluation.

A. True
B. False

12. How many measures did the National Quality Forum recently endorse for mental health?

A. 2
B. 3
C. 4
D. 5

Answer Key: 9. C; 10. A; 11. A; 12. 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. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

functional status tools for that and getting them into treatment in a medical home that can follow up on them." ■

ED leaders reverse poor flow trends

Satisfaction ranking: From 'worst to first'

How's this for a turnaround? A few years ago, patient satisfaction levels in the three EDs of the Cambridge (MA) Health Alliance were in the lowest decile in Massachusetts, and now they are consistently in the top quartile. In fact, adds **Assad Sayah**, MD, FACEP, chief of emergency medicine for the system, "In the last couple of months, we've been in the first or second percentile in the state."

This turnaround in patient satisfaction is the result of a broad-based undertaking to improve patient flow and the patient experience in the EDs, which has achieved several other impressive results. For example:

- Door-to-doc time has been reduced from 90 minutes to 12 minutes.
- The rate of patients who have left without being seen (LWBS) has fallen from 4.8% to less than .5%.
- The average length of stay has decreased by 13% to 2.5 hours.
- The EDs, which used to be on diversion 8% of the time, have not gone on diversion in four years. During those four years, the total volume for the three EDs has risen from about 80,000 patients a year to 100,000 patients a year.

Shortly after he arrived, Sayah recalls, the ED leadership was put in charge of a multi-disciplined group whose task was to improve flow in and out of the ED. "When I got here, things had been done the same way for a very long time," says Sayah.

Sayah says he had a lot of support from the administration. The group he headed represented the ED, administration, radiology, the lab, and admissions. It included nurses and physicians, including hospitalists. Recommendations for improvement came from many different areas. "One person cannot affect change. You have to own flow as an institutional problem, not just the ED's problem," he says.

Still, it was the ED that had to lead the way, says **Luis Lobon**, MD, MS, FACEP, the site chief of emergency medicine at the Cambridge Hospital campus, who came on board shortly after Sayah did. "What was very clear from the beginning was that we needed to clean our own house," he says. "We were not expecting miracles from the other departments."

So, the ED "pioneered" the change by eliminating diversions two years before such a practice was mandated statewide. Lobon says, "By doing things of that nature, it sent a clear message that we were dedicated to changing the experience of the patient."

Still, says Sayah, the "biggest piece" of the process centered around the other departments. "You can do all you want to upfront, but if you can't decompress the ED from boarded and admitted patients, you are fighting a losing battle," he says. "Three of the five teams addressed these issues: doctor-to-doctor handoffs, nurse-to-nurse handoffs, and early patient discharges."

In terms of new process changes "up front," one

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

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

COMING IN FUTURE MONTHS

■ Easing the workload of data abstraction

■ More on credentialing and privileging

■ What's new in quality surrounding childbirth

of the most notable was the creation of the position of "patient partner." This is a non-clinical individual who Sayah likens to the host or hostess who first greets you when you enter a restaurant.

"They are helpful PR people who can answer your questions in more than one language," notes Sayah. On two of the campuses, that position is staffed 12 hours a day, and on the third that position is staffed 18 hours a day, he says.

"When the patient comes to the door, the first person that meets them is the patient partner," says Sayah. "He speaks to them in their language. If they cannot, we have a translation phone that answers immediately."

The patient partner asks the patient three questions — name, date of birth (or Social Security number), and chief complaint. "They do a 'mini-reg' which takes 30 seconds, after which that information is accessible by computer to all of us, so we can order tests and produce a chart," Sayah explains. "The patient partner creates the initial chart, puts the bracelet on the patient, and brings them to the ED immediately so there is no sitting involved."

There is no waiting room. In fact, Sayah adds, the reception areas ultimately might be converted to clinical use. Lobon says, "The most important principal involved here is that the patient comes to the ED to see a physician. They do not come to watch TV, or see a triage nurse, or talk to registration about insurance. They want a physician, and that's what we give them."

Most of the patients (those requiring sub-acute care) are taken to the rapid assessment area. "Historically this area was occupied by express care, [ED] administration, and triage," says Sayah. "We merged the space together and the staff together."

For example, notes Sayah, the department previously had one triage nurse and two express care nurses. Now it has three rapid assessment nurses. "There is no bottleneck," he says. "Two EDs have five rapid assessment rooms, and one campus has nine, all of which have nurses and PAs; the doctors have been moved to the acute side."

Sayah says that 40% of patients never move out of the rapid assessment area. Registration personnel will perform a bedside registration using a wireless mobile registration station. "The patient is discharged right from the same room," says Sayah. ■