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CMS draws mixed reviews with the release of proposed ACO rules

Beware of bias in quality measures, critics say

The release by the Centers for Medicare & Medicaid Services (CMS) of a proposed rule to govern the operation of Accountable Care Organizations (ACOs), a new form of organization that may consist of physicians, hospitals, other health care providers and suppliers, has drawn a mixture of praise and criticism from quality experts interviewed by *HBQI*. The rule, as is typical with CMS proposals, has been made available for public comment, and observers anticipate the final rules will be issued in the fall. The start date for the new program is Jan. 1, 2012. *(For more information on ACOs, see the January 2011 issue of HBQI.)*

The proposal outlines quality standards that ACOs must meet in order to benefit from financial incentives (The Medicare Shared Savings Program) being offered by CMS. They fall into five key areas:

- patient/caregiver care experiences;
- care coordination;
- patient safety;
- preventive health;
- at-risk population/frail elderly health.

ACOs could also be vulnerable financially if they fail to meet these standards. "An ACO will be rewarded for providing better care and investing in the health and lives of patients," said Donald M. Berwick, MD, CMS Administrator, in a statement released by CMS. "ACOs are not just a new way to pay for care but a new model for the organization and delivery of care."

KEY POINTS

- Patient-centered approach should lead to more consistent, efficient care.
- Timely sharing of data, multiple payment models seen as benefits to hospitals.
- Greatest concerns center around implementation difficulties.

"I think an ACO absolutely makes sense because it centers around populations of patients," says **Joan Phillips**, MSN, RN, ACNS-BC, administrative director and chief nurse executive, who oversees Integrated Medical Services for Beaumont Hospitals in Royal Oak, MI. "It's a great idea, but it will be challenging to meet some of the requirements."

The concept of an ACO "absolutely assists in coordinating patient care," she continues. "As a nurse I can tell you we try to be a 'nurse navigator' and help patients through the system, but that's hard even for us — and we *know* the system. One of its good points is that it helps create that continuum of care for patients to help link care from prehospital to hospital to outpatient to rehab. It will be a huge task, but once we do that our patients will get better care."

The program, she continues, also provides a focus on the patient in a more consistent manner. "Now, it's fragmented," she observes. "Every provider is concerned about their little domain; this helps connect those dots with the patient at the center. I hope it will decrease unnecessary testing and overall medical costs."

"It's a mixed bag," adds **Amanda Forster**, a spokesperson for Charlotte, NC-based Premier, Inc. "CMS got some things really right. For example, there's a real willingness to share timely data; upon request they will make performance data available on a monthly basis, and that's critical. They've also allowed for multiple payment models, so you can test a few different approaches. That's critical, too, because hospitals and health systems are definitely at different points in their journeys."

Forster says CMS got a lot of legal issues right, as well. "They cleared up things a lot around clinical integration, granting safe harbor, and antitrust concerns," she observes. "All those things were greatly helpful, and clear away a lot of barriers that had stood in the way of integration and overcoming fragmentation." She adds, however, "Some tweaking needs to be done for them to be more effective." *(The proposed rule and joint CMS/OIG notice are posted at: www.ofr.gov/inspection.aspx.)*

Why just Medicare?

One of Forster's criticisms of the program is that the approach may be too limited. "Pursuing accountable care is a smart move — a good move — but there are a lot of options on how to engage and with whom; Medicare is not the only market with which to pursue an ACO," she says. "There are lots of populations and potential payer partners we should be thinking about. You can start with your own system's employees, provider-sponsored plans, commercial insurers, unions, all of whom can work out different agreements. We've been working with our own accountable care collaboratives; members of our implementation group were working on accountability in the private market before any rule was out. From our experience, we've discovered a lot of different places where you can play and not necessarily be in the Medicare market."

Forster also says CMS should rethink the shared savings amount it has put forward. "We think it should be 70%-80% of the total versus 50%-60%," she says. "The reason is that, especially in the initial years, the investment required to trans-

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EDITORIAL QUESTIONS

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form your status quo model will be significant in terms of technology and process change."

Phillips also has concerns, particularly about technology. "Developing an IT infrastructure is probably the biggest challenge for most hospital systems; not only do they have to provide infrastructure in the system, but create a 'bridge' to the medical office for the physician, so there will be a smooth flow of information," she notes.

Another challenge, she continues, is that hospitals will have to create "medical homes" for patients within physician offices. "We'll have to do a lot of work to help practices create this medical home that meets all the CMS criteria," she says.

But will they work?

Paul Frisch, JD, senior compliance consultant, with Apgar & Associates in Portland, OR, has real concerns about whether hospitals and health systems should participate in ACOs. "I think it's a challenge; are they going to have the success or failure of the 10 large groups that worked in a CMS study for five years?" says Frisch, who previously served as general counsel to the Oregon Medical Association. "Six out of the 10 had problems, and only two of the 10 were actually profitable," he says. (*The New England Journal of Medicine* published an analysis of this demonstration project. See Reference 1 at the end of the article.)

"The question I raise is this: If these organizations that were essentially self-selected for their size, financial acumen, and for their expertise in delivering coordinated care couldn't make a go of it, what is to suggest that any group that decides to form an ACO will have any better luck — or more importantly, will they do worse and be a disaster?" Frisch says.

Many organizations think they can do better, he says. "If that's true, great — but I see it [the study] as a cautionary tale. Most organizations have no idea what kind of financial investment is going to be needed.

"If I were a hospital or a physician group, the first thing I'd want to do is take a very close look at the results of that study and see why we were different enough not to run across the same problems," he continues. "Also, I think a lot of tools identified as part of coordinated care, particularly EMRs, are overrated. Everything I read and people I've talked to think there is unrecovered reduction in production."

Concerns about guidelines

Frisch also has real concerns about guidelines. "The whole principle of this new type of managed care — and that's really what it is, just with a different vocabulary — is that since what we're looking for is excellent quality and low cost, guidelines are a holy grail," he says. "The dirty little secret is that everyone who works on them does not necessarily have to disclose conflicts of interest."

Frisch says that in a lot of the work done in clinical practice guidelines, it turns out that researchers received financial support from drug companies or medical device firms. "When people are considered experts, large companies come to them and pay them to give speeches about clinical matters that positively affect these drugs," he notes. "That's a very significant problem."

How might that impact ACOs? "It affects what guidelines to choose: Who's behind them, and who paid people to promote those guidelines? Nobody knows for sure," he says. If this were not an issue, he continues, we would not have seen the recent reports by the Institute of Medicine on developing standards for systematic reviews of clinical practice guidelines. *("Clinical Practice Guidelines We Can Trust": http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx.)*

"The IOM has it right; before we get too far into reliance on clinical practice guidelines, there needs to be a thorough vetting of them to make sure no undisclosed influence or biases exist, or if there is a lack of scientific evidence in support of the guidelines," Frisch says.

A done deal?

Quite often when CMS issues proposed rules, when the period for public comment ends and the final rules are issued, observers find that not much has changed. Frisch believes that will be the case here. "I think there will be a lot of public comment and a large record of industry comment, but as a practical matter I think it is a done deal," he asserts. "The reason I'm concerned with that is we really have a deadline at the end of this year, so whatever those rules dictate, things are going to be set in stone fairly quickly. It's probably more important with IOM calling for these standards, but I don't think there's enough time; people are in a rush."

Forster disagrees. "It's probably premature to say this ACO model makes sense or not because CMS made it very clear they want feedback," she says. "If you present good reasons for why something

needs to happen they are signaling that they're willing to make changes. So, whether people should make a 'yes' or 'no' decision really depends on what CMS needs to do next, and what we see in the final rule."

Forster adds that CMS "almost went out of their way to say CMS welcomes comments. The difference, say, between proposed rules for shared savings versus proposed and final OPPS [Outpatient Prospective Payment System] rules is that this is a wholly different concept for CMS to take on. They acknowledge that this is a totally new and different area for them, and that they're open to other opinions."

The other thing to bear in mind, she adds, is that while this is the "permanent program," CMS says it will be introducing some pilot programs that could also be based around accountable care principles. "So, for instance, you might want to participate in a bundle payment pilot with CMMI [The Center for Medicare and Medicaid Innovation]," Forster says. "There will be a lot of different tracks for Medicare, and then a whole spate of private and other payers."

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System achieves dramatic improvements

Key domains measured

Quality professionals will tell you that one of the greatest barriers to success is lack of physician buy-in; but that buy-in is often difficult to achieve. Imagine the challenge faced five years ago at the Rochester General Health System (RGHS) in Rochester, NY, when physician satisfaction surveys showed results as low as the 11th percentile. Today, those results are approaching the 90th percentile.

How did RGHS achieve such a dramatic turnaround? In short, it measured one key area at a time — i.e., administrative response time, communication, tools and equipment, ease of practicing medicine — and worked with physicians to address each one.

But this success was really part of a much bigger undertaking, says **Mark Clement**, president and CEO, who assumed his position five years ago. "We went to work on improving not only physician confidence in quality care delivery all over the system, but overall satisfaction with practice and the working environment," he says. "It was the result of a strategic planning process I took leadership through."

'Immersion' is first step

Clement says that after his arrival, he immersed himself in the system for 90 days, learning all he could about an enterprise that includes two hospitals, three long-term care facilities and several hundred private and employee physicians. He got out to the front lines of the different business units, spoke with affiliates, and met with physicians and other team members.

"Several themes emerged," he recalls. "Historically, the system had gone through a difficult financial turnaround, and that almost always leaves some challenges as relates to culture. I heard loud and clear from the doctors that they felt we were not as responsive as they wanted us to be; they did not have the kind of voice they wanted to have in terms of making improvement and identifying things they wanted to change. I also heard they did not find the practice environment as convenient and efficient — from the hours they worked to how they processed orders and shared information."

KEY POINTS

- Physicians involved in designing specific solutions.
- CEO "immerses" himself in system to obtain feedback from physicians.
- Significant improvements achieved in infections, mortality rates.

It also became clear to Clement that "Our long-term success really turned on our ability to improve clinical care, outcomes, patient safety, and working in greater alignment and partnership with the doctors. We believed the current finance and payment system was outmoded and the fee-for-service model had to give way to rewarding providers less for volume and more for value. We wanted to provide the best care in the most appropriate setting."

Quantifying the problem

The first step in any improvement, Clement asserts, is organizational awareness around the importance and the imperative of the improvement. "A lot of what I had heard was anecdotal; I wanted to quantify physician satisfaction," he shares. What he found was that satisfaction "was not that great. Our community hospital was around the 10th percentile, and our larger tertiary facility, Rochester General, was in the 30th."

Between 60% and 70% of the doctors participated, "So the results were representative of what they were thinking and feeling," he says.

Improving physician satisfaction, he continues, "really requires the entire organization to get behind the initiative. We shared the information pretty openly and widely, and did not sugarcoat it; we basically said 'It is what it is.'"

This, he says, created some discomfort within the organization, but that was intentional. "We worked to create an open, honest, transparent culture; a lot of organizations don't do that," he says. "We used the information to create discomfort around how we performed on a number of fronts — team-member satisfaction, patient satisfaction. Then, everyone considered it important to develop a patient-centered, team-based model."

Organizing improvement teams

Once Clement created larger organizational awareness and the imperative that things needed to improve, he began to organize teams. "If we had done this within a vacuum, without those elements, I think it would have been less effective," he says.

Areas requiring improvement were addressed by both system initiatives and "local" initiatives, Clement says. "We created a systemwide steering group to address physician satisfaction — key physician leaders, department chiefs, two very strong executive champions — senior executives from each of the two hospitals — and me," he says. "We helped set priorities, and cascaded both them and improvement expectations to the local level."

So, for example, community-based physicians had expressed displeasure with how the ED communicated with them when they treated their patients; there was also general dissatisfaction with the level of quality care and timeliness in the ED.

"We sought to improve not only quality of care but wait times, the number of patients who left without being seen, overall patient satisfaction, and the way they communicated back to the primary care providers," Clement says. We held the ED leadership, the chief of emergency medicine, nursing leadership, and the administrator accountable; they were challenged to go to work on and fix those issues." Over a 12-24 month period, he reports, "We saw dramatic improvement."

Another issue was raised by the hospitalists, who handle 70%-80% of the hospital's admissions. "We heard complaints about handoffs — communication at critical decision-making times during the patient stay and at discharge, as well as communication and collaboration with primary care providers," Clement says. "We pulled a PI team together to develop clarity around communication standards. For example, at the point of admission, what are the expectations of the hospitalists? When critical clinical decisions have to be made, such as whether surgery is needed, which of them require collaboration with the community-based primary care provider?"

Clement specifically asked the chiefs of services and administration leaders to assume responsibility for physician satisfaction scores. He adds that he believes in "an alignment, accountability and performance management system that cascades system goals and imperatives; all clinical and administrative leaders need their own goals." So, for example, the chief medicine at Rochester General has an annual goal related to improving physician satisfaction.

"Satisfaction has gone to well above the 80th percentile in the last three or four years, with dramatic improvement in virtually every area," Clement reports. "And physician confidence in quality of care is in the 90th percentile."

Physicians are essential

During the past several years a number of successful quality initiatives have been undertaken by RGHS, but Clement says success would not have been possible without involvement of the

physicians. "It can't be done without the active participation and collaboration of physicians and physician leaders," he says. "As a result of my initial immersion, it was clear that in order to improve clinical outcomes, patient safety, and all the areas we needed to improve, we needed to engage our physicians." The system has invested a great deal in physician leadership, he adds, including Leadership Development Institutes held three or four times a year.

"We have saved lives as a result," he notes. "For example, our infection rates have dropped rapidly; we've gone 600 days without a central-line infection."

All of this fits within the overall vision Clement has brought to the system. "Over the last three years, through a strategic planning process we developed a vision that is part of what the whole organization is trying to do," says **Christine D'Amico**, vice president of organizational development. The plan is expressed around key "pillars," that include service, quality, people, financial performance, and growth.

"If you are a physician leader and have a position of authority, you have goals tied to the pillars," explains **Richard Gangemi**, MD, senior vice president for academic and medical affairs. "So, for example, it has been a system goal to decrease mortality, and physicians will have quality goals — whether they are related to central-line infections, urinary-tract infections, or surgical-site infections — and as they work on those goals to improve their scores they are aligned to drive adverse events and mortality rates down."

This type of data, he adds, has in turn helped raise physician satisfaction. "If you look at the goals, there is clarity as to where we want to go, how we will measure success, and how we will measure outcomes," says Gangemi. "Clarity is the pleasing part to the doctors."

This success required the participation of numerous physicians, he continues. "We have 600 managers, and most of them have quality goals," he shares. "Many of them are around issues like decreasing infections, decubitous ulcers, proper use of antibiotics, reducing MRSA or *c. difficile*, and so on. As those leaders reach their goals there's a cumulative effect; it all adds up and affects the mortality rate."

Board is critical

Gangemi adds that it's impossible to overstate the importance of the board's role in this success. "Most systems spend the lion's share of their time around finance and strategy and growth; our board spends the first half hour to 45 minutes of their meetings solely on quality," he says.

In fact, he continues, "The dashboards we have around quality and safety actually had a large contribution from them — what they wanted to see, how visually they felt more comfortable looking at certain display methods, and what was more meaningful to them," says Gangemi. "So, while we could show them graphs, they wanted us to punctuate the mortality rate report with the number of lives saved. They wanted us to say, 'We saved 15 lives this month.' That was more meaningful to them."

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Protecting workers said 'integral' to quality care

OSHA rule, respirator design supported

The H1N1 influenza pandemic might prompt lasting changes in the personal protective equipment for healthcare workers and the rules that govern them.

In the wake of the pandemic, a new report from the Institute of Medicine (IOM) supports the creation of an infectious disease standard with protections that parallel those in the Bloodborne Pathogens Standard. The Occupational Safety and Health Administration (OSHA) has included such a standard in its regulatory agenda, although no draft language has been issued.

The IOM panel also supports the establishment of standard criteria for facemasks and the development of a powered air-purifying respirator (PAPR) specifically for healthcare.

Although the report is primarily designed to guide future research, it wades into issues that have been hotly debated and urges that they not be sidelined until the next pandemic. Healthcare providers need clear guidelines about how to protect workers from a novel viral respiratory infection,

and there needs to be more research on the protections provided by facemasks compared to respirators, the panel said. The bottom line: "While there are clear gaps and deficiencies in our knowledge base…there should be universal acknowledgement that PPE [personal protective equipment] use is an integral component of providing quality health care."

The IOM report is an important step toward a respirator that healthcare workers will tolerate and wear, says **Lewis J. Radonovich**, MD, director of the National Center for Occupational Health and Infection Control in the Office of Public Health and Environmental Hazards of the Veterans Health Administration in Gainesville, FL, and Washington, DC. "What's needed now is development of respiratory protection devices that are tailored to the needs of healthcare workers," says Radonovich, who is spearheading a project to work with manufacturers on improved design.

Confusion over H1N1 guidance

From supply shortages to differing guidance, challenges emerged for facilities in the effort to protect healthcare workers from the novel influenza virus.

The Centers for Disease Control and Prevention (CDC) advised using N95 respirators when caring for patients with the novel influenza, but some state or local health departments recommended using facemasks unless performing aerosol-generating procedures. "Delayed and/or disparate recommendations often led to confusion among health care personnel and their employers, who had to decide what to tell personnel about what type of PPE to wear and when," the IOM panel said.

The result was that healthcare workers in different parts of the country or at different facilities received different levels of protection from the H1N1 influenza. "During the 2009 H1N1 pandemic, the California standard was the only workplace standard in the United States that required a mandatory level of worker protection to be provided to health care personnel," the panel said.

Bill Kajola, industrial hygienist with the AFL-CIO in Washington, DC, and a member of the IOM panel, says, "What we found was wide variation in the use of personal protective equipment during the H1N1 pandemic. Some employers adhered to the CDC and OSHA guidelines in their entirety; other employers followed some of the recommendations; and other employers did very little." An infectious diseases standard "is a means to put everybody on the same level playing field as far as the protections that all healthcare workers should expect," he says. *(Editor's note: The IOM report, "Preventing Transmission of Pandemic Influenza and Other Viral Respiratory Diseases: Personal Protective Equipment for Healthcare Personnel Update 2010," is available for free download at www.nap.edu/catalog.php?record_id=13027.)* ■

Why aren't patients in compliance?

Low health literacy leads to poor outcomes

When patients don't follow their discharge plan and end up back in the hospital or fail to keep their chronic disease under control, resulting in complications, it could be that they simply don't understand what they're expected to do.

Patients have to understand what their health care providers are telling them. If case managers can't communicate effectively, it doesn't matter how much time you spend teaching patients about their condition and how to manage it. They're not going to follow their treatment plan if they don't understand it, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA, firm.

"There's often a big gap between what the healthcare professional thinks was explained and what the patient and family members understand. Healthcare can be complicated with so many diagnoses, medications taken many different ways, and so many levels of care that people who are literate, savvy, and interested may still be confused," Osborne adds.

Low health literacy is a problem that leads to poor medical outcomes for millions of Americans and adds millions of dollars in costs to the healthcare system. People with low functional health literacy have higher rates of healthcare utilization and $50 billion to $73 billion in additional healthcare expenditures, according to the Partnership for Clear Health Communications at the National Patient Safety Foundation.

A new report by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) found that low

health literacy in older Americans is linked to poorer health status and a greater risk of death. The report also found an association between low health literacy in all adults and more frequent use of hospital emergency rooms and inpatient care, compared with other adults. The report updated a 2004 literature review and included findings from more than 100 new studies.

The inability of many Americans to read, combined with the use of medical jargon that even people who can read have difficulty understanding, creates a tremendous healthcare literacy problem, adds **Gloria Mayer**, RN, EdD, chief executive officer for the Institute for Healthcare Advancement based in LaHabra, CA.

"When patients aren't familiar with the terminology the case manager uses, they miss the message and they don't understand what they need to do so that translates into non-adherence," she says. About 90 million adult Americans can't read above the fifth grade reading level, Mayer says, pointing out that most health education materials are written between the eighth grade and college level.

Don't confuse health literacy and literacy, Osborne warns. "Being a struggling reader is just one reason why some people have trouble understanding healthcare instructions," she says. There's no way to determine a patient's healthcare literacy just by looking at them or talking to them. "Somebody may be well educated and have a good job but doesn't understand medical terminology," Mayer adds.

As people age, health literacy levels often decline just at the time they may be experiencing more chronic conditions, taking multiple medications, and dealing with the stresses of life. "Older people may also have diminished hearing, vision, or memory, making it even harder for them to understand," Osborne says. "When people are in pain, afraid, or sick, they're often overwhelmed and at least for a while, nothing they are told sinks in," she says.

Understanding medical terms and instructions can be particularly difficult for people for whom English is not their first language, Osborne says. "A person may have the words to talk about the weather or food but they may not have the fluency needed to understand their health conditions and ask questions," she says.

Be aware of the subtle differences in languages, Osborne says. For example, when native English speakers are told to take medication once a day, they take it one time. But in Spanish, the word "once" means eleven. "People may be taking 11 times the right amount of medication because of the word choice," she says.

"When patients transition from the emergency department or the inpatient hospital to home, or the hospital to a post-acute facility, the patients and caregivers assume a great deal of responsibility for seeing that the patient follows the treatment plan and avoids readmissions," Osborne says. "Often, it involves mastering new concepts, learning unfamiliar terms, and having expectations placed on them that are hard to meet."

Mayer advises healthcare professionals to speak in "living room language" and avoid medical jargon when talking to patients. Instead of using terms such as "myocardial infarction" use "heart attack." Substitute "pee" for "urine," and use "X-ray" instead of "radiology," Mayer suggests.

Remember that patients can absorb only two or three things at a time. Even if you have 20 items on their chart that need discussing, break it into small portions. "If people are sick, they are even less likely to understand everything you are telling them," Mayer adds.

Instead of telling patients to take medication with food, be more specific: Advise them to take it after a meal or with a cracker, depending on the medication, she says. If you tell patients to take a medication twice a day, they may take it an hour apart. "Instead, say take one pill at breakfast and one at dinner," Mayer recommends.

Know your audience, Osborne advises. Look at where they are along the continuum of care, and gear your educational efforts to that. "Someone who is newly diagnosed with a serious illness looks at things very differently from someone who has been living with the condition for years," she says.

"Case managers who work with patients over the telephone have an added challenge because they can't see the other person's expression or know if they are distracted," Osborne says. "If you're not communicating face-to-face, ask the patient if now is a good time to talk, and listen carefully for cues that they may not understand."

Mayer says, "Make sure that any written materials you give patients are in simple language. Avoid giving patients brochures from pharmaceutical companies because they tend to use medical jargon." Instead, rewrite the information on the brochures using easy-to-understand language.

Materials you give your patients should be

written on a fifth grade level. If the material is describing how to do something, like giving yourself an insulin injection, pictures can be invaluable.

"Some people argue that college-educated patients would be insulted by easy-to-read materials but in fact, nobody ever complains that something is too easy to understand. That's why we should make it easy for everyone to read, regardless of their literacy level," she says. ■

Home monitoring cuts cardiac readmissions

Program gets patients to follow treatment plan

When Ocean Medical Center in Brick, NJ, and Meridian At Home care agency collaborated on a remote monitoring program for heart failure patients, the readmission rate for heart failure dropped from 14.93% before the program began to 4.84% in the first eight months of the pilot program.

The project received the first-ever Excellence in Quality Improvements Award from the New Jersey Hospital Association.

The program provides appropriate heart failure patients with remote monitoring devices on a temporary basis in an effort to get them in the habit of weighing themselves daily and calling the doctor when their symptoms indicate that they are experiencing exacerbations, says **Sandra Elliott**, director of consumer technology and service development at Meridian Health. A remote monitoring nurse case manager continues the education the patients received in the hospital and helps them understand what is causing their weight gain and how excess weight can impact their ability to breathe, she says. "Rapid weight gain in heart failure patients can signify water retention, which is a tell-tale sign that something is wrong with the operation of the heart," Elliott says. "This program offers great benefits to the patient. They can remain under the watchful eye of the hospital in the comfort of their own home, and the patient's health can be monitored and tracked in an extremely accurate and safe manner."

When administrators of the health system began analyzing the impact that healthcare reform would have on its hospitals, they determined that hospital readmissions are one area in which the health system is at risk for losing reimbursement. Ocean Medical Center was chosen for the pilot project because the hospital serves a large population of older retirees with chronic diseases and was experiencing a high rate of readmissions for heart failure, Elliott adds. When the heart failure readmissions prevention team reviewed the medical literature, it determined that many patients with heart failure who were readmitted were not comfortable in assessing their own symptoms, which led them to delay seeing their doctor until the symptoms were so severe that they ended up in the emergency department or were readmitted to the hospital. The team looked at available technology and explored ways to make it work financially.

"We wanted something that was easy to implement and low-cost and that easily could be adapted at other hospitals in the system," she says. "I got involved because my role is to focus on everything outside the traditional health system walls to help people through technology to take care of themselves as best as possible."

Case managers at Ocean Medical Center assess their heart failure patients for eligibility in the program and work with the pilot project coordinator to educate the patients and their families about the program and enroll them. Patients who are eligible for the program must be cognitively capable of using the equipment, be able to manage at home without help, and have eyesight that enables them to read a scale. Patients who are in active treatment for other major diseases, such as cancer, are not appropriate for the program, Elliott says.

The nurse case manager in the hospital educates the patients about heart failure, the importance of monitoring their weight, ways to keep the condition under control, and signs and symptoms that indicate they should call their doctor. The nurse case manager at the home health agency continues the education after patients are enrolled in the program.

A home care agency nurse installs a comprehensive remote monitoring device in the homes of patients receiving home care. The device measures vital signs including weight and blood pressure and asks the patient questions about their health every day. Patients without home care services receive a wireless scale and a cell phone communicator, a special type of cell phone that is pre-programmed to transmit data to the home care agency computer system. They are signed up

to an automatic calling system that places a call every day and asks patients key questions, such as their weight, any swelling, breathing problems, or other issues.

When patients submit answers that indicate they might be having an exacerbation, the telemonitoring nurse receives an alert. That nurse calls the patient and talks with them to find out what has been going on. "Many times, the patient just needs some additional education," Elliott says.

"The nurse repeats the education the hospital case manager presented but often education at the right moment is more effective." For example, the nurse was able to identify that one patient's weight gain occurred when he ate rotisserie chicken from a particular market and wasn't aware of the high sodium content. "No booklet tells patients that rotisserie chicken has so much sodium it will adversely impact their condition," Elliott says. "The nurse takes advantage of the teachable moments."

When the remote monitoring nurse calls patients, she assesses the situation and often suggests that the patients call their physicians. The nurse might call the doctors' offices to alert the staff to expect the calls, but has the patients make the calls themselves so they'll become accustomed to taking charge of their own healthcare, Elliott says.

Patients who do not receive home care services stay in the remote monitoring program for a minimum of 30 days and have the option of continuing the monitoring for an additional 60 days at no charge. Patients who are receiving home care services are switched to the wireless scale and cell phone communicator monitor when their home care visits are completed.

The organization is analyzing whether making daily automated phone calls without providing the wireless scale and cell phone communication is as effective as the combination of the phone calls and the technology. The calls cost less than 10 cents a day, compared to $600 for the wireless scale and cell phone communicator, Elliott points out. "The purpose of this program is to get patients accustomed to monitoring their weight and symptoms so they know when to see the doctor and avoid emergency department visits and hospitalizations," she says. "It takes about three weeks of monitoring to change behavior. When we identify the most cost efficient ways to help patients avoid rehospitalization, we plan to roll the program out to other hospitals." ■

TJC proposes 90% flu shot goal

Standard modeled after HHS plan

Proposed changes in a Joint Commission infection control standard may accelerate the trend toward mandatory influenza vaccination policies.

The Joint Commission accrediting body, based in Oakbrook Terrace, IL, requested comments on changes that would set a goal of 90% for influenza vaccination of staff and licensed independent practitioners, such as physicians, by 2020.[1]

While the Joint Commission is not specifically advocating mandatory influenza vaccination, hospitals that have rates above 90% often have such a policy.

"We think we can get there [with voluntary programs] through education," says **Bill Borwegen**, MPH, health and safety director with the Service Employees International Union (SEIU). "But if this is a de facto mandatory requirement, we think it's a massive overreach that isn't demonstrated by scientific evidence."

In fact, the Joint Commission is recommending a goal, not a policy, says **Robert Wise**, MD, vice president of the division of standards and survey methods.

"We are not suggesting it be a mandatory requirement. This [decision] is really at the level of the hospital," says Wise, who notes that the target date is in nine years.

The Joint Commission cites the 90% goal in the U.S. Health and Human Services Action Plan to Prevent Healthcare-Associated Infections.[2] However, the action plan simply notes the Healthy People 2020 goal of 90% vaccination of health care personnel. It also points out the variation in vaccination rates among different health care settings and differences in measurement among different facilities.

"Coverage among health care personnel working in hospitals was over 60%, while for those health care personnel in long term care facilities coverage is well below 50%," the action plan says. "Healthcare settings should tailor their strategies to their setting, workforce, and region."

The Joint Commission plans to issue a final standard before the start of the 2012 flu season, Wise says. The accrediting agency aims to raise the dialogue and emphasize the importance of increasing vaccination rates, he says. Hospitals

may choose to avoid the pushback that can occur with mandatory policies, including potential legal issues if employees are unionized, by opting for voluntary programs, he says.

"There is more attention now than ever before about this issue and there's more debate than ever before. We'll find out what's successful and what's not, and people will learn from each other and how to achieve [the goal],"he says.

The Mayo Clinic in Rochester, MN, has achieved a vaccination rate of about 80% with a voluntary program. **William Buchta**, MD, MPH, medical director of the Employee Occupational Health Service, notes that the Joint Commission will judge hospitals on their compliance with their own policies and program aimed at meeting the goal, not on the attainment of the goal itself.

"I think you can stay within the Joint Commission standards without making it mandatory, you just have to be very careful in how you word your policy," he says. "They're very forgiving about not meeting goals as long as you have a plan."

For example, Buchta says he could envision a policy that sets a mandate in units with especially vulnerable patients, such as bone marrow transplant or neonatal intensive care.

Employees in those units who did not want to be vaccinated could transfer to other positions in the hospital but would not lose their jobs, he says.

A policy also would have to account for years in which there are vaccine supply disruptions, leading to lower vaccination rates.

Meanwhile, as the years go by, technology changes.

"Hopefully, we'll have a better vaccine by 2020," he says, noting that a mandatory vaccine policy would be easier to implement and more acceptable if it was a one-time vaccine. "Hopefully in five to ten years this argument will be a moot point. That's what I would love to see."

REFERENCES

1. The Joint Commission. Standards Field Review: Influenza Vaccination of Staff and Licensed Independent Practitioners. Oakbrook Terrace, IL. April 5, 2011. Available at http://bit.ly/dKiioP.
2. U.S. Department of Health and Human Services. HHS action plan to prevent healthcare-associated infections: Influenza vaccination of healthcare personnel. Available at http://1.usa.gov/m19whI. ■

Professional group targets patient safety

Patient safety professionals are moving toward more prominence and stature in the health care community with the recent launch of the first professional organization devoted to their work.

The American Society of Professionals in Patient Safety (ASPPS), based at the National Patient Safety Foundation (NPSF) in Boston, officially launched recently as the first and only individual membership program for the patient safety field. The announcement was made by **Diane C. Pinakiewicz**, president of ASPPS and NPSF.

Established to advance patient safety as a unique and vital health care discipline, the ASPPS was created to build an engaged, focused community of individuals committed to accelerating the delivery of safe patient care, Pinakiewicz says. The ASPPS made its debut with 175 inaugural members.

"Ensuring patient safety has never been a more important priority for our healthcare system," says Pinakiewicz. "For too long, the patient safety field has lacked needed cohesion and lines of communication. Today, we are taking the next step toward establishing the consistency in safety practices and tools that will help healthcare professionals keep patients safe."

The ASPPS also announced plans to establish a certification program designed to elevate the patient safety profession through patient safety competencies.

Using criteria determined through clinical research and review of best practices, the certification for professionals in patient safety (CPPS) will enable healthcare professionals to implement strategies to reduce medical errors. Taken

COMING IN FUTURE MONTHS

- 'Partnership for Patients' wins widespread support from quality community
- New behavioral health treatment options offered with 'comfort rooms'
- Medicare patients spending less time in the hospital at end of life

together with membership in the ASPPS, this certification program will provide a level of professional development for patient safety practitioners that has not previously existed, Pinakiewicz says.

The CPPS certification program is expected to begin in January 2012, she says.

"The ASPPS and the CPPS certification will bring a level of professionalism to the work," Pinakiewicz says. "It also will bring some standardization to the competencies so that when someone is certified, we can feel comfortable there are certain things they know and know how to do."

Membership in the ASPPS is open to professionals whose primary responsibility is patient safety, including risk managers. Others who could be eligible include medical students, providers, quality leaders, and patient safety advocates.

"The need for a patient safety professional organization began to emerge as we saw risk management evolve from a reactive effort to a more proactive discipline to improve patient safety," Pinakiewicz says. "The ASPPS was established in recognition of the fact that patient safety is a discipline that has competencies associated with it, that people have a strong commitment to, and that people need a structure to organize around."

More information about the ASPPS is available at http://www.npsf.org/hp/ASPPS.php. ■

NHPCO publishes new report on end-of-life care

The National Hospice and Palliative Care Organization (NHPCO) has published a report about end-of-life care, emphasizing the importance of more personal and private discussions about the topic.

"Private Conversations and Public Discourse: The Importance of Consumer Engagement in End-of-Life Care" provides a framework and national agenda for consumer engagement in end-of-life issues, according to the NHPCO.

The report addresses several stakeholders, including individuals, healthcare providers, policymakers, employers, and the media.

The report is available as a free download at caringinfo.org. ■