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AHC Media

Report to Congress gives structure to healthcare reform requirements

HHS report outlines priorities, goals, and sample strategies

Some states have highly developed quality improvement organizations (QIOs) that have for years worked with healthcare organizations to improve quality, share information, and tackle problems. But those states that have not made it a priority will have to in order to meet requirements set out by the National Quality for Strategy, released late in March by the Department of Health and Human Services.

The report to Congress aims to give structure to health care reform's requirement to promote higher-quality and lower-cost healthcare (it is available online at http://www.healthcare.gov/center/reports/quality03212011a.html#container) and focuses on three aims: providing quality care, promoting healthy communities, and reducing costs associated with health care. The first of those aims directly affects quality professionals, with a stated goal of making care better, more patient- and family-centered, and safer.

The report also lists six priorities:

- making care safer by reducing harm caused in the delivery of care;
- ensuring that people and families are engaged as partners in their care;
- promoting effective communication and coordination of care;
- promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- working with communities to promote wide use of best practices to enable healthy living;
- making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

It is the first four of these that have the most impact for hospital QI departments.

Among the specific tasks for QIOs working closely with providers at all levels is to create QI programs that meet specific goals outlined in the strategy — for example, reducing deaths from cardiovascular disease. Another task set out for QIOs is to "drive quality improvement through collaboratives at the State level…" while also noting that local-level efforts are a vital resource.

"I noticed right away that they didn't mention any tactics in the report," says **Jonathan Sugarman**, MD, MPH, chief executive officer of Qualis Health, which serves as the QIO in Washington state and Idaho. "I think it's

by design that they don't have a lot of measures in this initial report. This is just a high-level framework that is open to discussion right now."

He does find it interesting that this came out just as many QIO contracts were coming up for bid, and requests for proposal — called a statement of work — have been released. "The Centers for Medicare & Medicaid Services (CMS) have let it be known that they want to make the scope of work we are tasked with highly aligned with this strategy," says Sugarman.

The appendix and the list of priority areas *(see chart pp. 64-65)* offers a glimpse at how connected QIO work, CMS goals, and strategy goals will be. For instance, one goal is to eliminate preventable healthcare-acquired infections (HAIs). CMS, meanwhile, has called for a reduction in central-line infections. The statement of work for the QIOs also mentions catheter-associated urinary tract infections (UTIs). Sugarman says that it is clear that all parts of government related to healthcare seem to be converging on similar issues of import.

While this may mean that some QIOs have to merely continue on the paths they are already walking, for others it will mean new work, Sugarman says. Some states haven't jumped on the QIO bandwagon. Legislatures haven't had it on their radar and, with money tight, it's not something they look forward to implementing now. "There are states that have robust reporting and some where politically, they haven't demanded it," he says.

Similarly, there are QIOs that exist and are strong, but haven't been as collaborative with local organizations as the strategy implies is going to be necessary. In Washington, there have been nearly six years of collaboration between Qualis and local health departments on issues related to antibiotics. Other places may not be used to working together at that level. Some hospitals, likewise, will have to learn to work with their competitors in ways that are new and different from the way they are used to working.

Healthcare providers and facilities will also have to get used to providing more information for consumers, Sugarman says. "We are used to federal reporting, but attention is going to be increased and become much more universal than it is now. Payment approaches are also going to bring more emphasis to this."

May you live in interesting times

Sugarman says he'll be watching how local and federal priorities intermingle. "We want local priorities to include nationally significant issues," he notes. "The interesting devil in the detail is that some communities have the infrastructure to do this. It will be of note to see how well QIO contractors are able to align what they are doing at the federal level and how they can combine activities to ensure they are not doing two processes to work on the same thing. And how it will be measured isn't clear yet.

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Here's an example: the National Healthcare Safety Network requires infection rates as the measure for central-line associated bloodstream infections. That may not jibe with what works on a local level, depending on the processes used. Purchasers may want some other method of measurement. What do you do to make sure you don't have to do the same thing twice over? Another area of confusion might be on reducing readmissions. But how do you define what is preventable and what isn't? How do you note what is a planned readmission and what is because you left a sponge in someone? "I don't think anyone will say that every readmission is a bad thing," Sugarman says.

There is also likely to be a greater emphasis on giving patients a role in QI projects. "Best practices in patient safety all have patients involved — and not at a distance. This is familiar to staff at some hospitals, but unfamiliar at others. What are the implications of that?" There are hospitals that fear that close engagement, while others — like Virginia Mason in Seattle — have become committed to putting patients at the table "at every level," Sugarman says. "This isn't explicit in the strategy document, but the priority on developing the capacity to act on patient-reported information means I think you have to think about integrating more patient feedback into your QI."

This and other details still have to be worked out — the initial report is just a starting place, designed "to begin a dialogue that will continue" throughout this year, the report notes. Future versions will include more specifics, as well as long- and short-term goals.

In future issues of *HPR*, look for stories that further outline how the National Strategy for Quality will impact QI departments and what you can do now to be ready.

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MRSA program reaps rewards at VA

Prototype expanded throughout the system

Mention the U.S. Department of Veterans Affairs (VA) hospital system to QI professionals and you'll likely hear about any of the dozens of projects and programs developed at the VA that have percolated throughout the country — and beyond — with great positive impact on patients.

A month ago, one of the VAs biggest successes — combating methicillin-resistant Staphylococcus aureus (MRSA) — was trumpeted in the *New England Journal of Medicine*[1]. It started out as a project at one VA facility in Pittsburgh in 2002, says **Rajiv Jain**, MD, chief consultant of specialty care services in the VA Office of Patient Care Services. "The objective then was to see if a bundled approach of strategies was put into the surgical, and then intensive care units, if we would decrease MRSA infections."

The bundle consisted of checking every patient's nasal cavity for the presence of MRSA, using universal precautions for patients who tested positive, hand-washing protocols, and changing the culture of the facility to ensure that infection control was not just the responsibility of doctors and nurses, but of every single person who had contact with the patient.

The result was a "significant" decrease in MRSA infections, Jain says. They expanded it to all units in Pittsburgh with enough success that in 2007, the protocol was expanded to all VA facilities.

The national project, which measured rates between 2007 and 2010, resulted in a decline from 1.64 infections per 1,000 patient days to .62 per 1,000 patient days in the ICU. In non-intensive care settings, the MRSA infection rate fell by nearly half, from .47 per 1,000 patient days to .26 per 1,000 patient days.

Going from a local effort to a national one isn't easy. Jain says they were concerned about making it work in 150 facilities when each one had its own particular issues. To that end, they brought people from each facility to Pittsburgh first to see how it worked there, how each component of the bundle was implemented, and get feedback from those who used it daily.

After launch, the team was available to provide guidance to any facility that needed it.

Martin Evans, MD, program director for multidrug-resistant organisms at the VA Office of Infectious Diseases, says Jain's insight was to find a single person at each facility as a key person to provide support — the MRSA Prevention Coordinator — whose role it was to ensure that the protocol stayed up and running smoothly, to monitor success, deal with problems, and troubleshoot any issues that arose.

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National Quality Strategy Priorities and Goals, With Illustrative Measures

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
#1 **Safer Care**	**Goal:** Eliminate preventable health care-acquired conditions **Opportunities for success:** • Eliminate hospital-acquired infections • Reduce the number of serious adverse medication events **Illustrative measures:** • Standardized infection ratio for central line-associated blood stream infection as reported by CDC's National Healthcare Safety Network • Incidence of serious adverse medication events
#2 **Effective Care Coordination**	**Goal:** Create a delivery system that is less fragmented and more coordinated, where handoffs are clear, and patients and clinicians have the information they need to optimize the patient-clinician partnership **Opportunities for success:** • Reduce preventable hospital admissions and readmissions • Prevent and manage chronic illness and disability • Ensure secure information exchange to facilitate efficient care delivery **Illustrative measures:** • All-cause readmissions within 30 days of discharge • Percentage of providers who provide a summary record of care for transitions and referrals
#3 **Person- and Family-Centered Care**	**Goal:** Build a system that has the capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with health care **Opportunities for success:** • Integrate patient feedback on preferences, functional outcomes, and experiences of care into all care settings and care delivery • Increase use of EHRs that capture the voice of the patient by integrating patient-generated data in EHRs • Routinely measure patient engagement and self-management, shared decision-making, and patient-reported outcomes **Illustrative measures:** • Percentage of patients asked for feedback

National Quality Strategy Priorities and Goals, With Illustrative Measures

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
#4 **Prevention and Treatment of Leading Causes of Mortality**	**Goal:** Prevent and reduce the harm caused by cardiovascular disease **Opportunities for success:** • Increase blood pressure control in adults • Reduce high cholesterol levels in adults • Increase the use of aspirin to prevent cardiovascular disease • Decrease smoking among adults and adolescents **Illustrative measures:** • Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg • Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100 • Percentage of patients with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period • Percentage of patients who received evidence-based smoking cessation services (e.g., medications)
#5 **Supporting Better Health in Communities**	**Goal:** Support every U.S. community as it pursues its local health priorities **Opportunities for success:** • Increase the provision of clinical preventive services for children and adults • Increase the adoption of evidence-based interventions to improve health **Illustrative measures:** • Percentage of children and adults screened for depression and receiving a documented follow-up plan • Percentage of adults screened for risky alcohol use and if positive, received brief counseling • Percentage of children and adults who use the oral health care system each year • Proportion of U.S. population served by community water systems with optimally fluoridated water
#6 **Making Care More Affordable**	**Goal:** Identify and apply measures that can serve as effective indicators of progress in reducing costs **Opportunities for success:** • Build cost and resource use measurement into payment reforms • Establish common measures to assess the cost impacts of new programs and payment systems • Reduce amount of health care spending that goes to administrative burden • Make costs and quality more transparent to consumers **Illustrative measures:** • To be developed

SOURCE: US Department of Health and Human Services

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"You can say we are one system, but things are local," says **Gary Roselle**, MD, program director at the VA Office of Infectious Diseases. "The mission was to have central guidance, but local implementation. It's not that we ever changed the bundle itself, but implementation strategies were local. I'd bet there were 150 different ways this was implemented."

Jain notes that local modifications included deciding what intensive care unit to select — some chose coronary care, some chose the medical ICU. "All we cared was that it was an ICU first." When they were told to expand the program, they decided where to go next — a surgical ward or some other unit.

The choice of where to put the hand sanitizing dispensers — most chose by the door, but location didn't impact outcomes — and whether to use a rapid or standard MRSA test were also left to each VA facility.

No part of the bundle is off-the-charts strange — although there are some hospitals that weren't used to and weren't happy about testing every patient for MRSA. But Roselle says having a checklist makes a difference in outcomes. "You may think each item itself is straightforward, but you have to make sure each item is checked off, all the time and every time."

Jain says that bundles are useful and are often used — but usually just in the ICU. What makes this different is that MRSA impacts more than the ICU, and this bundle can be applied across all acute care units.

The positive impact of the program was not a surprise. The degree of change? Roselle notes that it was "a nice reward." Another positive that came out was a reduction in some other difficult organisms that plague hospitals. Evans says that some of the VA hospitals looked at vancomycin-resistant enterococci (VRE) and C. difficile.

"Much of the way they are spread is like MRSA," says Evans. "We thought that the components of the MRSA efforts, and the culture change resulting, would probably impact other organisms." In ICU and non-ICU settings, facilities that looked, indeed, found a reduction in VRE rates, and in non-ICU settings, C. difficile rates decreased. "They weren't the targets, but they were impacted."

One other note the physicians made related to another study in the same issue of *NEJM*. Huskins et al found that looking for MRSA and VRE in ICU patients — and then implementing a barrier precaution protocol for those who test positive — didn't affect infection rates. The lack of benefit of active surveillance, which was the only thing that any of the other VA facilities had issue with in the bundle, probably relates to the way they surveilled, says Evans. "When a patient was admitted, they did the culture, but the results came five days later 60% of the time. That won't have an impact on what you did with that patient until then."

The VA is using much more rapid testing — in some facilities such as the one in Lexington, they require test results before a patient is sent to a unit. "That's very different than what Huskins and his group did," Evans says. "It didn't work because they didn't use the surveillance the same way we did. They were using precautions in people who had a history of MRSA. But only 10% of our patients fit that characterization. If only 10% of patients are getting precautions, and only half the time they should have been, the last line of their paper, which says that active surveillance as achieved during their trial isn't effective, is not surprising."

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1. Jain R, Kralovic SM, Evans ME et al. Veterans Affairs initiative to prevent methicillin-resistant staphylococcus aureus infections. *N Engl J Med* 2011; 364:1419-1430. ■

Who's at the table for your root-cause analysis?

A crowded house makes for better understanding

Failure and near-misses offer a significant opportunity to change the way you do something in a way that will benefit patients. But is there a best method of doing a root-cause analysis

(RCA)? According to St. Joseph's Hospital in St. Paul, yes.

Those in charge of RCAs presented a best practice for RCAs at the November Minnesota Alliance for patient safety conference.

People often assume if they have a program in place, it must be effective. But According to **Rosie Emmons**, RN, performance improvement specialist at the hospital, it's not a comfortable process. Emmons has been doing training in RCA across her state for five years. The sessions are always full. That tells her that people are looking for ways to improve how they investigate sentinel and other reportable events.

Here are a few suggestions.

• **Put them all in the room.** She thinks one mistake people make is limiting who is at the table. It's not enough to have the people directly involved in the event involved in the analysis of it. Rather, you have to look wide and then go deep. Everyone who had anything to do with it needs to be there. That means people from the lab, transportation, or even the day nurse if the event happened at night.

"Often those people may not have a lot to add, but they can help you get a bigger picture of what happened," says **Robert Moravec**, MD, St. Joseph's medical director. "A couple days ago, we were trying to understand a surgical event, but until we saw the device in question and opened it and looked at it and saw how the event happened, it wasn't clear to us. Even though everyone who was in the room at the time was there, we had to go further."

Emmons adds that if you are going to change a process as a result of the adverse event, you have to have everyone at the table who will be affected by that change.

• **Stick to the path.** Another mistake is getting sidetracked by tangents — even if they are important. Emmons says you can be talking about an issue related to staffing and how not having enough nurses on a particular shift was an issue in a particular event. If you aren't careful, you can end up talking about how hard it is to plan for a night when there are so many admissions "and before you know it you are talking about staffing in other scenarios."

They may be important issues, but you can't lose focus of your main task: talking about the event at hand and developing a strong action plan to deal with it.

• **Look for strength.** Make sure you go with a strong action plan. If you don't make clear changes, you're going to reinforce the way you currently do things, which is what led to the problem to begin with, Emmons says. "Nothing will change." You have to make a clear break from the way you did things in the past and start doing it a new way. Simply putting up a poster or sending out a reminder memo about an existing procedure won't bring you the change you seek. "If you are sitting in a room doing a root-cause analysis, you already know this is a repeated problem that relates to a sentinel or reportable event."

This isn't to say you have to go completely back to the drawing board, says Moravec. "You may just need to change one small step in a bigger process." For instance, in surgery, if you have an object fall into a patient and it isn't realized until later, you may only need to change a process by repositioning a tray or keeping surgical sets behind the patient until required.

• **Look from every angle.** One of the reasons it's important to have a room full of people rather than one or two is that everyone has a different perspective. Think of the movie *Vantage Point* and how what happened changed depending on who was telling the story. Emmons says by the time an hour has passed, she will have people with a better understanding of what happened and why because of the variety of viewpoints. "Everyone has to be on the same page and see it all the same way. Then we look at the main issues and determine how we will improve." That means letting everyone have a chance to tell his or her story.

Can there be conflict and finger-pointing? Yes, says Emmons. Sometimes they have to do follow-up meetings or take time outs — "I explain that this isn't about blame but about fact-finding," she says. But ideally, everyone in one room at one time as close to the time of the event is best.

• **Leading from the head.** That's easier to do if you make root-cause analyses something that the leadership in the hospital takes seriously. Moravec is convinced that St. Joseph's does it better than other hospitals, and the main reason is that he or — sometimes and — someone else at the senior level is present at every single one of these meetings. "Our CEO has mandated that a senior leader is at every root-cause analysis. It might be our CEO or our CNO, or executive director of patient care. If it involves a doc, I'm there, or the director of surgery. And the senior staff holds the directors and reports accountable for implementing whatever change is decided. I don't think most places are like that."

If you are a nurse on the day shift and the event

involved a night-time fall, you might think it's not important that you show up. But if your chief nursing officer is coming in — on her day off — for a meeting, are you going to miss it? Doubtful, says Moravec. The culture is that this is an imperative, not an option. "Lending a level of importance to the event helps everyone take it more seriously."

• **Preaching to the choir.** When you are part of a multihospital system like St. Joseph's, having buy-in at the top helps when it comes to spreading the gospel of change across facilities. "We may have an ER event and put in an action plan. But we have physicians that work in three ERs and so we have to put it in place at all of them. We have to keep track of where it is in the organization. Meanwhile, the other hospitals have their own changes that they try to spread to us," says Moravec.

Because senior staff are so involved in every root-cause analysis, and they also are involved in inter-hospital committees involving patient safety and quality improvement, mandating change is probably easier in the HealthEast system than in others. "We keep tweaking things," Moravec notes. "We have documents about RCAs and actions, and a database where we note where things are on the spread to other areas. We bring these things to site quality meetings and review them there, and to the system patient safety committee and review them there." They continue to evaluate new models of reports both for inter- and intra-hospital spread. In something of a meta-QI statement, Moravec notes that when they figure out what works for documenting the spread, they'll spread that out, too.

Discussions about what's happening elsewhere and who is responsible where for what all happen regularly. But there are barriers to it even in a system that has worked on making QI, well, spreadable, says Moravec. "You are working against the habits of highly effective people that have been ingrained for 20 years of practice; they have developed workarounds that have worked so far. They haven't had a failure at their site and they are short on time." That's why having a strong action plan is imperative, he adds. "Putting it on a piece of paper and emailing it out, that's not going to do it."

Other issues they grapple with include changes that involved facilities or equipment expenditure or that have to be approved by medical staff. How to handle those is an ongoing challenge with no simple answers.

• **Measure it.** People may not think you need to worry about a topic like measurement when doing a root-cause analysis, but Moravec says it's vital. "A good RCA will also put in place a measurement program. If you are doing a checklist for the OR, after you make the change, you want to look at the next N cases to see if it is done and verify the change."

• **Find a secret weapon.** Moravec says Emmons is a secret weapon. "She has taken this on with a passion and skill set that not many have," he says. "She is objective, non-judgmental, and able to ask why at three or four levels." For instance, a surgeon may try to take ownership of an error. She'll ask why something happened. If he says it was because of something else, she'll ask why that happened. She will keep doing this up the list of reasons until she is satisfied they found the ultimate "why." Many people stop at one or two such questions.

She is also determined to create a strong action plan. That she is a nurse makes clinical staff respond more readily to her. And Moravec says that while she is very patient, she is happy to interrupt and willing to get someone who is sitting in a corner to open up. That circulating nurse who is nervous because the chief of surgery is at the table? Moravec says Emmons has a unique ability to get that person talking and telling his or her side of the story. "She can pull people in."

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Choosing the right measurements is key

How to measure what you measure

For some organizations, finding out where you fit in compared to other organizations is something they do regularly and well. But what they should really be doing is measuring how they compare to themselves in the past and figuring out a way to improve what they do now, says **Steve Meisel**, Pharm.D., director of patient safety at Fairview Health Services in St. Paul.

He gave a presentation on the problems with

QI measurement tools — framed like a "point-counterpoint" skit from old *Saturday Night Live* sketches — at the November meeting for the Minnesota Alliance for Patient Safety to look at several ways of measuring safety and talked about their positive and negative traits.

"Everyone has flaws. There isn't a generically good, let alone perfect, tool that works well for everything," he says. "And depending on who you are, you might choose different metrics. Some might be demanded by an interest group, some might be self-assessments that ask you whether you do these 150 things or not." National Quality Forum, Leapfrog, CMS — there are dozens of organizations that want you to measure things and show how you measure up against others. Meisel says none of it means your patients are safe. "It just means you do these things or do them well."

Best practices are a great idea. Doing them is good. But does that mean that you don't make mistakes? If you do all of them, and all of them well, Meisel says you can't promise that all your patients are safe, that you will have no bad outcomes — or if you do none of them that you will have no good outcomes.

Self-assessments have a natural bias in them that leads to more positive results than are true. That said, they can be a great guide to figuring out where you need work. For instance, if a pharmacist wants to figure out the integrity of the medication system and does the Institute for Safe Medication Practices assessment tool, you might very well find after completing it that there are areas you need to work on, he says. And there are some great best-practices tools from the Association of periOperative Registered Nurses that could help you figure out if you are doing all you can to reduce wrong-site surgeries.

"One problem with measurement is an inability to differentiate error from adverse events and outcomes," says Meisel. "Most errors don't cause bad outcomes. You give two anti-acids not one. Nothing bad happens. But it is still an error. Some can cause harm, or cause waste and rework. That's different than safety. We haven't done a good job defining this."

People mix up adverse events and errors, Meisel says. "We have to report any serious event. But when it's released to the media every January, the headline is that so many errors hurt so many people last year. But some errors are wrong-site surgery. Some are physical assault of staff members. They aren't the same thing, but they are measured the same way."

We have to stop measuring to look for the absence of bad outcomes. "People will die in healthcare," he says. "There will be complications. What is safety is the knowledge that we are preventing all we know how to prevent, and are learning how to prevent those we don't currently know how to prevent."

Language is important in measurement. For some things, there are standard definitions — what is an infection, for instance. However, another metric may not have just one definition. Pressure ulcers are fairly standard in how they are graded, but AHRQ has certain included indicators and CMS has others. In one, if you are a quadriplegic you are excluded; in the other, you are not. That can change the way your hospital looks when compared nationally with one data set or another. "In some respects, it doesn't matter what you choose as long as you use it for directional purposes. If you go up for one, you will probably be going up for all."

Everyone will choose something different, and everyone will gather data differently. "You are better off looking at internal problems — what occurs most frequently and has the highest risk where you are. Develop your metrics, make sure they are outcomes-oriented, and check regularly internally," Meisel says. Indeed, he calls benchmarking a "prescription for mediocrity." You can say you are as good as everyone else, but if everyone else is mediocre, what good is that?

Another issue Meisel has with measurement tools as they currently are used is that a lot comes from administrative datasets. "The numbers are a reflection of coding more than of clinical care," he says.

Trigger tools are also problematic for him. The Institute for Healthcare Improvement has one that lists dozens of issues that you should look for in medical records reviews to see if an adverse event is associated with the trigger. An example might be if a patient was transferred to the ICU or returned to the OR. "The problem with that tool is that if you only do 20 records a month, if it happens less than 5% incidence, it won't get picked up. You tend to get the relatively frequent but less serious issues. You don't see wrong-site surgeries, but you probably will see nausea from narcotics that isn't life threatening."

Ask Meisel to dream up his ideal world of measurements and tools, and he says he would concentrate on the half-dozen things we know are big issues in safety like falls, wrong-site surgery, and

retained foreign objects. "Develop a metric that will work for you that would also be a headline in a paper: We have done away with narcotic over-sedation or no wrong-site surgery in five years. Those are the metrics that are meaningful to the public."

Don't look at things that are internally focused on tactics and processes or are very obscure like doing a failure mode analysis. "Those are things we should do, but that's not what I want to report to the board," he says. "The same is true with other metrics that have roles but aren't important. Sure you can measure culture. But just because you have a positive culture doesn't mean you are safe. It means you have the capacity to embed process changes that others might not be able to do because culture isn't as positive. That's not a safety measure in itself, though. You still work on it, but not a great banner."

The toolbox of the quality professional has to have everything in it. You do the best practices, you have the good culture, you even do the self-assessments. But if you want to be patient-centered, you have to focus on the things that mean something to patient outcome and measure against the population that means something to your patients — that is, yourself.

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Conferences offer a way to learn from others

Learning from others is a great way to avoid mistakes and be inspired. Almost every state has an opportunity for QI professionals to take part in patient safety and quality improvement conferences.

For a list of upcoming conferences, check out these websites:

- AHRQ Patient Safety Network: http://www.psnet.ahrq.gov/browseResourceType.aspx?resourceTypeID=134
- Patient Safety and Quality Care: http://www.psqh.com/event-calendar.html
- National Patient Safety Foundation: http://www.npsf.org/npsfac/o/
- The Minnesota Alliance of Patient Safety conference, held in November, lists presentations here: http://www.mnmed.org/News/NewsFullStory/tabid/2266/ArticleID/3841/CBModuleId/3252/Default.aspx#TCAB.). ■

Memorial Hermann takes home Franklin

CM in and out of the hospital shines

It was nice to win a national award for case management last winter, says **Pat Metzger**, RN, MSA, system executive for care management at Memorial Hermann in Houston. But that wasn't the aim when the program started a decade before the Franklin Award landed on her desk. Then, the system figured the only way to survive the coming healthcare environment was to redesign case management. Some of what they did, particularly in terms of observation units and improved community health, explains why they won the award, and it has lessons for the QI community.

They started from the ground up, asking what did they want case management to do and how did they want it to change the way they deliv-

CNE QUESTIONS

21. The National Strategy for Quality aims to
    A. cut provider costs and improve standards
    B. reduce Medicare expenditures for HAIs
    C. improve patient safety, community health and reduce costs
    D. help QIOs connect with their counterparts around the country

22. The VA program reduced what bugs in ICUs?
    A. MRSA, VRE and C. difficile
    B. MRSA and VRE
    C. VRE and C. difficile
    D. MRSA

23. According to one expert, to have a great RCA process you need
    A. a good team leader
    B. people who are willing to accept fault
    C. a willingness to let people vent
    D. leadership participation

24. Medicare blood transfusion rules make patients pay for
    A. the first three units
    B. all transfused units after 30 days in the hospital
    C. any blood transfused after 3 units
    D. all transfusions

Answers: 21. C; 22. A; 23. D; 24. A

ered healthcare. Using a system approach, they revamped every policy and procedure and made sure that what was used in one hospital, in one unit, in one room, was the same in every other setting in the system. "That gives us a common platform against which we can measure our performance," she says.

They look at several indicators — length of stay, cost per case, avoidable days, number of hours in observation, patient satisfaction scores, and avoidable ICU days. They look at administrative data like response times from third-party payers and how able they are to move patients from one level of care to the next outside the organization.

One major issue they dealt with in the decade-long change was with observation services. "We brought in key leaders from across the system — nursing, physicians, executives — everyone," she recalls. "We looked at what observation is, CMS requirements for it, where we meet them and where we don't. We then did Six Sigma breakout groups and looked at workflow processes and procedures to change the way obs services worked for us."

CMS regulations changed so that observation services start times changed. "If patients are receiving other monitored services, you have to back out those times from the hours observed. So if someone is going to the cath lab from obs, you had to back out those minutes in the cath lab." First, they calculated the average time for a cardiac catheter procedure. "We automatically deduct that from the total observation time. We are moving to a time where we can time stamp when they get there and when they leave, but for now, that's how we work it."

Every hospital in the system has to track metrics like the number of hours in observation services, the number who were in for less than a day, those in 24-36 hours, and those who were in over 36 hours. "The goal was to decrease our total hours, and we saw a lot were staying longer than 24 hours," Metzger says. "Medicare will pay for up to 48, but only if you are waiting for results of tests and procedures done in the first 24. We wanted to make sure we were not ordering new tests at hour 25 that weren't related to original cause."

Another QI element that came out of the summit related to documentation. There are specific documentation requirements related to physician intervention, frequency of intervention, and tools that remind the nurse or doctor to jog his or her memory that this patient needs to be speeded along. Memorial Hermann created an electronic check sheet that automatically hits the nurse with a task list every two hours.

Doctors also needed prompts to promote behavior change. Physicians came on board and developed 32 common observation services pathways that get implemented when the patient is entering the unit. "There are prompts for docs to check on status, or to order tests," she explains.

Aside from the observation unit work, Metzger implemented a Medicare summit where she asked questions about Medicare rules of participants. "That helped us determine what areas of Medicare knowledge we needed to work on." For

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 this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

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

- Getting patients involved in QI
- CLABSI reduction using infection control nurse
- IT and patient safety: What can it do for you?
- QI in OB: the latest and greatest

instance there was a question about blood administration. "People didn't understand that whether in- or out-patient, the first three units of blood are the patient's expense. After that, they have to pay 20% copay. We did this with our senior executives, nursing leaders, case managers, and physicians."

When a case manager had to talk with a physician before about why they were doing something, physicians often balked, wondering who the case manager was to question the doctor.

But they often had to go back to patients and explain that they were going to have a bunch of expenses they weren't anticipating. The Medicare quiz put case managers and physicians on the same page.

Memorial Hermann still uses the quiz in case management classes for staff. "I think our knowledge about Medicare has improved from it."

The award also noted the improvements in limiting readmissions. Houston has the highest population of uninsured patients in the country. They developed the COPE program — Community Outreach for Personal Empowerment — which helps frequent fliers in the ED manage their health and get connected to community resources. "That's saved us about $4 million since we started," Metzger says. They also started a chronic disease management program for CHF and diabetes patients that has saved another $9 million. They use telephonic case management — daily, weekly or monthly depending on the risk stratification of the patient. They will be expanding that to COPD patients soon.

Case management may have been a path to an award for Memorial Hermann, but Metzger says you need to jump on this bandwagon now. With all the new CMS regulations and payment changes, hospitals need to realize they "own patients for 30 days after discharge. We need to choose our post-acute partners strategically and partner only with those people who understand that we don't want patients bouncing back but still getting exactly the care they need when they need it."

Putting a team and program in place that takes the patient into account from the moment they come in, always with an eye on appropriate discharge, is the way of the future. "We are laying the groundwork," she says. "We are finding that those providers are excited about the potential to do this and potentially really improve healthcare for patients."

For more information on this topic contact Pat Metzger, RN, MSA, FAACM, FAABC, system executive for care management, Memorial Hermann Hospital, Houston, TX. Email: Pat.metzger@memorialhermann.org ■