YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

November 2012: Vol. 37, No. 11
Pages 121-132

IN THIS ISSUE

Follow us on Twitter @HospitalQI

Financial Disclosure:
Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

DNV Healthcare, Joint Commission emphasize differences

Four years on, upstart nears 350 clients

In the few years since DNV Healthcare became the first new company in 40 years to win deeming status from the Centers for Medicare & Medicaid Services (CMS), some 320 of the 5,800 registered facilities have opted to use the OH-based company rather than The Joint Commission (TJC). So far, 250 of those facilities have been surveyed and accredited, says **Yehuda Dror**, president of the organization. It may not seem a large number, but the growth rate is increasing at a pace that Dror says is validating.

"No one else has started something completely new like this. In the first year after we received deeming authority in late 2008, we had to wait for people to come join the party," he says. Organizations want to do due diligence before they switch, and while DNV was well known and highly regarded outside healthcare, it was unknown within it. That meant selling the first folks on the switch was hard. But as more organizations make the change, word is spreading. "The more references they have to check, the easier it gets for us."

Dror says he has found the whole decision-making process to change from The Joint Commission (TJC) to DNV interesting to watch. "They can make decisions to buy multimillion-dollar pieces of equipment in a matter of weeks. But switching accreditation bodies takes months or even years." *(For more on how the process a hospital goes through to make the change, see related story page 123.)*

He believes that what sets DNV apart is the integrated use of ISO 9001 (a set of standards for quality management created by the International Organization for Standardization in 1987) and focus on the CMS Conditions of Participation (CoPs). The former means that there isn't a focus on a quality improvement project here and another project there, but a systemic approach to quality. "If you don't understand an overall quality management structure, then what you do is incidental and doesn't relate to the whole organization. ISO 9001 provides a great infrastructure to hospitals. It helps you to understand where to look when there is a problem."

Having the CoPs as the basis of standards means a facility doesn't have to duplicate data collection. "There are plenty of metrics out there," says Dror. "You have to find a balance between how much you measure and the returns

you get on those measurements. We don't want to focus on measuring, but on the objectives."

Potential clients often ask Dror how they should prepare for a survey. "They spend so much time preparing for it like an exam. We don't want them to do that, but rather to do what's right for patient safety. We may end up giving them more findings, but unless they are jeopardizing patient safety, there is no penalty. Just take the findings and use them to improve."

So many times, a surveyor will leave the quality staff looking through their policies and wondering just why they do something, he says. "Sometimes it's done because it is mandated. But sometimes, it's just someone's interpretation of a rule. If it works, keep it. But our position is that if it isn't mandated, there isn't a good reason to do it, and it doesn't work, don't do it."

Older doesn't mean out of it

The Joint Commission looks at the competition with an increasingly serious eye. Six months ago, the organization moved **Ann Scott Blouin**, RN, PhD, FACHE, from her role as executive vice president of certification and accreditation to a new role as executive vice president of customer relations. "The purpose was to better understand the voice of the customer and respond in a more consistent manner," she explains.

She explains that there are a bevy of methods being used now to keep customer needs and desires front of mind: a customer loyalty survey administered by third party to CEOs of the organizations TJC certifies, a customer value assessment in which clients are asked their expectations of the survey process, and a post-survey chance to grade TJC against those expectations. A newly hired director-level position assists Blouin in staying in contact with clients.

She and other customer relations staff respond to positive and negative comments as received, and Blouin says that the number of complaints has dropped "dramatically" since 2008. She trends the data and looks for patterns. If a client does leave, there is an exit interview, the results of which are forwarded to the executive director of whichever certification program — hospital, lab, etc. — the client is part of; anything that isn't clear from that interview inspires Blouin to make a call to the organization for further information.

Along with that continual focus on clients, she says there are things that make TJC different from both DNV and the other deemed accreditation provider, Healthcare Facilities Accreditation Program (HFAP, which has about 200 clients). TJC is the only one that accredits across the continuum of care, and Blouin emphasizes the role it played in developing the Baldrige criteria. It has a close relationship with CMS, including its attendance at TJC board meetings, weekly meetings between the two at TJC's

Hospital Peer Review® (ISSN# 0149-2632) is published monthly and Patient Satisfaction Planner™ is published quarterly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

Editor: Lisa Hubbell

Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Associate Managing Editor: Jill Drachenberg, (404) 262-5508 (jill.drachenberg@ahcmedia.com).

Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

Washington, DC, office, and using that office as a base from which to lobby on Capitol Hill.

She thinks the robust collaborative endeavors that TJC fosters among clients, as wells as the large number of tools they make available offer something special to clients. Cost responsiveness — no fee increases in the last several years — and customer focus prove that TJC understands its clients, Blouin notes.

Dror says there is plenty of room for more than one organization in accreditation, and indeed, competition is good for both, and Blouin says she agrees. "They fill an important role," Dror says. "One of them is to keep us on our toes." ■

What makes a hospital change accreditors?

Two facilities outline their rationale

At the 100-bed Morehead Memorial Hospital in Eden, NC, the journey from TJC to DNV took two years, says **Susan Netherland**, RN, MBA, director of quality management and compliance officer at the facility *(for a description of that two-year journey, see story page 125)*. "We were TJC-accredited for years, but we had concerns after our last survey," she explains. "There were many small picky things, and so many standards and so many elements of performance, that it was hard to meet them all. And it was all subjective to the surveyor. We had one surveyor tell us something was a great idea, and another that it wasn't. It wasn't the outcome that seemed to interest them, but how we got there. We thought that was wrong and our medical staff were increasingly unhappy. They wanted the big picture of quality to be the most important thing to the accreditation body."

The thing that first got the Morehead Memorial administration interested in the DNV process was its focus on the CMS Conditions of Participation (CoPs), rather than a separate set of standards. "We all know them, and we all have to abide by them," Netherland says. The CoPs come with interpretive guidelines, she notes, while if you have six different Joint Commission surveyors and a single standard, you may get six different interpretations of it.

Netherland likes that DNV also bases its accreditation on ISO 9001, which is an internationally recognized management system that impacts every part of an organization — from housekeeping to neurosurgery, every employee from porter to chief executive. DNV gives a facility three years to reach ISO 9001 status, and returns annually to check on progress. "That's an excellent quality structure," she says.

Netherland says she was impressed with how focused the organization was on outcomes during the survey, which occurred during three days in July. If you choose to mark the right surgical site with a balloon bouquet attached to the appropriate body part rather than with a felt-tipped marker, that's fine, she notes. That there are no wrong-site surgeries is the important thing.

Before making the final decision, Netherland says they had to check with all payers and bond companies to make sure they would accept the DNV accreditation. The lab at the hospital, which was also TJC-accredited, was another issue. You can't maintain TJC lab accreditation if the hospital itself isn't using TJC. So, Morehead Memorial transitioned to the College of American Pathologist (CAP) accreditation.

After letting TJC know it was dropping from its program, the organization conducted an exit interview, Netherland notes. When she had her exit interview with TJC, Netherland says she was blunt with the organization about the reasons they were changing, the strong desire from the medical staff, and the problems they had with previous surveys and surveyors.

Among the stories she shared: an instance when a second survey was required for findings related to paperwork that could have been forwarded by email. Instead, they paid $6,000 for what amounted to a one-hour visit by a nurse so old that had she been required to do any climbing to look for something, she wouldn't have been able to, Netherland notes. Another issue: They didn't get the final accreditation certificate from a 2010 survey until this last spring. Why? There was torn furniture and they were required to monitor it for 18 months. "Nitpicky things like that drove us away."

All of the 1,000 employees at the hospital received training on the new accreditation program. "We explained the switch, why we were making it, and what DNV would be looking for."

The survey itself wasn't largely different — DNV uses tracers, like TJC. Netherland says that they seem to be very policy-driven and will ding you if you have a policy that specifies a specific action and you can't prove it was done.

"No one ran away from these surveyors," she says. "They were relaxed with us and answered our questions. I even wondered if they weren't doing a good job because I wasn't in a panic."

DNV looks for patterns of problems, she says, rather than single incidents. For example, there was an open carton of milk in a nutrition refrigerator. But it was just one carton of milk in one refrigerator, and the hospital wasn't cited for that, but educated on the finding. Surveyors didn't just mention issues to address, Netherland continues. "They also told us about the 'wow!' moments where they found something outstanding. On the last day, one surveyor told us she would be happy to be a patient here."

The findings are structured into Non-Conformity 1 and Non-Conformity 2 findings, as well as findings that are related to the immediate threat to patient safety. They had none of the latter. Non-Conformity 1 findings need to have a quick fix — with an action plan returned to DNV within 10 calendar days and send measurement of success within three months. Non-Conformity 2 problems are checked at the next annual visit.

In the former category, Morehead needed to get a separate permit for anesthesia services, and improve temperature monitoring of refrigerators. Most of the Non-Conformity 2 issues related to data missing from physician reports.

In a year, at least one person from the original survey team of four will return for the next survey. Netherland says that continuity is another plus to her.

TJC isn't completely absent from the Morehead world, Netherland says. The hospital will continue to use some of the organization's standards, like using two patient identifiers. And it will keep up with the sentinel event alerts issued by the commission. DNV doesn't yet have the extensive website and tools available that TJC does. But they are quick to answer questions through the online "drop box" program. Listservs for other organizations will stand in for TJC collaboratives when it comes to searching for solutions to common problems.

The cost isn't a whole lot different, she says. "The surveys are a little more expensive, but there isn't an annual fee and you don't have to buy all the standard books. I think it's a break-even situation, or maybe a little cheaper with DNV over the three-year accreditation period."

As the facility moves forward with ISO certification and continued accreditation from DNV, Netherland says she continues to get questions from peers about their experience. And she's happy to sing DNV's praises. "We are just the fourth hospital in North Carolina to go with them," she says. "People are interested in what we did, but still skittish. They worry that patients will care about the change. The Joint Commission has done a great job marketing itself, but patients care that you are accredited, not who does it."

She says Morehead will continue to evaluate accreditors and the accreditation process, but she would be surprised if they went back to TJC. "This was the most amazing survey process I've been involved with in the 44 years I've been a nurse."

Positive experience from both

Good Samaritan Hospital in Downers Grove, IL, changed from TJC to DNV in April. It is one of 10 hospitals in the Advocate Healthcare System that is changing, and was in the group of three that went first, says **Marty Dietrich**, MPH, RHIA, CPHQ, director of quality improvement and regulatory affairs for the hospital.

She was on the steering committee that made the decision to change. For them, there was no issue with The Joint Commission, but rather a determination to be ISO 9001 certified. "The Joint Commission had talked about moving that way, but there were no great plans as to when," she says. "As a Baldrige organization, we are very process-driven, and you can line up Baldrige and ISO criteria next to each other and they match up very well."

The ISO 9001 platform improves service consistency and operational efficiency, says Dietrich. "It increases patient satisfaction scores and enhances customer perception — a lot of them have heard of ISO through jobs in manufacturing or other industries. We think it gives us a competitive advantage and an internationally recognized designation that gives us access to a wider quality form."

The Joint Commission used Good Samaritan as a training site for international surveyors, and Dietrich says they had — and continue to have — a great relationship with the organization. But they wanted to stick with the CoPs as basic standards and add the ISO 9001 certification.

When she went through the first survey with DNV, she says she was surprised at how informal and low-key it was. "With TJC you have a formal presentation on the first day, but DNV wasn't

interested in that. We had provided them with a lot of information ahead of time, and they were quite familiar with us. They knew about our quality plan — there was a closed-door evaluation of it — and our scope of service for every single unit and department in the hospital. They used the tracer methodology like The Joint Commission, but I think they are more interactive with the staff."

There are more findings, and while TJC requires that you be in the 90th percentile and have 90 days to fix problems, DNV is focused on improvement, Dietrich notes. "If half of your records aren't complete, they won't expect you to reach 90% within 90 days. Unless it is a condition-related finding, they are happy to see that you are making progress within three months, and they'll check again when they resurvey you in a year," Dietrich says.

The findings at Good Samaritan were not much different from those that TJC found the last time they were there, she says. "Level two findings like documentation issues — signing and dating of things."

DNV surveyors lead the survey more, and Dietrich says she felt less in control, but that was fine. "They knew where they wanted to look when they came in. They asked for a list of contracted services. They looked for patterns. They dug deeper if they saw something that troubled them." One thing that she likes about the DNV process is that it emphasizes to the organization as a whole that quality isn't just the property of a single department. Rather, it is everyone's responsibility.

Dietrich says the surveyors were knowledgeable about healthcare, having worked in the industry recently, and for years. "They understood the constraints and responsibilities," she notes. "They were interested in bringing things to our attention and helping us find ways to solve problems."

The informality threw some people at Good Samaritan for a loop initially. "They wondered if their being so relaxed somehow meant there would be some serious dings," she recalls.

The findings went to the regulatory committee, which has key leaders from a multitude of departments and disciplines. They suggested fixes and ways to improve. Now there are continual mock surveys and no sense of having to rush to get ready for what's coming next spring.

There are things that she wishes were different, like a more robust and interactive DNV website, perhaps a way to communicate with other clients about problems and how to solve them.

DNV president **Yehuda Dror** notes that there is a symposium coming up that will have some 250 participants and will include a presentation from a hospital on how to prepare for and achieve ISO 9001 certification.

Five more Advocate Healthcare hospitals are due to be surveyed before the end of the year, with the remainder getting their turn under the microscope in the early part of 2013. With TJC testing ISO 9001 certification programs, Dietrich says Advocate will likely re-evaluate certification options in the future. "The door is never shut for them," she says. "We will continue to look at what they are doing."

Meanwhile, TJC's national patient safety goals will continue to be part of Advocate's quality improvement and patient safety program. "They are excellent, and we think even though DNV isn't looking at them, we see value in continuing." Other Joint Commission programs will also stay on Dietrich's radar.

In the next issue, Hospital Peer Review *will look at some hospitals that evaluated DNV and opted to stay with The Joint Commission for why they consider TJC a better option for them.*

For more information, contact:

- *Yehuda Dror, President, DNV Healthcare, Milford, OH. Email: yehuda.dror@dnv.com.*
- *Ann Scott Blouin, RN, Ph.D., FACHE, Executive Vice President, Customer Relations, The Joint Commission, Oakbrook Terrace, IL. Email: ablouin@jointcommission.org.*
- *Susan Netherland, RN, BSN, MBA, Director of Quality Management/Compliance Officer, Morehead Memorial Hospital. Eden, NC. Telephone: (336) 623-9711x2364. Email: snetherland@morehead.org.*
- *Marty Dietrich, MPH, RHIA, CPHQ, Director, Quality Improvement and Regulatory, Advocate Health, Downers Grove, IL. Telephone: (630) 275-1477. Email: marty.dietrich@advocatehealth.com.* ■

What's taking so long?

One hospital's two-year trek from TJC to DNV

Two years sounds like a long time to move from one service provider to another, but it wasn't dawdling that stretched the time for Eden, NC-based Morehead Memorial Hospital to shift its accreditation surveys from The Joint Commission (TJC) to DNV, says **Susan**

Netherland, RN, MBA, director of quality management and compliance officer.

After getting complaints from medical staff, the executive management team investigated the alternatives and decided to look in depth at DNV, scheduling a conference call between the board, medical leadership, and DNV executives. That was followed by Netherland reaching out to several DNV client hospitals for references and investigating any cost differential between TJC and DNV.

Netherland and her team checked with insurers and financial institutions to ensure a change was acceptable to them, as well as with the Commission on Cancer, which accredits the Morehead cancer center. DNV then did a site visit.

"The thing that took the longest was trying to ensure we could make the transition between Joint Commission visits," she says. "We also had to transition the lab to be certified by the College of American Pathologists (CAP), which required about a year of preparation." The last TJC survey was February 2010, and TJC was due again in early 2013.

Before then, she needed to educate staff on the change, ramp up understanding of the Conditions of Participation on which DNV bases accreditation, and also start learning about ISO 9001. "Another issue that made our transition a little longer was that we had a fairly large turnover in nursing leadership and some things could not move forward until that structure was back in place." ■

TJC annual report shows safety improvement

620 hospitals named top performers

The 5th annual Joint Commission (TJC) report on patient safety, "Improving America's Hospitals: The Joint Commission Annual Report on Quality and Safety 2012," presents proof positive that hospitals are getting the quality message that TJC wants them to learn. This year, it lists more than double the number of top performing hospitals as in 2011, with 620 of the more than 3,300 hospitals submitting data to TJC achieving that status. To gain such recognition, they must score 95% or better on both the composite score from all the measures, and for every measure for which there are more than 30 eligible cases or patients.

While just under a fifth of reporting facilities were top performers, the vast majority — just under 89% — had a composite score of at least 90%, more than four times the total that reached that level a decade ago.

The number with the 90 or above composite score might have been higher, but the 2012 report includes new measures for inpatient psychiatric, stroke, and venous thromboembolism (VTE) care, whose addition resulted from the 91.7% that got a 90 or above composite score last year.

Another 583 hospitals were just short of making the Top Performer mark by missing the 95% cutoff on a single measure.

All of the measures tracked for more than a year have shown improvement over the last 12 months. Most of the measures are well into the 90-100% category. The new measures, though, lag a bit but still show improvement. VTE care is up 7.2 points to 89.9%; stroke care is up 2.2% to 94.9; and inpatient psychiatric services is up from 80.5% two years ago to 87.3 in this past year.

While maybe a third of the reporting hospitals show themselves to be astonishingly safe facilities worthy — or very nearly worthy — of being called a top performer, it's by no means an easy designation to get, say **Jerod Loeb**, PhD, executive vice president for the division of healthcare quality evaluation at TJC.

Indeed, if you look at the lists of top hospitals that make it into consumer publications, few of those facilities make the grade in TJC's annual report. "The academic medical centers are underrepresented here, although there are more of them this year than last." Their representation actually increased by half — from 6% of the top performers to 9%.

But the fact that relatively few academic medical centers are listed is of interest. Loeb says they are very large organizations with huge staff and vast numbers of patients. Getting something right 95% of the time, and remembering to document that you did so, seems to be much harder for those large organizations. While many large hospitals will note that they serve much sicker patients, Loeb says that won't fly with these measures, because none of them are related to severity of illness.

As a cancer patient, Loeb says he has experienced care in both a large cancer center and a small community hospital. "I think it's easier in the latter to get things done. My hope is that this will be a stimulus to those bigger facilities to talk more about how to ensure the mundane stuff gets done and documented, like getting aspirin or beta-blockers to

the appropriate patients in a timely manner."

And while Loeb encourages organizations to talk to each other to find answers to some of the problems they encounter — there are solution sharing opportunities through the Joint Commission website — he is a firm believer that "when you've seen one institution, you've seen one institution. When you have a vexing problem in healthcare, the reasons at one hospital might be different than another. If you don't find the reason behind the failure specific to your facility, then your solution will be a failure."

For example, if hand-washing is a concern, maybe you find that placement of the hand sanitizer is a problem. So you place it near the entry and exit of the room and expect your compliance to go up, particularly if that worked at a facility like yours. But if you don't consider issues specific to your hospital — like having someplace for a nurse or doctor to put a chart so they can use the dispenser — then simply moving your hand sanitizer dispensers won't help solve your problem. "The old notions of best practices working everywhere doesn't hold," he says.

For those who still need to get that last little bit up to 95% and beyond, Loeb says to do a root cause analysis for even the everyday things. "Most of the time, they save root cause analysis for tragedies and sentinel events," he says.

Loeb says the 95% bar is high, but he knows that if there are 95 patients getting what they need every time, then there are five others who aren't. "Put yourself in the mind of a CEO who is being asked to defend not getting it right all the time," he says. "We have seen steady increases, predating a connection to incentive payments and public reporting. I think that for now, this is fine, but in a year or two, I bet the rules will be tighter. I would love to see some sort of reward for hitting that 100% mark, but at the end of the day, healthcare is local and a uniquely human endeavor."

What's it take to be the best?

Just getting to that 95% bar is difficult enough, and takes everyone in a facility working together. The more people you have, the harder that is, says **Donna L. Zubay,** BSN, MBA, CPHQ, chief quality officer and facility compliance officer at Oro Valley (AZ) Hospital. "If you have a constant rotation of new people and residents, it must be hard to achieve this kind of goal," she says. For her facility, it took having hospitalists on board, seeing pretty much every heart failure and pneumonia patient.

Zubay says the hospital uses an EMS provider whose staff relay what's going on in the field to the medical personnel at the hospital. They have built a level of trust over the years that allows the physicians to trust the technicians bringing in the patients implicitly. They work together to ensure that standards related to something like cardiac or stroke care are met on time for every single appropriate patient.

Despite being a top performer, Zubay says she still watches the new measures related to stroke and VTE carefully. "Getting the registration piece done quickly enough to get someone to the cath lab or whatever is tough." The hospital has been in the high 90s for most measures for a while. Getting to 100 is tough. For a 144-bed facility with an average census in the 60s, there are some kinds of cases and patients that are rare. Miss something on a single door-to-balloon measure or ACE or ARB inhibitors on discharge for one patient and you risk going below that 95% level, let alone the perfect mark.

She says constant teaching from the quality department and auditing of patient charts while the patient is still in the hospital helps them continue to perform at an exceptional level. "Concurrent auditing is important. If you don't know if you need some information in the chart — the injection fraction for a heart failure patient that might have been done in the cardiologist's office before admission, for instance — you have a problem. Knowing something is missing after the patient leaves is too late."

She also makes it a point to tell physicians or nurses whenever something from one of the measures is missed or is missing. "We talk about this stuff regularly," says Zubay.

Another Top Performer, Bon Secours Maryview Medical Center in Portsmouth, VA, puts its excellence down to involving everyone from food service to contractors in quality and quality improvement, says **Warren Austin**, MD, chief medical officer for the facility. "Someone from security may help the pneumonia team. Everyone is a part of our culture of excellence."

And while Austin says he knows the hospital is an outstanding facility, there was still an element of surprise at being named among the best of the best. "But while getting awards is great, great care is better."

The hospital aims for 100% on every single core measure, he says. "If you are at 61 minutes for presurgical antibiotics, you fall out of that 100%. It doesn't matter if it was because of some surgical

delay or other uncontrollable reason. There are a lot of moving parts and you have to have everyone involved, everyone playing a part."

A current goal for Bon Secours Maryview is zero healthcare-acquired infections. "Sick people come to the hospital and spread their germs," Austin says. "We work towards zero, we shoot for the moon, but it's very hard." And while 99% seems like a great score for an algebra test, he says they don't celebrate for anything less than perfect. "We might share that something is 97%, but there is no party."

Indeed, make it a point to remind your staff what 95% really means, says **Ruth Ragusa**, RN, vice president of organizational effectiveness at South Nassau Community Hospital in Oceanside, NY. "If you or your mother or your child were one of the 5% that didn't get some treatment or care in the right amount of time, you'd be concerned. If you present this to your staff and they applaud the 95%, remember to remind them that of those 1,000 patients, 50 didn't get the very best care. Remember the ones you miss."

For more information, please contact:

• *Jerod Loeb, Ph.D., Executive Vice President, Division of Healthcare Quality Evaluation, The Joint Commission, Oakbrook Terrace, IL. Email: jloeb@jointcommission.org.*

• *Donna L. Zubay BSN, MBA, CPHQ, Chief Quality Officer and Facility Compliance Officer, Oro Valley Hospital, Oro Valley, AZ. Telephone (520) 901-3608. Email: Donna.Zubay@orovalley-hospital.com*

• *Warren Austin, MD, Chief Medical Officer, Bon Secorus Maryview Medical Center, Portsmouth, VA. Telephone: (757) 398-2200.*

• *Ruth Ragusa, RN, Vice President of Organizational Effectiveness, South Nassau Community Hospital. Oceanside, NY. Telephone: (516) 632-3999.* ■

Bon Secours hospital gains recognition

The same week that Bon Secours Virginia Health System got the news that one of its hospitals was named a Top Performer by the Joint Commission *(see story above)*, it got news that another of its facilities, Bon Secours Mary Immaculate Hospital in Newport News, VA, achieved a long-held goal: to reach Pathway To Excellence designation by the American Nurses Credentialing Center (ANCC), indicating it has created a positive work environment for its nurses as determined by a rigorous review process. It is the third hospital in Virginia to achieve the designation. All three are Bon Secours facilities.

The facility had to show it had implemented 12 quality initiatives that research shows make a difference to both the nurses working at a facility and their patients. Those standards are:

- nursing control of nursing practices;
- a safe work environment;
- systems to address patient care and practice concerns;
- a good orientation program;
- a qualified CNO who participates at all levels of the organization;
- professional development that is available and utilized;
- fair compensation;
- recognition for nursing achievements;
- work-life balance is encouraged;
- an emphasis on collaborative relationships;
- competent and accountable nurse managers;
- evidence-based practices and robust quality improvement program.

It took two years to complete the process, including an application, the compilation of reams of documentation, review by an accrediting commission, and a survey of nurses that at least 51% of them had to return and whose result must be at least 75% positive. **Jeff Doucette**, MS, RN, vice president of patient care services and chief nursing officer, says that they had a 69% participation rate and "great" positive responses.

The designation lasts for three years, and is often the first step an organization takes on its path to Magnet status, also awarded by the ANCC. "Hospitals that meet this criteria have better outcomes, better patient and physician satisfaction with the quality of nursing care, and a recognized positive work environment for nurses," he says. "This is the only organization and program that links the nursing experience to outcomes."

Doucette encourages other organizations who believe they have a great nursing staff to look at the program and consider going through the process. Even smaller facilities for which Magnet status isn't a good fit can take this step in adopting the foundational core of the Magnet program, he says. "Pathways offers you a chance to let your staff know — and the community you serve know — that you value your nurses and understand that

what they do impacts patient outcomes.

Doucette says Mary Immaculate will continue to work toward Magnet recognition, and is thrilled to reach this point on the journey. "As an early adopter of the Pathways program, we want to get the word out about it. This is the validation of what we have invested in our nursing team and its development." ■

OIG work plan a useful guide for quality

Readmissions a continued focus

It must seem as though the number of important things to read and digest that come across a quality manager's desk is never-ending. But the 2013 Office of Inspector General (OIG) Work Plan should be at the top of your to-do list. It gives you a clear view of the things that are a concern for the OIG and with which you should ensure you are in compliance, says **Mike McGinnis**, a director and senior consultant with Warbird Consulting Partners in Shaver Lake, CA.

Of the 25 or so investigations related to hospitals that are listed in the plan, about half are new, he says. It is on those new items that you should focus your attention *(for a list of the investigations, see box page 130)*, McGinnis says.

Among those that are new is bundling. The OIG will look at whether bundling outpatient services delivered within two weeks of admission into a single DRG might result in some savings, McGinnis says. The current rule is for three days prior to hospital admission.

The OIG is also interested in looking at payments for cancelled surgeries. "They want to make sure that a subsequent real surgery takes place after the cancelled one."

If you are working with a quality improvement organization (QIO), this is of interest to the OIG, which wants to assess barriers those QIOs experience when working with hospitals.

Rules around mechanical ventilators, which require a minimum of 96 hours for a patient to trigger payment, is also on the agenda, he says. This might be a particular concern for quality staff since getting patients off ventilators as quickly as possible is important to patient safety.

For those working in long-term acute care hospitals, interrupted stays are something the OIG has its eye on, and if you have a home health agency in your hospital, McGinnis says you should be particularly aware of the OIG's interest in the face-to-face rule that requires physicians who certify that a Medicare beneficiary is eligible for home health actually see the patient in person. "Make sure that your agency understands the rules, follows them, and documents that they are followed," he advises.

McGinnis suggests that utilization review, the chief financial officer, and quality improvement departments take a look at the work plan separately and together. "The OIG does us a favor by publishing this. It tells us outright what the areas of concern are. You can look at your history, at your data, and see if you are compliant in these areas. If you are not, set up systems to ensure you become compliant or create projects that will lead to it," he says. "This should be your blueprint."

At Sierra View District Hospital in Porterville, CA, **Donna Hefner**, RN, MS, CPHRM, the executive director of risk, has already been through the work plan. She calls it a great reference.

"For me it's a great communication tool," Hefner says. "It helps me convey what is important to the appropriate people on the compliance committee to share with their respective staffs."

For any item that is marked as new, Hefner says she and her team will do an audit to see if the hospital is compliant. Already looking at the payments for cancelled surgeries issue, they are pulling charts and having representatives from all disciplines look at the information to see whether they need to make changes, corrections, or implement a quality improvement project. They will continue to focus on any emergent issue until compliance is 100% or there are three consecutive quarters at the required benchmark.

"I've found it to be one of the most useful reports over the years," Hefner says.

A complete copy of the work plan is available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

For more information, contact:

- *Mike McGinnis, Director and Senior Consultant, Warbird Consulting Partners, Shaver Lake, CA. Telephone: (559) 788-6102. Email: mmginnis@warbirdcp.com*
- *Donna Hefner, RN, MS, CPHRM, Executive Director of Risk, Sierra View District Hospital, Porterville, CA. Telephone: (559) 788-6193.* ■

Selected OIG Work Plan topics related to hospitals

New topics indicated by *

* Inpatient Billing for Medicare Beneficiaries
* Diagnosis Related Group Window
Hospitals—Same-Day Readmissions
* Non-Hospital-Owned Physician Practices Using Provider-Based Status
* Compliance with Medicare's Transfer Policy
* Payments for Discharges to Swing Beds in Other Hospitals
Acute-Care Inpatient Transfers to Inpatient Hospice Care
* Payments for Canceled Surgical Procedures
* Payments for Mechanical Ventilation
Admissions with Conditions Coded Present on Admission
Inpatient and Outpatient Payments to Acute Care Hospitals
Inpatient Outlier Payments: Trends and Hospital Characteristics
Reconciliations of Outlier Payments
* Quality Improvement Organizations' Work With Hospitals
Duplicate Graduate Medical Education Payments
Occupational-Mix Data Used To Calculate Inpatient Hospital Wage Indexes
Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices
Outpatient Dental Claims
Outpatient Observation Services During Outpatient Visits
* Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending
Critical Access Hospitals — Variations in Size, Services, and Distance From Other Hospitals
* Critical Access Hospitals — Payments for Swing-Bed Services
* Long Term Acute Care Hospitals — Payments for Interrupted Stays
* Hospitals' Experiences with Drug Shortages
Medicare and Medicaid Security of Portable Devices Containing Personal Health Information at Contractors and Hospitals
* State Determinations of Hospital Provider Eligibility and Program Participation

National summit looks at overuse of treatments

TJC links with AMA subgroup

More than 200 people gathered in late September to discuss the problem of doing too much for patients. Physicians from the American Medical Association's Physician Consortium for Performance Improvement (PCPI) and The Joint Commission (TJC) held the symposium on overuse of five treatments or procedures:

- heart vessel stents;
- blood transfusions;
- tympanostomy tubes for fluid behind the ear drum;
- antibiotics prescribed for viral infections such as the common cold;
- early scheduled birth without medical need.

Along with participants from the two sponsoring organizations, there were other health care professionals, representatives from payer organizations, and patient advocacy groups present at the meeting, says **Jerod Loeb**, PhD, executive vice president of the division of healthcare quality evaluation at TJC.

He says that there were both believers and nonbelievers in overuse when the work groups convened to discuss the matter months ago. And even though there is plenty of peer-reviewed information that these practices are widely misused to the detriment of both specific patient health and the overall health of the community, there were dubious attendees at the summit.

"Even when there is consensus, it still happens," says Loeb, recalling a line from one of the speeches given at the summit: One man's overuse is another man's income. "What we need to do is find exemplars out there to help others get religion."

The next step is to put together a white paper that will outline the problem and then come up with potential solutions, Loeb says. For now, he suggests quality managers focus on the topics as a quality and safety issue, not a fiscal one. "Reducing these practices will reduce preventable harm, even if it's hard to see," he says, noting that antibiotic resistance is something we hear about as a public health issue, not in terms of a particular patient being harmed because he or she was given antibiotics when the problem was a simple cold. "We need to create the view that this is a

quality improvement problem."

Bernard M. Rosof, MD, chairman of the PCPI, says that physicians need to understand the impact that these unnecessary treatments have in terms of efficiency and cost, too, but that is secondary.

In every case, Rosof says the problem comes down to communication between the patient and the physician and in creating better shared decision-making. "Patients need to ask questions, and physicians need to communicate about why they make certain recommendations to patients and why they don't make others. This takes time, and that's a commodity of value to physicians."

While this particular partnership works on its consensus paper and best practices, there are resources out there that can help physicians do a better job. The American College of Physicians and the American Board of Internal Medicine both have problems related to making good treatment choices and improving patient communication. Share data on early planned deliveries and tympanostomy. Eventually, there may be financial or regulatory repercussions for organizations and physicians that don't get a handle on this, Rosof says. "If you aren't working on this, or don't participate in programs to reduce it and have outliers, I'm sure eventually your payment will be impacted." ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

CNE QUESTIONS

1. ISO 9001 was created in
a. the 1950s
b. 2008
c. 1987
d. 1969

2. To be a Top Performing Hospital you must:
a. Score 95% on all individual measures and have at least a 95% composite score.
b. Have a 95% score on all measures where you have at least 30 patients
c. Achieve a 90% composite score and 90% on all individual measures
d. Score 95% on all but a single measure and a 95% composite score

3. OIG's 2013 work plan includes new investigations related to
a. multivial drug use
b. service bundling
c. same day readmissions
d. outlier payments

4. The recent summit on overuse looked at five conditions. Which one was NOT one of them?
a. elective hip replacement
b. ear tubes
c. early induction of childbirth
d. inappropriate prescription of antibiotics

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 nurses on board with evidence-based care

■ Pressure ulcer success stories

■ Accreditation field report

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Hospital Peer Review	0 1 4 9 _ 2 6 3 2	10/1/12
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
James Still, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and complete mailing address)*
Russ Underwood, same as above

Managing Editor *(Name and complete mailing address)*
Jill Drachenberg, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Ableco, LLC	299 Park Avenue, New York, NY 11201
GSC, LLC	500 Campus Drive, Florham Park, NJ 07932
Natixis	9 West 57th Street, 35th Floor, New York, NY 10019
NewStar Financial, Inc.	500 Boylston Street, Suite 1250, Boston, MA 02116
Fortress	1345 Avenue of the Americas, 48th Floor, New York, NY 10105
PNC	1600 Market Street, Philadelphia, PA 19103

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor, Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** October 1999 *(See Instructions on Reverse)*

13. Publication Title: Hospital Peer Review			14. Issue Date for Circulation Data Below: September 2012	
15.		Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a.		Total Number of Copies *(Net press run)*	456	682
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	293	423
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	18	2
	(4)	Other Classes Mailed Through the USPS	18	6
c.		Total Paid and/or Requested Circulation *(Sum of 15b. (1), (2),(3),and (4))*	329	431
d. Free Distribution by Mail *(Samples, complimentary, and other free)*	(1)	Outside-County as Stated on Form 3541	12	11
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e.		Free Distribution Outside the Mail *(Carriers or other means)*	20	20
f.		Total Free Distribution *(Sum of 15d. and 15e.)*	32	31
g.		Total Distribution *(Sum of 15c. and 15f)*	361	462
h.		Copies not Distributed	95	220
i.		Total *(Sum of 15g. and h.)*	456	682
j.		Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*	91%	93%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2012 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: James S. Still — Date: 09/26/12

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form **3526,** October 1999 *(Reverse)*