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AHC Media

Whither peer review?

Has the time come to go back to the drawing board?

Grena Porto, a principal consultant with QRS Healthcare Consulting in Delaware, has made a career out of advocating for patient safety and improved quality. It should not have surprised some people, then, when she posted on a patient listserv all the reasons why she believes peer review doesn't work and detailed a number of cases to illustrate why.

In her August post, she wrote: "Beyond these...stories, which some might be tempted to cast as individual instances and 'outliers,' I have had the experience…of being told by physicians and nurses of bad practices on the part of physicians which have gone unaddressed by the organizations in which they occurred. In two instances, the physicians engaged in practices that were so egregiously inappropriate that they could have been charged with criminal conduct but were not only because no one would report them. In these same two instances, the organizations dealt with the situation by simply 'talking' to the physician. No further action, including documentation of the behavior, was taken."

Porto says that rather than such cases being rare, as many assert, we can't know the prevalence of such cases because they are often hidden away and not reported. "My guess is that there is at least one such situation ongoing right now in all 5,000 or so hospitals in this country — no exceptions," she wrote.

"How many people have to be injured, assaulted and sexually abused before we finally figure out that we have a system that does not do anything but protect physicians at the expense of patients? I have respected colleagues that will argue that peer review does work," according to Porto. "My question is — how is that possible if physicians get away with criminal conduct, sometimes for years, while colleagues look the other way?"

In an interview with *HPR*, Porto says that peer review is a great idea that just doesn't work the way people want it to. "It's like communism — a nice theory, but in action it doesn't pan out," she says. "It doesn't work because people can't put aside their personal agendas to make it work. And we are asking it to deal with things that it wasn't designed to address — like bad actors and situations where it isn't just about good practice versus bad practice, but also about bad behavior — sometimes criminal, sometimes intentionally bad behavior."

Cases in which bad behavior isn't dealt with effectively can be chilling on others who want to report patient safety and quality problems to their

facility's peer review program, says **Mark Smith**, MD, MBA, FACHE, a principal consultant with HG Consultants. It's almost as bad as not having a program, to have one and have reports of problems go unheeded, he says. "It makes people wonder why they should bother and is very bad for morale."

Smith acknowledges that peer review isn't perfect, but he thinks it is getting better and that the cases Porto refers to are not only few and far between, but getting fewer over time. "I believe that 10 or 15 years ago, egregious behavior was more prevalent," Smith says. "But I'll be the first to say that there is still too much of it around. These instances are proof that something is wrong in these places and it isn't working there."

The fundamentals of peer review are sound — a place where you can gather to discuss cases where there was an adverse event or harm was done and determine its cause, counsel those involved, and work to create an environment where the error isn't repeated, he says. But there is no statutory regulation as to what peer review is, and even those best practices that are known don't result in everyone doing them the way they should be done, he says. "It is true that there may be instances where bad behavior and heavy hitters who add revenue are the same people," he says. "Those heavy hitters may be dealt with differently. And while I believe it's getting better, there is truth to that."

Physicians still find it difficult to confront their peers, too. They may need them for referrals, says Smith. Conversely, they may be competition, and some of what is said during peer review can be as bad to a good physician as it can be good to a bad physician, he says. "Historically, peer review was something done only by specialties, so there is a history of your partners and competitors doing the review. And everyone has a bias in those situations."

But even among those who see big problems with peer review, there is no consensus that it should be scrapped completely, that it is imperfect universally, or that it should be handled by some third-party organization rather than by physicians themselves.

Improving the process

However, experts in the field do have many suggestions for improving the process. Among them:

1. Open up the party. Smith suggests making peer review multidisciplinary. That reflects the move toward teams and interdisciplinary cooperation in healthcare, too. **Fay Rozovsky**, principal and founder of the risk management consultancy The Rozovsky Group in Bloomfield, CT, says there is an argument to be made for team cre-

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dentialing and reviewing, too. What happens to a patient is the result of a whole slew of people working together — hopefully working well. But only the physician is subject to peer review in most states.

2. Look at a wider array of data. Move away from case review where the specifics of a single case may never recur, Smith says, and look instead at rate data. "Let's say a gastroenterologist does a colonoscopy and causes a perforation. He recognizes it, calls a surgeon, and it is taken care of with no complications or lasting harm to the patient." Typical peer review will note that perforations are a known risk, and the physicians acted appropriately. But if you knew that no one else in the hospital, or the county, or the state, had a perforation rate as high as this physician, there may be something to learn. "If the national average is 0.5% and his is 1%, you need to see what he is doing differently," says Smith. "And if his is 0.1%, you still may want to see what he does differently so others can mimic it."

3. Create a culture of accountability. Physicians are competitive by nature, and Smith says the best organizations are those where physicians want to see their data and how it compares to their peers. "They know that concerns will be acted upon and not swept under the table, and that there will be change."

4. Check your litigation files. If you don't see every single case that is subject to legal action in peer review, Smith believes something is wrong with your peer review system.

5. Make credentialing incremental. If hospitals gave provisional privileges to physicians, it would be easier to dislodge bad actors more quickly, says **Skip Freedman**, MD, the executive medical director of AllMed, a Portland, OR-based independent review organization. "You can extend provisional privileges if you have concerns, and you can review their body of work — or some part of it — before you allow them to advance," he says. While the peer review process is the same for those with provisional and full privileges, the former do not have all the protections of the latter.

6. Review prospectively and regularly. Don't wait for a problem, says Freedman. Rather, do a certain number of cases in all high-risk areas — and a few in areas that have less risk — at regular intervals.

7. Use external reviewers. Having someone working in a similar-sized hospital of a similar type from outside your organization and area of operation removes the potential for bias to creep into reviews, says Freedman. You can easily ensure that someone from a teaching hospital isn't reviewing someone at a small rural facility and vice versa, he says, and it is not prohibitively expensive, as many administrators and executives fear. Indeed, while many see peer review as it is now as a pure cost, having a good external peer review system can lead to reductions in insurance premiums because insurers see that kind of rigor as evidence you are serious about reducing risk, he notes. "Never mind that no one looks at peer review and calculates the economic benefit of patient safety."

8. Create qualifications for reviewers. Rozovsky says that people make assumptions that those who sit on peer review committees are qualified to do so. "How do you train them to do that, though?" Whether internal or external, there is often no training in place for this group of people who sit in judgment of their peers.

9. Remember the patient's role. As CMS and other payers extend their payment rules to include 30 days after discharge, some attention needs to be paid to the patient's role in bad outcomes, says Rozovsky. "You can have a patient with congestive heart failure or pneumonia who has a great discharge planning process and still comes back within 30 days with the same diagnosis. But if the patient refuses to follow the care plan, and the outcome is bad, then the hospital is dinged by CMS, the attending comes up for peer review, and they call him on the carpet for patients bouncing back. The physician can be faulted for patient behavior, over which he has no control."

10. Get the information you need from the start. Rozovsky says many of these cases seem to revolve around physicians who moved from organization to organization or from state to state and were given positive or neutral references by the organizations they left as part of their exit agreements. "All institutions should have a release form that says if you want privileges, it's not a right and you have to abide by our rules," she says. "If a physician wants privileges, then they have to sign documents allowing us to collect data from the places listed as references. If they refuse, they cannot be credentialed."

With all the changes afoot in healthcare, this

is a good time to look at your peer review process and fix what is not working, says Rozovsky. There is no real national guidance on what peer review should look like — there is some criteria from The Joint Commission, and some state agencies mention how to evaluate peer review programs. There are other resources, however, such as specialty colleges and professional groups, as well as a variety of consulting and law firms that offer training on the topic.

Look beyond the usual suspects and common approaches, though, she says. For example, the Citizen Advocacy Center in Washington, DC, has tried to use a different way to improve care that doesn't involve punishment such as losing a license, but instead advocates retraining and returning to practice under supervision. The system is used in places like North Carolina, where the Board of Nursing has used it with good effect, says Rozovsky, and UC San Diego has a program for disruptive providers.

Porto believes that large-scale restructuring of peer review is long overdue. While it may be true that peer review has improved over the years, it is still far from where it needs to be. She believes that payers, accreditation organizations and CMS need to get behind such an effort, not because peer review itself is a bad idea, but because it doesn't work reliably enough to serve as the primary foundation for review and improvement of care. "Maybe there are cases where it works some of the time. But no one gets it right all of the time."

Freedman doesn't think things are as dire as Porto contends. "It works most of the time because most things in medicine turn out okay, and the ones that don't aren't usually anyone's fault," he says.

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Top performers named in JC report

Data point to what makes a good hospital great

They come from 45 states, represent 14% of Joint Commission-accredited hospitals, and are the first class of hospitals to be recognized as top performers in the commission's annual report. Their stellar showing was based on performance related to 22 accountability measures in areas such as heart attack, heart failure, surgical care, and children's asthma care.

The data were drawn from more than 3,000 facilities, 405 of which achieved aggregate scores on all the measures of 95 or better, and of 95 or better on individual scores where there were at least 30 cases to count.

In other findings, the report noted progress in using evidence-based treatments, with nearly 97% performance ratings in composite scores. For heart attack care, there was an 11.5 point increase to 98.4% in the last 9 years, and for pneumonia, hospitals met goals 95.2% of the time, up from 72.3% in 2002. Surgical care results improved to 96.4%, up 14.3 percentage points since 2005, and the 2010 children's asthma care result reached 92.3%, up 12.5 points since 2008.

The total number of hospitals that achieved composite accountability measures greater than 90% has dramatically increased since 2002; it now stands at 91.7%, a more than 71-point increase.

Not all of the report was good: Hospitals need to do better providing fibrinolytic therapy within 30 minutes of arrival to heart attack patients, as only 60.5% of hospitals achieved 90% compliance or better. And just 77.2% of hospitals reached 90% compliance in providing antibiotics to pneumonia patients in the intensive care unit.

Joint Commission statistician **Stephen Schmaltz**, MPH, PhD, says that The Joint Commission decided to use those 22 accountability measures in determining the top-performing hospitals, but the set isn't stagnant. Indeed, they have already determined that there will be some additional measures added to the next annual report — a measure set for stroke and for VTE. Accountability measures meet four criteria: It is based on strong research; it captures whether evidence-based care has been delivered; it addresses a process proximate to the outcome; and it has minimal or no unintended adverse outcomes.

Schmaltz says that some measures that are important — like counseling for smoking — don't meet all the criteria and thus aren't used in the top performing hospital evaluations.

Since public reporting started in 2004, Schmaltz says hospitals have improved year on year, and he doesn't think that is going to stop now. "I think there will be even more top performers next year from hospitals that were close this year and want to prove something."

While there is a lot of attention being paid right now to the top performing hospitals, Schmaltz says they also look at those hospitals that are not doing well to see if there are common issues. So far, they know that they tend to be smaller, are more likely to be rural, and probably have issues with resources. The Joint Commission will continue to study them, he adds, looking for why some hospitals don't do well or don't improve over time.

Doing well starts to take on new import in January, he says: Hospitals that don't reach the 85% threshold will have to produce an improvement plan on how they will go forward. In the interim, he suggests that those who want to improve take a look at the JC website's solutions center for ideas on how to improve.

The complete report is available online at http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2011_9_13_11_.pdf.

For more information on this story, contact Stephen Schmaltz, MPH, Ph.D., Statistician, Joint Commission, Oak Brook Terrace, IL. Email: sschmaltz@jointcommission.org. ■

Taking the measure of measurement

Do you make any of these common errors?

Imagine the ongoing dismay of a high school math teacher who year in and year out has to teach students how to do the problems the right way, and year in and year out sees the same mistakes over and over again. That's kind of what it must be like for **Betsy Jeppesen**, BSN, vice president of program integrity at the Bloomington, MN-based quality improvement organization Stratis Health, and her colleague **Liesl Hargens**, BA, MPH, an epidemiologist.

The amount of data that passes before their eyes is immense, and the errors seem to repeat themselves. So given a soapbox to stand on and a megaphone to shout through, just what would they tell those who collect and submit data to remember and double check? Here is a six pack of things they would like to see:

1. Remember companion measures. Jeppesen says that people often set up process measures or outcome measures, but not the two together. "We like to see both because the process measure lets you know if the change is embedded in the practice — whether you are checking the box on the checklist every time — but it can't tell you if the change is making the system or process better," she explains. "That's why you need an outcome measure." Take the example of falls and fall risk assessment. You want to reduce falls and you think that if you do more risk assessments, you can prevent more from occurring. You have to remember to measure both whether you are doing that assessment, and whether that change is affecting the number of falls.

2. How you measure matters. Hargens says doing things the easy way — say, through chart audits — will not always give you the answer you need. The data collection method has to be matched with what will get you the most helpful and accurate information. Take the example of surgical time outs. When a project coordinator creates a program, she might decide to just look at charts to see if a pre-surgery time out checklist was completed. "But that won't tell you if the time out process and checklist has enough rigor to prevent an error," Hargens says. To get an accurate picture of whether your time out process is improved, you need to use observation, critique the method, and examine exactly how it is carried out.

3. Consider alternative methods for extremely rare events or processes. You might want to choose something to measure that has the potential to cause great harm — say, postpartum hemorrhaging. However, such events are extremely — and thankfully — rare. Hargens says trying to measure an improvement on something that happens very infrequently may take a very long time to collect enough data to determine if your change was effective. Jeppesen adds that if an event is really rare, you aren't going to get enough chances to see how it is handled or in the case of a rare procedure, it can be difficult to predict when a particular process will be used. Consider combining data for similar cases

or events that may benefit from a similar safety intervention to increase your population size and opportunities for monitoring the improvement. For rare events, consider monitoring and calculating the time between events as an alternate measurement strategy.

4. Know what you are collecting and how. Hospitals collect a vast amount of data, says Jeppesen. They do it for any number of organizations and reasons, and in many different ways. Trying to minimize duplication and workload of all that data mining can lead to mistakes and measurement fatigue. "When you are trying to measure and track for so many different requirements, measurement can become ineffective and lead to drawing the wrong conclusions from the results."

She suggests creating a matrix of the various organizations to which you are reporting, the measures you are collecting, and whether any of them line up appropriately so that you can use one measurement for two purposes. "QIOs can sometimes help with that," Jeppesen notes. "Just make sure when you are using measurements for multiple purposes, there is a true match."

Setting up a measurement plan that doesn't give you accurate results or actually help you draw accurate conclusions about your improvement effort can cost additional resources in the long run. Easier is attractive, but if you don't get it right the first time, you are making more work for yourself later, she adds.

5. Sample when you have to — and consider what type of sample to use. Hargens says that she frequently sees "convenience sampling" when someone draws information or a population that is readily and easily available, rather than alternative sampling methods.

Random sampling or stratified sampling may be more appropriate in some situations to limit the introduction of bias and assure you are getting a true picture of whether an improvement is having the intended effect for the population you are targeting for your improvement.

For instance, if you need a sample of 30 patients and choose every third patient that comes into the hospital, that limits the bias that could come from selecting only those patients that are available on a given shift or a particular unit. "Those patients selected on a particular shift or unit may not be typical of the population targeted for improvement."

"A convenience sample has some benefits in that it is simple and easy to design," explains Jeppesen. There are instances in quality improvement work when it is OK to use this method of "sampling," she says. "If you are pilot testing something and want just enough information to see if you should continue, that something is being adopted, then convenience sampling can be used."

6. Pick the right frequency or length of time. Jeppesen says people often do not know how long to continue to monitor or measure something in order to draw accurate conclusions. "If you are doing something where you draw samples of cases at three separate intervals, you might not see the data changes within those time periods," she says.

If you are looking at something at 30 days, 60 days and 90 days, you might have something that looks like an improvement, but miss variability within those 30-day periods.

She brings up pressure ulcers and how one improvement project looked at patients in three different months. The general trend was improvement, but within that, "it bounced all around."

Jeppesen notes that nurses, who do a lot of the heavy lifting in quality improvement, haven't had training in this area and are often uncomfortable with measurement.

Planning a project out — including the details of how you will measure, what you will measure (and why) and the frequency at which you will measure (and why) can help. "Weigh the pros and cons of the approach you are taking for measurement. If after an intervention you find you have very different results than you expected, you might want to go back and check your measurement again to assess the reliability of the information. But if you plan carefully up front, you can have more confidence in the conclusions you draw from your data and the implications for next steps."

Think of the companion measures, the kind of sample you need, inclusions, exclusions, and the approach for collecting data.

There are some places to get some training on this topic, including a measurement guide that Stratis Health did — http://www.stratishealth.org/documents/MN_AE_Health_Events_Measurement_Guide.pdf. Hargens suggests the state hospital association and area quality improvement organization for guidance, too. The latter often provide online or virtual training sessions.

The Institute for Healthcare Improvement (http://www.ihi.org/search/pages/results.aspx?k=data%20measurement&r=%22owstaxIdIHIx0020Topic%22%3D%23a972b1ef-8906-44a5-a33d-30866482e923%3A%22Data%20and%20Measurement%22) and the National Association for Healthcare Quality (http://www.nahq.org/about/onlinestore/datatools.html) also have resources available.

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RAC rules finalized

T-minus 10 weeks to get ready

The final rule related to recovery audit contractors (RACs) for Medicaid was released in mid-September (http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf), just over three months before it goes into effect. It provides a variety of guidance and opt-outs for states that have many compliance experts scratching their heads.

The final rule includes the following provisions:

• It requires that RACs

— hire a full-time medical director who is either an MD or DO;

— hire certified coders unless the state deems otherwise;

— let providers know their audit policies and protocols;

— limit reviews to the three years after the event being audited;

— establish a set limit on the number and frequency of records requested.

• It allows states to determine how to extrapolate audit findings, externally validate RAC findings, and decide what kinds of claims should be audited.

• It prevents audit of claims that are already being audited or have been audited by another entity.

• It requires repayment of any contingency fee if on appeal, a determination is reversed.

• It requires states to provide incentives for determining underpayments.

• It allows exclusion of Medicaid managed care claims.

"For me it is a lot of uncertainty," says **Monica R. Freedle,** corporate compliance project specialist at Legacy Health in Portland, OR. Her organization operates in two states that are on different timetables for finalizing just what the rule means in each. Oregon appears to be "taking the liberties in the law to use all the exceptions," she says. Meanwhile, as of press time, there was virtually no information on what Washington is doing. Freedle says she probably has the best and worst of it — Oregon being a little ahead of the curve compared to most states, and Washington a little behind.

Lack of definition

Legacy has already been introduced to the Oregon auditor, but there is not even information on who the Washington RAC will be. "I'm dreading all this lack of definition right now," she says.

What Freedle does have are some vague projections. She knows that Oregon is choosing to look back the full seven years, but that might be 100 charts per quarter, or 400 every 75 days for each of the five hospitals. "Nothing is defined, although they seem in Oregon to be willing to work with extensions. We don't know how aggressive they will be, though, and it's hard to proactively guess."

If the number of charts required is at the higher end, Freedle thinks she may have to make some new hires to handle the additional work. But she can't plan on that yet. Meanwhile, she has a concern about how being an organization on two state borders will affect her operation. "It is possible with a hospital right on the border that we will have Washington audits for Oregon hospitals and Oregon audits for the Washington hospital."

Freedle says she is happy that most of the processes the RACs in both states will follow are already established. It is, in a world of unknowns, one thing she is counting on.

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SOS: Summer of surveys tests NC hospital

Leadership buy-in key to success

One survey every three years is trying enough. But for Novant Health's Presbyterian Hospital in Charlotte, NC, that would have seemed like a vacation. Between June and August of this year, the hospital had a Joint Commission survey, a CMS survey, and the regular biannual visit from the local health department. Getting through the ordeal with success depended on many factors. Making physical changes to the area used by those running the survey was detailed in last month's *Hospital Peer Review*.

But it was more than just the physical setup that helped things run smoothly. **Paula Swain**, director of accreditation and regulatory for Novant Health/Presbyterian Healthcare says that the attitude, assistance, and attention paid by hospital leadership to the situation made all the difference. Her feeling was echoed by **Sheila Moore**, RN, BSN, MHA, MBA, vice president of professional services at Presbyterian Hospital. "We didn't kick everyone off and say, 'Hey, we'll see you when it's over.' We were there through it all. We did not let it happen in a vacuum. We made sure that if someone needed something from us, they got it."

Every tour done by surveyors and their guides was followed up with a report to leadership to see if there were hot-button trends, to ask for help, and to receive kudos. "We weren't just tucked away in a command center," Moore says. Those daily debriefings included summations from the Joint Commission and CMS during the respective surveys. They often took on a pep-rally atmosphere with the focus on the "big game" the next day.

Swain says leadership was near instantaneous when something was needed. "If surveyors asked for something, we could reprioritize. We worked as a group with a great degree of camaraderie." So if there was a question about whether H&Ps were in some charts during one tour, the briefing would illuminate it, and the command center would focus on making sure that every chart was complete; if one exit sign was not lit up, all were then checked.

"We know that the commission looks for patterns," says Moore. "If they find it once, they will point it out and use it as a learning opportunity. If they see it somewhere else, though, they will start looking for it. The briefings and our tight communication helped us to eliminate any appearance of patterns."

The fact that Presbyterian staff were so on the ball, so quick to make any needed repairs or changes, the way that surveyors treated them also changed, says Swain. "We were so operationally woven together that if they asked, we had it. We were wish granters — accurate, on target, and efficient. And so if we said we did something, they believed us. That kind of trust is earned."

Elizabeth Steger, RN, MSN, vice president of patient care services says they worked hard to create surveyor/guide teams that worked well together so that trust could be built.

Turning every no into a yes

Leadership also made sure that everyone knew that they would move heaven and earth to help them achieve goals. So when an engineer found a sprinkler system was malfunctioning, and someone from construction said there were no parts, and someone else said there was no labor to get it done overnight, Swain says leaders made sure that every "no" turned into a yes, and by the next morning, the system was fixed. Moore says the key was to let people say their "no," but then attack the problem "one bite at a time, asking what it will take to make it happen."

The willingness of leadership to back up others flowed the other way, too. Moore says that when there was an issue with a clock used in dialysis that she was trying to fix but could not, "all these people from materials management and construction came together to brainstorm the issue and come up with a solution."

That teamwork across job functions led to a level of trust that was new, Moore says. "You never wanted to be the one who was responsible for a finding. There was accountability and ownership, and people who are proud of what they do, and want to do the right thing, want to do it whether someone is looking or not. We worked so hard that all of us were invested in the outcome."

That cross-function cooperation continues. People who worked together for five or 10 days, who didn't know anything about each other's jobs before, now have additional resources for problem solving.

The gift of presence

Leaders can be change agents, says Swain, but it takes more than a single person. Moore says there isn't "a more inspirational leader than [COO] **Amy Vance**, but even she needs help sometimes. It takes all of us together."

Vance says that the idea that leadership wouldn't be an active participant in surveys is surprising. "Why wouldn't I be part of it? But it had apparently never happened, that a leader had sat down with interest, passion, and concern," she says. "Magical things happen when leadership is present. It is not that I did anything — there were teams to do everything. But my presence made a difference. And that was an awakening itself."

She says another element of the success came from transparency. There was "a no-holds-barred telling of it all," says Vance. "Leaders often paint a negative picture that can fracture morale, or they are such overenthusiastic cheerleaders that their view is seen as unrealistic. For me, and our leadership team, being honest and transparent meant that it was okay for the whole team to follow suit. They believe in you, trust in you, and know you will walk through fire for them. So they will for you."

Moore says that at the end of the survey, The Joint Commission presented a stack of papers that was maybe a half an inch thick, and they told her that it was the thinnest packet they had ever given out, regardless of the size of the hospital. "We are an old building, and surveyors were here for more days and hours at a time than we had ever experienced. But there was not a single finding related to patient care standards in behavioral care. Dialysis was usually an area of weakness, but it was a strength this time. We expected a much thicker packet."

The whole process was, admittedly, stressful. But it was also fun. "Yes, fun," Moore repeats. "We had withdrawal afterwards. People made extreme sacrifices; they missed family events; they cancelled vacations. But there was camaraderie that continues now."

Joy Greear, MBA, MHA, vice president of professional and support services agrees that the experience was entirely positive. "I think it was good for so many people to be involved, to see the surveyors in action and on site. We were all connected to this process, and that gave everyone a personal accountability. A bond was created; there was networking; new relationships were forged. I think we got more problems solved in the survey than in the entire previous year — just from the networking that happened."

For more information on this topic, contact:

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- *Joy Greear, MBA, MHA, Vice President of Professional and Support Services, Presbyterian Hospital, Charlotte, NC. Telephone: (704) 384-4000.*
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Does accreditation mean better outcomes?

Journal of Hospital Medicine *study results*

Being accredited by The Joint Commission makes a difference in outcomes for patients with certain diagnoses, according to a study in the October issue of the *Journal of Hospital Medicine*[1]. Accredited facilities out-performed their non-accredited peers on standardized quality measures of acute myocardial infarction (AMI), heart failure, and pneumonia, and the difference between the two groups of hospitals expanded over time.

Author **Steven Schmaltz**, MPH, PhD, associate director of the Department of Health Services Research, and his co-authors looked at data from 2004 to 2008 and found that even though they started at a higher baseline level, accredited hospitals not only performed better, but had greater improvements in performance than other hospitals. They were more likely to have what was deemed superior performance — greater than 90% adherence to quality measures — with only 69% of non-accredited facilities achieving that status

compared to 84% of the accredited facilities.

The study looked at 16 different measures, all of which are among the accountability measures The Joint Commission will require accredited hospitals to meet starting in January. The measures were:

For AMI:

- aspirin at admission;
- aspirin at discharge;
- ACE inhibitor for LV dysfunction;
- beta-blocker at discharge;
- smoking cessation advice;
- PCI received within 90 min;
- thrombolytic agent within 30 min.

For Heart Failure:

- discharge instructions;
- assessment of LV function;
- ACE inhibitor for LV dysfunction;
- smoking cessation advice.

For Pneumonia

- oxygenation assessment;
- pneumococcal vaccination;
- timing of initial antibiotic therapy;
- smoking cessation advice;
- initial antibiotic selection.

The complete study can be seen at http://onlinelibrary.wiley.com/doi/10.1002/jhm.905/full.

REFERENCE

1. Stephen Schmaltz S. Williams SC, Chassin MR, Wachter R. Hospital Performance Trends on National Quality Measures and the Association with Joint Commission Accreditation. *Journal of Hospital Medicine*, 2011, October; 6 (8): 454-61. ■

NAHQ announces annual award winners

The National Association for Healthcare Quality (NAHQ) honored several people in September for their efforts to improve quality and safety in healthcare. Among the award winners was Cynthia Barnard, MBA, CPHQ, director of quality strategies at Northwestern Memorial Hospital in Chicago, who was given the first ever President's Award for volunteer activities above and beyond traditional duties. Barnard has chaired the internal task group for Ensuring Integrity of Practice in Healthcare Quality & Patient Safety, organized survey research, managed meetings of partnerships and served as one of NAHQ's key voices.

Other awards presented included the Luc R. Pelletier Healthcare Quality Award for developing an outstanding performance improvement program. Winner Kathleen Masiulis won for her Provider Initiated Pay for Performance Program that uses quality metrics to allocate at-risk funds among the network's 10 hospitals.

NAHQ fellowships were awarded to Norma Torres Delgado, MHSA, CPHQ, FNAHQ, the associate chief executive officer at San Lucas Hospital in Puerto Rico and Marsha Moxley, MA, RN, CPHQ, FNAHQ, vice president, Clinical Quality at TeamTSI, Inc. Delgado hosts a healthcare quality radio show, volunteers to help others with surveying and quality improvement, and is a mentor for many local healthcare organizations. Moxley instructs CPHQ review courses, coaches, and speaks nationally on quality topics.

The Gold Award for Association Excellence recognizes a state affiliate that supports and advances the activities of NAHQ. It was given this year to the Florida Association for Healthcare Quality (FAHQ), which has had strong membership growth since 2008, increased educational offerings with higher attendance, promoted Healthcare Quality Week (HQW), generated media activity around the state conference and HQW and produces a quality newsletter sent to more than 600 healthcare community members on quality issues and initiatives.

The Silver Award for Association Excellence went to the Mississippi association, and NAHQ gave the Bronze Award to the Virginia asso-

ciation. The Texas state association won the Association Education Program Award, and Connecticut received honors for its website and newsletter. ■

COMING IN FUTURE MONTHS

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■ More stories from the survey trenches

■ Quality secrets of top-performing hospital?

CNE QUESTIONS

1. According to Mark Smith, MD, MBA, FACHE, a principal consultant with HG Consultants, one way to improve peer review is to make it multidisciplinary.
A. true
B. false

2. Joint Commission top performing hospitals are judged on
A. All the core measures they report to CMS and the commission
B. Only accountability measures
C. Measures that have not improved since public reporting started
D. Only those measures chosen by commission statisticians

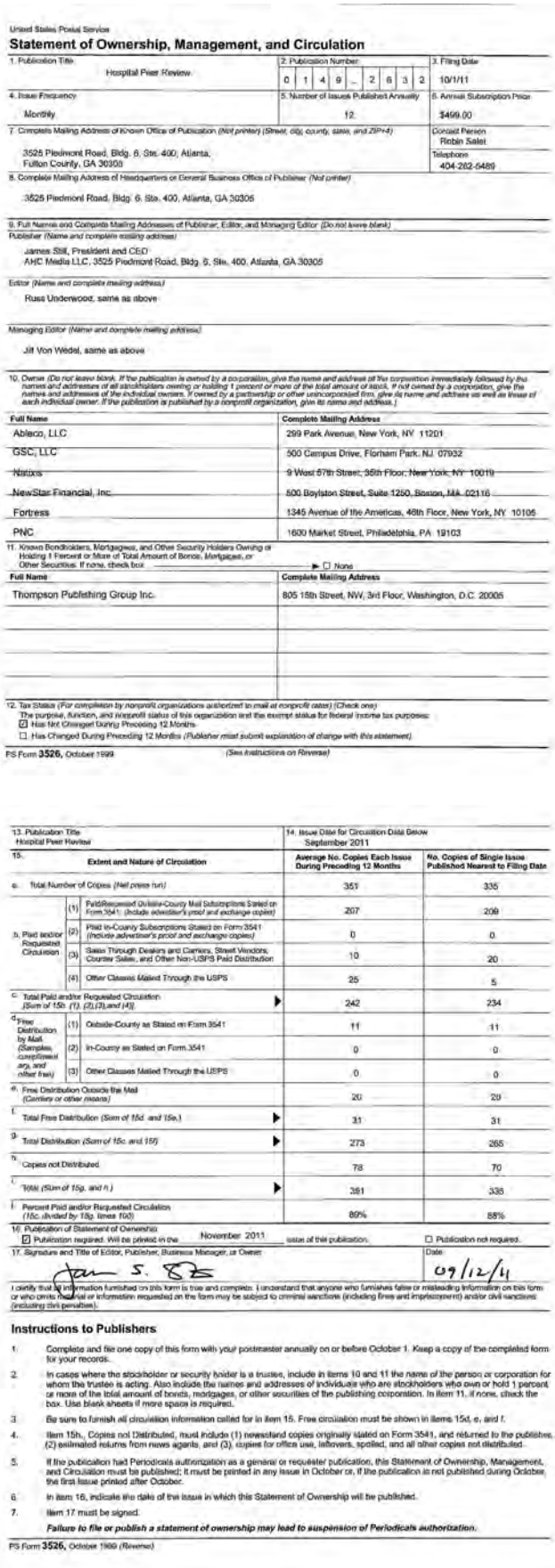
3. One common mistake made in creating measurements for QI programs is
A. Not using both process and outcome measurements
B. Math errors
C. Improper estimation
D. Rounding of sample sizes

4. According to Amy Vance of Presbyterian Hospital, leadership's role in JC surveys should be:
A. To do the end-of-survey cheerleading
B. To never let staff say they "can't" get something done
C. To be there from the start to the end doing whatever needs to be done
D. To be behind the scenes in the control room.

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.



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