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Current data plus continuous feedback can equal QI success

Many names for improvement programs that work

The regular collection and sharing of data with stakeholders to find and fix problems goes by many names — the Virginia Mason Production System, Toyota Management System, Lean, Six Sigma, Quality Improvement Circles. All are based on the notion that to make things better, you need to look at data often and make changes quickly based on what you see. It is an idea that is gaining traction in healthcare as more peer reviewed studies showcase its potential for success. *(For a look at some recent studies involving successful use of CQI, see box, page 99.)*

Some of the biggest proponents of continuous feedback are hospitals that have achieved Magnet status. (For more on the Magnet model, see <http://nursecredentialing.org/Magnet>.) “There are challenges to continuous knowledge,” says Pat Reid Ponte, DNSc, RN, FAAN, senior vice president of patient care services and chief nursing officer at Dana Farber Cancer Institute in Boston, a Magnet facility. She also serves as executive clinical nursing director at Brigham and Women’s Hospital, which does not currently have Magnet status. “You have to have a mechanism for measuring that is valid and accurate. One of the biggest hurdles is, you have to measure what you want to improve, know the baseline, and monitor it.”

That said, the very best organizations will track data regularly, and strive for early recognition of areas that need to improve, she says. And one set of improvements isn’t enough for these top organizations: The improvement has to continue, which means continually measuring those data points and analyzing them. In short, there is a lot of hard work, but it’s the kind of work that pays off.

Most hospitals have some structure in place to make sure regular monitoring of key data happens, but what they regularly measure is often only what is mandated by payers, the government, or regulatory bodies. “Most organizations do some of this already,” says Reid Ponte. “What moves it to the next level is to have centralized hospital resources and people who are experts in quality improvement and measurement working on this.”

“Resource intensive” is a phrase that crops up often when Reid Ponte talks about great CQI. She says an organization must have knowledgeable staff that can regularly look at data — monthly, weekly, or even daily depending on the project and the frequency of the process you are trying to improve — and spot potential problems early. “You have to wait for

enough data points to see trends,” she says. “If you are looking at diabetes care and are trying to improve blood sugar levels for inpatients, then you might look at the levels daily over a few months to get adequate data to see trends. But if you want to improve patient access to care, you might need more time to see a trend.”

While being statistically sure you are improving

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Editorial Questions

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can take months, you can still see problems by looking at the data regularly within some longer time frame, Reid Ponte adds. “The more often you measure, the greater potential to see change. It might be random variation, but it’s important to note and consider.” For some kinds of studies, every discrepancy from the norm you are trying to achieve may merit investigation, whether it is part of a snapshot in time or something you see in a longer-term trend chart. For instance, if you are trying to instill a culture where there are uniform catheterization procedures in the ICU in order to reduce infections, you might want to look at every deviation from the procedure you set up to find out why it occurred. “Regardless, the more you measure, the more potential to see change.”

Close by Dana Farber, Massachusetts General Hospital is using continual feedback to exert change in one of its imaging departments, as described in a recent study in *Academic Radiology*.¹ The project was created as a method of reducing cardiac computed tomography angiography (cCTA) and still achieving good image quality. Getting it right is highly dependent on the training, education, and experience of the physician and technologist, according to author **Brian Ghoshhajra**, MD, MBA, director of the clinical cardiac CT and MRI imaging and cardiac MR PET CT program in the hospital’s department of radiology. By providing near-real time feedback through weekly dose reports, the team hoped to achieve the best images with the least radiation.

Between April 2011 and January 2013, the authors looked at 450 consecutive patients who had physician-supervised cCTA for clinically indicated native coronary evaluation. A third of the patients were from before the weekly reports began, a third after the initiation of the reports, and to ensure that any positive outcomes were maintained over time, a third were done after the study was completed in September 2012. Doses declined “significantly” during the intervention period, he says, and were maintained afterward. The number of outliers also declined and held after the study was completed.¹

Using this method enables the team to provide care with lower radiation doses “than that of an invasive diagnostic angiography or the most commonly used noninvasive modality, nuclear myocardial perfusion imaging,” the study notes.¹

They have used similar continual feedback methods for projects related to imaging times in cardiac MRIs and contrast doses for people with renal failure having CT scans, says Ghoshhajra. The former,

to be published later this year in the *Journal of the American College of Radiology*, led to a reduction in scans exceeding 120 minutes from 28% to 8% while maintaining image quality. In the latter, which will also be published later this year (in the *Journal of Computer Aided Tomography*), Ghoshhajra says that they were able to reduce the IV contrast doses for CT angiography of the chest, abdomen, and pelvis from a standard 120 mL to a record low of 20 mL. “This allows a whole new population of patients in renal failure to undergo scans required for plan-

ning minimally invasive aortic valve surgeries.”

Doctors never anticipate they are doing anything other than the best for their patients, but this kind of feedback can show them that they may have room for improvement, he says. “It’s a way of raising their consciousness.”

The authors opted to do weekly reports because trainees were in the department for a week at a time. They charted 11 separate decisions to be made to get the best image at the lowest dose. While Ghoshhajra says they could have micromanaged those decisions

Five studies on the benefits of continuous feedback

1. In January, Carolyn Coffin, MPH, RDMS, RVT, RDCS, BOEC, a professor in diagnostic ultrasound at Seattle University, published a study about using various continuous quality improvement (CQI) methods to reduce exam time and lessen the potential for worker injury in an ultrasound department by standardizing processes. (Coffin CT. The continuous improvement process and ergonomics in ultrasound department. *Radiol Manag.* 2013 Jan-Feb;35(1):22-5.)

2. Geisinger Health System in Danville, PA, was the subject of a study in which CQI was used to develop high reliability in cardiac surgery. Gaps in established care guidelines were reported back in a continual manner to the team, and processes were redesigned as needed. The result was 100% compliance within three months. (Berry SA, Doll MC, McKinley KE et al. ProvenCare: quality improvement model for designing highly reliable care in cardiac surgery. *Qual Saf Health Care.* 2009 Oct; 18(5):360-8.)

3. Transfers between a hospital and skilled nursing facility in Rapid City, SD, got the CQI treatment, where inefficient transfers had been a plague to the two entities since the 1990s. Using CQI methods, they developed forms and processes, including asking staff a simple question: Have any problems occurred with transfers lately? When the answer is yes, a task force studies the problem and develops changes to procedures. Along with improved efficiency, the two organizations saw a reduction of 30-day readmission rates for patients discharged to the facility to 14.75%, lower than any reported state or national average. (Sandvik D, Bade P, Dunham A, Hendrickson S. A hospital-to-nursing home transfer process associated with low hospital

readmission rates while targeting quality of care, patient safety, and convenience: a 20-year perspective. *J Am Med Dir Assoc.* 2013 May;14(5):367-74.)

4. In Pittsburgh, a CQI project related to smart pumps was implemented through a health system that includes 14 hospitals. Led by pharmacists, the team created a program where smart pump data is continuously transmitted to a main server and findings regularly posted on the system’s intranet. Metrics include rates of compliance with preprogrammed infusion limits, what drugs spur the most alerts, and which drugs are associated with overrides of those alerts. Over 18 months, nuisance alerts were reduced by 10% over each of four smart pump library updates, which led to better responses to real issues, like rapid infusion errors and pump workarounds. (Skledar SJ, Nicolai CS, Schilling D, et al. Quality-improvement analytics for intravenous infusion pumps. *Am J Health Syst Pharm.* 2013 Apr 15;70(8):680-6.)

5. In Nova Scotia, Canada, a group of researchers looked at how well CQI programs in place at pharmacies for at least a year worked. Users reported a perceived reduction in medication errors, higher confidence that the pharmacists were doing the right thing, and better understanding of dispensing and related processes and workflow. They also noted more willingness to talk about errors and a higher emphasis on quality and safety throughout the staff that became entrenched in workflow. (Boyle TA, Bishob AC, Duggan K, et al. Keeping the “continuous” in continuous quality improvement: Exploring perceived outcomes of CQI program use in community pharmacy. *Res Social Adm Pharm.* 2013 Mar 22. pii: S1551-7411(13)00021-1.) ■

with checklists, they chose instead to “let smart people react to the data.” There was no singling out — just a scatter plot of data points sent to everyone via email. “No one wants to be the outlier,” he says.

Ghoshhajra says his department currently keeps six months of data on scatter plot charts and the last week of doses in numbers for the entire team to see. He also checks to see what the outlying patients might have in common that could affect their imaging process — such as irregular heart rates.

Continuous feedback is a great tool, Ghoshhajra says. “It isn’t always the right choice, though. Not all of medicine is like an assembly line where you do the same thing over and over. But if you are doing a lot of something, then CQI methods can help you improve.”

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EHRs, quality measures: Study points to problems

AHA suggests collaboration to ease transitions

Electronic health records (EHRs) are supposed to make your life easier — everything at hand, collected automatically. But that’s not always the reality, and that fact is highlighted in a new report from the American Hospital Association (AHA) on how well hospitals are using EHRs to report on clinical quality measures. There are currently about 90 measures that hospitals have to collect for various quality programs, and the number seems to

increase regularly.

The report notes the potential of EHRs to “ease the burden” of quality reporting, while improving the ability to see performance in real time. Meaningful Use Stage 1 requires providers angling for financial incentives to report on 15 measures with some 180 data points. But the rapidity with which the program was implemented and subsequently altered means that accuracy may have suffered. The report notes these problems:

“• existing measures modified for calculation by EHRs without robust testing to determine if all of the data were available in existing EHRs;

“• known errors in the [measures] and lack of implementation within EHRs to test the feasibility of data collection or validation of results; and

“• lack of mature e-specification development and updating process.”

Several organizations were visited for the report, all of which had been lauded — by the industry, the press, and the government — for their efforts related to Meaningful Use, electronic health records, and quality improvement programs. They had been ahead of the curve in these areas by as many as 10 years, according to the report. And they all figured that the stage one requirements would be pretty straightforward for them to implement. Their actual experience was not what they expected.

According to the report, the organizations all conducted a gap analysis to compare the requirements against what they were already capturing, and all found a large gap — a lot of the data was there, but not captured in the right format. It took a lot of time and money to modify what they had in place so that it met Meaningful Use requirements. The hospitals all reported that they expected to rely on the electronic clinical quality measure (eCQM) reporting tools to perform eCQM calculations. If they had integrated EHRs, it was easier than if they had unique systems with little or no interoperability.

So they created workarounds — like manually entering data that was already in the system, but somewhere else. Validation of eCQM results was the source of a lot of effort but little success. Says the report: “Two hospitals were able to validate their technical ability to capture the necessary data; however, the use of these data fields was inconsistent, and they did not achieve clinical validation. One hospital achieved technical validation and did not directly compare the results of the eCQMs and the corresponding chart-abstracted

measures from which the eCQMs were derived. As an ongoing step in the eCQM validation process, three organizations developed a staff-intensive and unsustainable concurrent review process to encourage documentation directly by nurses or order-entry by physicians.”

These were not nay-saying hospitals that wanted no part of the new rules. They were all committed to the process and expected Meaningful Use to be part of a successful overall quality program. They figured they could get quality data from the EHRs, use all of the quality data they collected and share it with others, and use the EHR for clinical decision support related to the eCQMs. What they found instead were specifications that were hard to access, complex, sometimes inaccurate, and not maintained over time. There were technology challenges with tools that didn't work as expected and didn't generate accurate results in an efficient way.

Clinicians objected to the additional work that didn't seem to improve patient care in any way, since a lot of what they had to do was already included in the record in some other manner. Hospitals interviewed spent between two and 18 months of physician and nursing leadership time per measure making changes, and staff has to spend additional time making sure what is included is correct and manually correcting what is not.

“Organizations either spent considerable time in re-work to revise and validate the eCQM measurement process with the eCQM reporting tool, or chose to ignore the results in favor of those derived from the chart-abstracted versions of the measures,” the report says.

The hospitals also reported that all this extra time and money meant other things didn't get done — such as implementing medication bar coding programs.

The recommendations will bring cheers from many: Slow the pace of transition and use fewer, better tested measures; make EHRs and eCQM reporting tools more flexible; improve standards for EHRs to make them more user-friendly and easier to achieve Meaningful Use requirements; test the eCQMs before adopting them; and provide guidance and tested tools that will support hospitals in this transition. The summation: These tools should work for clinicians. Right now, clinicians are working for them and not getting much in return.

Diane Jones, senior associate director of policy at the AHA, says anyone involved in quality in a

hospital can gain insight from the report, which includes a list of the workarounds developed by the interviewed facilities, as well as in-depth policy recommendations.

“One of the most interesting results from these interviews is that the people traditionally responsible for quality improvement and measurement are not tightly aligned with the IT department,” she says. In some cases, they may not even know each other. But the best programs are those where the IT staff and QI staff are closely involved and collaborate often.

The number-one to-do item that emerges, Jones says, is that you have to develop that collaborative relationship. “You can't possibly address the issues related to Meaningful Use if you don't have a close relationship. Reach out to that other department. Foster bridges, bring people together. This is really a team effort.”

The report seems like a downer, but Jones says one of the positive lessons is that there is a clearer picture of what's hard and not working, even for hospitals that had a lot of EHR experience before meaningful use. “We thought if we talked to people across departments — finance, IT, nursing, quality — we could get a picture,” she says. And the picture is of difficulty overcome by collaborative environments, not people working in individual silos without knowledge or care of what someone else is doing down the hall.

The complete report can be seen at <http://www.aha.org/content/13/13ehrchallenges-issbrief.pdf>.

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Quality award winner engages patients

What do you have in common with the winners?

The American Hospital Association and McKesson have chosen Boston's Beth Israel Deaconess Medical Center (BIDMC) as the 2013 Quest for Quality prize winner, citing the hospital's emphasis on achieving the Institute of Medicine's six quality aims for healthcare — care that is safe, effective, efficient, timely, patient-centered, and equitable. The hospital was chosen by a multidisciplinary committee

and received a cash award of \$75,000.

“We haven’t decided what to do with it yet,” says **Kathleen P. Murray**, the director of performance assessment and regulatory compliance at BIDMC’s Silverman Institute for Health Care Quality and Safety. “I know it will be used to benefit everyone, because everyone here was involved in the quality that was recognized. Quality is part of everyone’s job.”

She thinks that what sets BIDMC apart and makes it a good choice as the prize winner is the utter dedication of the leadership — from the board, to the C-suite, to directors and managers — to quality and safety. All have absorbed the culture of safety. “We make it known through the actions of everyone that quality is the priority here,” says Murray. “If you come here and visit, you can tell, just like the committee did when they were considering us for the award.”

BIDMC prizes its quality transparency — the data about quality is available on the hospital’s website and includes things that many hospitals don’t, such as the Joint Commission reports they receive post-survey. They also keep all staff updated about adverse events in real time on the organization’s intranet, and openly and regularly discuss failures. Indeed, the theme of the last annual hospitalwide quality conference was “spectacular institutional failures.”

The overall knowledge of how the organization is doing creates “a healthy tension” in the employees and providers that encourages them not just to attain goals, but to try to surpass them, says Murray. Everyone sees via visible dashboards in the hallways just how well or poorly they are doing on key metrics.

One of the reasons BIDMC was singled out was the way the organization engages patients. Murray says that when there is a problem to be solved, patient advisory council members are asked for input. “They are game changers,” she says. For instance, when the hospital was working on a fall prevention program and wanted to make sure that patients and their families understood the risks, the council members said using dry statistics wouldn’t make them care. What they needed to include were real stories about real patients. BIDMC’s fall prevention pamphlet now includes a letter from a patient who was put on a fall prevention program but didn’t think she needed it. She fell. That makes more of an impact than numbers, Murray notes, and

it has led to other patient engagement programs making use of stories, which garner more attention than data among many people.

In a way, the notion of stories is something that has helped make quality a priority for everyone in the system. Each audience relates to something different, Murray explains. If you need to convince your CFO that quality is worth more resources, you need to put it in story form, in terms that will make sense to that particular person. For instance, if you don’t reach quality goals, you will lose revenue, and if you meet them, you might gain some. For the board, you might make the stories about market share and how improved patient satisfaction can raise that, or how being able to tout great QI results can be a talking point in the community.

In the end, regardless of how you get them there, Murray says that the way to emulate BIDMC is to make quality the job of every single person in the hospital. “It’s not just our job,” she says. “We are just the connector, the educator, the facilitator.”

Other hospitals recognized

BIDMC was one of four hospitals that the AHA and McKesson recognized. The others included Franklin Woods Community Hospital, which was named a finalist and won \$12,500. It’s a new hospital, and was honored for making patient-centered care part of its very design, which was based in part on patient input. As a result, there is a lot of natural light and elements of nature included in the building. The facility also created patient advisory councils, and requires employees to expressly commit through a contract to uphold the mission and principles of the hospital, including a dedication to patient-centered care.

St. Mary’s Hospital in Centralia, IL, and Vidant Medical Center in Greenville, NC, received citations of merit from Quest for Quality.

St. Mary’s was singled out for its “pervasive culture of safety, strong leadership and significant patient and family engagement in the care process,” according to the AHA-McKesson prize materials. Among the strengths at the hospital are its shared governance structure, which gets everyone involved in decisions that affect the culture of safety and teamwork.

Vidant Medical Center achieved notice for

having a complete turnaround in quality over the last several years, says **Rebecca Ross**, RN, MBA, assistant vice president for patient safety and quality. With 909 beds and more than 6,000 employees, analogies of big ships and how hard they are to stop and turn are inevitable. But Vidant Medical Center has turned it to the point that every single person who works at the hospital takes his or her responsibility for safety seriously and personally, she says.

The engagement of the board has been cited by the Institute for Healthcare Improvement as a “board on board” with quality.

Patients are highly involved, too. Ross says almost every quarterly board meeting includes a patient who tells a story about his or her experience with quality care. There are also patient advisors on the QI committee who are involved in decision making, including the policies, procedures, and facility design of a new children’s hospital that the Vidant health system is building. “We engage them in the care process, too,” she notes.

One example of the deep involvement of patients relates to a college student injured in a home invasion robbery. He was petrified, but strict visitation rules at the time left him without the comfort of family and friends for most of the day. When he succumbed to his injuries, he died alone. The sister told that story to the board. As a result, visitation rules were changed. “More importantly, I think that helped change the culture of the facility and got them thinking differently about patient-centered care,” Ross notes.

There are elements of each honored organization’s story that repeat through them all: a top-down culture of quality; quality as the responsibility of everyone; the use of stories to effect change; and the engagement of patients deeply within all aspects of the care provided.

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What patients’ feelings can tell you about quality

New standard focuses on subjective information

You can get hard numbers about things like infection rates and whether a heart attack patient gets aspirin within a specified time period in the emergency department. But can how a patient feels tell you anything important about quality? And can you put a number on something as fuzzy as a feeling? The answer to both questions is yes, and the National Quality Forum (NQF) and National Committee for Quality Assurance are developing standards that will put the patient voice forward in quality assessment. Initial efforts were published this summer.¹

The rationale for making patient-reported outcomes (PROs) a priority is that when a patient feels better, health care use (and thus cost) declines, the article notes. The information can also be helpful to providers in creating treatment plans that work toward goals that the patient has — such as being able to perform certain activities of daily living rather than simply completing some course of treatment or having an injury appear healed on an X-ray.

In the article, the authors describe a pathway for developing PRO measures that the NQF developed with a wide range of stakeholders. (A report on the pathway can be viewed at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=73012 and includes links to work material related to the kinds of information organizations will want to look at and how they can be measured.)

Among the items considered to be PROs are health-related quality of life, functional status, symptoms and symptom burden, health behaviors, and patient experience.

But many people will still ask: How can you be sure that what a patient tells you is true? “I don’t think you can look at this as an ‘either/or’ situation,” says **Karen Adams**, PhD, MT, vice president of national priorities at NQF. “The traditional ways we measure quality still apply, but it’s important to have the input of the patient, too,” she says. “How do you think your care was coordinated? What is your functional status? Are you reaching the goals you hope to reach? I see those questions as a compliment to what we are already doing. Without the feedback from the patient,

how do we really know we are providing the best patient care?”

“When I think about any measurement, you have to make sure you go to the right source for the information,” says co-author **Ethan Basch**, MD, MSc, director of the cancer outcomes research program at the University of North Carolina Lineberger Comprehensive Cancer Center at North Carolina Cancer Hospital in Chapel Hill. “A physician can’t understand your nausea and report how you are feeling. In other areas, we doctors are in the best position to report on things, but not all, and there is good data on that.” Indeed, Basch says that when clinicians do report on subjective patient information — how they think the patient is doing, for instance — data shows they are often far from correct.

In the past, it was hard to systematically go after this kind of information, Basch says. “But recently, not only has the science of developing and testing questions advanced, but because of interfaces available, it is more feasible to gather it.”

The chorus of groans at the thought of more data to gather will be heard throughout hospitals, but he says that if you are committed to providing patient-centered care, this is something intuitive and worth doing.

“The other piece of this is that when we do performance evaluations, we haven’t collected information on these particular areas,” Basch says. “We have focused on other dimensions of care. Part of our awakening to patient-centeredness is that a vital part of understanding true quality care is asking patients about their lives. If my treatment recommendations aren’t positively impacting patient lives, or I don’t understand how they are impacting patient lives, then I have an incomplete understanding of how I’m doing.”

Beyond how a patient feels, even something that seems as objective as functional status is better reported from the patient, he continues. “Clinicians are subject to bias there, too,” he says. “If one of my patients is fatigued, but not as fatigued as another patient, then I might report that the first patient is doing fine.”

He acknowledges that all measurements have problems and variability, but the science of developing questionnaires is advancing. “We have been doing this for decades, and people are pretty honest on paper, where face to face they might not be,” he says. “The results taken in aggregate, across the population, provide a true picture.”

Adams says the science around PRO tools is

“very robust. Some have been around for 30 years, have tested in multiple languages, and over ranges of health literacy. These tools can look for consistencies.” Likewise the science of creating questions that get to the true heart of the matter for patients is advanced. Not that these reported outcomes alone will give a whole picture. Rather, Adams says that patient perception of how they are doing must be combined with other indicators. Take the example of a physical therapist who will note that a patient has a certain range of motion, how much he or she has improved, and what the expectation of healing is. Maybe that patient is as far along in recovery as possible, and the therapist calls it a success. “But if you can’t get up from your chair and make dinner, that isn’t a success to you. We need to know that. We have to get this kind of information into routine practice.”

Patients are happy to share this kind of information. Further, Basch says that they want to see how the information they give you is used. “They say things like, ‘I never thought you’d ask,’” he says, and they want to see how other people like them have responded to the same questions.

The biggest issues, says Basch, is how to get information from hard-to-reach patients and ensure robust response rates. “You will have to make sure you don’t inadvertently exclude certain patient groups, like those who speak different languages, with low health literacy, or patients with imperfect access.”

This may be an additional burden, Adams says, but if you get good outcomes measures, the potential is a reduction in some of the process measures related to that outcome. “Those process measures can be useful for internal improvement,” but you won’t have to collect them for regulatory bodies any more.

There are skeptics, Adams says, who don’t believe that the patient can be the authority of useful information. “But we believe that the patient is the authoritative source for some things. How they experience care, how they feel, how something rates — they are the right source and you should go to them.”

As this moves forward, she says to have an openness “and receptivity to collecting this information in a way that becomes part of your flow, and that brings it back to the patient so they also learn and benefit from it.”

Basch agrees: “Patients have information that is unique, that we can’t get other ways, that is vital to understanding the impact and value of treat-

ment. Collecting this information is feasible, and there is a science to it. Be rigorous and thoughtful and don't just jump in."

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REFERENCE

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Alarm management becomes an NPSG

First phase starts in January

Just about everyone agrees that alarm management is a big issue in healthcare. *HPR* covered the topic of alarm fatigue earlier this year. (See "Alarm management gets renewed focus, *HPR* April 2013, page 39.) The sense that it is an important and increasing problem has put the topic on The Joint Commission's radar, which has put alarm management on its list of national patient safety goals. Beginning in January, hospitals are required to establish alarm management as an organizational priority and figure out what alarms are most in need of management for the specific accredited facility. That list must be based on input from medical staff and clinical departments; the risk to patients if an alarm is ignored or malfunctions; whether specific signals are required or simply add to noise and the creation of alarm fatigue; the potential for harm based on the facility's history of incidents related to alarm management; and published guidelines.

Phase II of the goal, which starts two years later, requires hospitals to develop and implement policies and procedures related to alarm management that address when alarms can be disabled, when parameters for alarms can be changed, who can change those parameters or turn the alarms completely off, which clinical

settings are appropriate for alarm signals, alarm monitoring and response, and making sure individual alarms are appropriately set and operate as they should.

In that second phase, hospitals will also have to demonstrate that staff and independent practitioners are educated about how to properly operate alarm systems they use and for which they are responsible.

"This is a high priority now," says **Vladimir Cadet, MPH**, an associate with the applied solutions group at ECRI in Plymouth Meeting, PA, who works with hospitals on alarm management reviews and policies.

He suggests starting with a multidisciplinary team of stakeholders — frontline staff, patient safety, clinical engineering, clinical staff, IT, and leadership. Ask them what they think is right and wrong with the alarm systems now in place. "That will give you a true perspective on the problem so you can develop an action plan."

Getting a cross-department team in place will also help prevent people from developing workarounds, which are often the result of one person being in charge of alarm management, he says. If a single person is the dumping ground for all the alarm fatigue complaints, that person may be tempted to just shut some of the most problematic alarms off. That is not the solution. "Getting everyone's input is the basis for making this everyone's responsibility."

After you create a team, Cadet says to analyze the current system, or hire an objective party to do so. Identify your patient safety vulnerabilities and measure incidents where possible (like the number of false alarms or complaints about noise in patient surveys) and find strategies to address those risks. It might be checklists, more education, or different technologies altogether. Once you create potential solutions, educate the stakeholders about the policies and procedures and start measuring changes in problematical alarm issues you identified previously.

One thing Cadet says you shouldn't do is copy what another hospital does as if it has the template for success. The Joint Commission notes in its announcement of the new patient safety goal that there is no one path to successfully managing alarms. Cadet says what works for Dartmouth or Johns Hopkins may work great for them, but not for everyone. A 100-bed community hospital will have a different set of

problems and solutions than a large academic medical center. Even within a class of hospitals, different things will work for different organizations. A 32-bed ICU where each nurse has two patients will likewise have different problems and solutions than a 12-bed ICU where every nurse cares for a single patient. Drilling down further, what works on one unit in your hospital may not be appropriate in another. Don't create a template and try to implement the same thing everywhere.

For more information on this topic, contact Vladimir Cadet, MPH, Associate, Applied Solutions Group, ECRI, Plymouth Meeting, PA. Telephone: (610) 825-6000. ■

Field Guide to NQF resources launches

New tool makes finding information a breeze

If you have tried looking for specific information on the National Quality Forum (NQF) website and been flummoxed by too many or too few query responses, you might want to check out the new Field Guide to NQF Resources. Launched this summer, it provides easier and faster navigation of the website and clearer answers to questions. Paired with the Field Guide and funded with the same Robert Wood Johnson Foundation money, the NQF also launched a new version of the Quality Positioning System (QPS), which will speed up access to information related to measurement and reporting.

The Field Guide includes simple explanations about quality measurement and what the NQF does, along with additional resources related to the topic a user is searching for. For example, if you are looking for information about how measures are endorsed, there is a drop-down list of common questions. There are also links to an NQF glossary, infographics you can download and use in your own work on topics such as reducing central line-associated bloodstream infections (CLABSI), and profiles of members and how they use NQF resources.

Tom Valuck, senior vice president of strategic partnerships for NQF, says that translating what the organization does into terms that are

meaningful and understandable to users is a key goal. "This is part of an effort to make what we do more accessible, better organized, and helps users understand what we are doing."

New elements include the ability to access the Field Guide even on mobile devices. "It's very comprehensive and gives answers to some of the most complex and challenging questions we get," Valuck says. An example of a hard question might be, How can an organization set priorities for improving quality?

"The guide will provide information relevant to those topics and also additional resources for users, including external resources."

The addition of user profiles is something he thinks will be of particular interest. "It puts a face on what we do, a real face of someone like you who uses our information to improve the care provided on the front lines," he says.

QPS Version 2.0 makes searching for endorsed measures and related information simpler. Search for CLABSI using the tool and you get a link to the measure with information on whether it's endorsed, who the steward is, and when it was last updated. It also allows users to create a portfolio of measures and to compare them against each other.

"The new version replaces the keyword search," he says. "You can still do that, but there is also more functionality, and it goes beyond finding a particular measure. You can see how others are using it and share your experience. You can search in different ways like whether it's a national priority or its endorsement status. The new version lets you save measures in portfolios you can share or keep private, and track measures you are interested in."

Another favorite feature for Valuck is the increased ability for users to comment on measures in an ongoing way, using both structured and unstructured questions about their usefulness. "This is very new: We haven't had this in an ongoing way before, and we think it's a great enhancement," he says.

Both new tools can be found at https://www.qualityforum.org/Measures_Reports_Tools.aspx.

For more information on this topic, contact Tom Valuck, Senior Vice President, Strategic Partnerships, National Quality Forum, Washington, DC. Telephone: (202) 783-1300. ■

AHRQ awards measures clearinghouse contract

The government's Agency for Healthcare Research and Quality (AHRQ) has awarded the healthcare consultancy and research organization ECRI the contract to operate, maintain, and enhance the AHRQ National Guideline and National Quality Measures clearinghouses, which get a combined 3.4 million visits each year.

The clearinghouses are searchable databases of evidence-based clinical practice guidelines and healthcare quality measures and related information. The goal is to give providers, payers, and other interested parties a way to get information on those measures and guidelines.

ECRI, based in Plymouth Meeting, PA, was given the contract to implement more rigorous inclusion criteria for both of the sites, and ensure that everything included in them used good science in their development. The organization will also indicate whether the individual items in the National Guidelines Clearinghouse adhere to the standards for development recommended by the Institute of Medicine.

The National Guidelines Clearinghouse is at <http://www.guideline.gov>, and the National Quality Measures Clearinghouse can be found at <http://www.qualitymeasures.ahrq.gov/>. ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at <http://hospitalreport.blogs.ahcmedia.com/>. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

■ How to create a QI goal calendar

■ How to improve patient experience

■ Accreditation field reports

■ An update on progress for the National Quality Strategy

CNE QUESTIONS

1. In a project related to imaging times in cardiac MRIs at Massachusetts General Hospital, continual feedback resulted in a reduction in scans exceeding 120 minutes from 28% to what?
 - a. 8%
 - b. 27%
 - c. 20%
 - d. 12%
2. What is the best thing a quality department can do to help improve implementation of Meaningful Use right now, according to one AHA official?
 - a. Lobby for a slower pace of implementation
 - b. Make sure the measures are accurate
 - c. Get to know your IT department and start collaborating with them.
 - d. All of the above
3. What does Beth Israel Deaconess Medical Center say is a great way to get patients more involved in quality issues?
 - a. Being a board member
 - b. Using stories to garner interest
 - c. Patient advisory committees
 - d. Educating the board about quality
4. Which one of these is NOT a good reason for collecting patient-related outcomes data?
 - a. There will be fewer process measures to collect
 - b. It makes for more complete performance evaluations of providers
 - c. When patients do better, they use less care
 - d. Providers don't get things like how a patient is feeling right

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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