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ORYX data to play key role in new JCAHO survey process

New process doesn't mean greater data collection burden

With the advent of "Shared Visions — New Pathways," a great many things about the Joint Commission's survey process will change in 2004, but the collection of ORYX data isn't necessarily one of them, says **Jarod M. Loeb**, PhD, vice president of research and performance measurement with the Joint Commission on Accreditation of Healthcare Organizations. Health care providers already are required to collect ORYX data, and by 2004, they will be transmitting the data to the Joint Commission.

"Shared Visions — New Pathways will not mean the hospital is going to incur any new burden in terms of collecting data," Loeb says. "They already have data if they're reporting sentinel events, or if there have been previous recommendations for improvement, and they will have data in 2004 from the core measures. So from the hospital's perspective, other than the fact that they will be doing a self-assessment, they're already going through these data collection in some way."

When the "Shared Visions — New Pathways" process was being developed, a key concern was that health care providers not be saddled with even more requirements for data collection or other burdens. Loeb says ORYX data will be key to helping the Joint Commission focus surveyors on the most important topics and to create more consistent performance from surveyors, but the hospitals won't notice a difference in how they provide ORYX data.

"This is a situation in which we really think the value will be enhanced without organizations having to do anything more, other than the self-assessment, to participate in the survey process in 2004," he says. "Any organization that is currently involved with the collection of data will see absolutely no new requirements with the new survey process."

Accredited hospitals began collecting core measure data in July 2002. Hospitals were allowed to choose from four core measurement areas. As

of Oct. 29, the Joint Commission reports, 2,100 hospitals chose heart failure; 2,000 chose community-acquired pneumonia; 1,600 chose acute myocardial infarction; and 950 chose pregnancy and related conditions.

The four options were offered because they are useful for the ORYX initiative and also for facilitating an individual hospital's organizational process improvement. A hospital can choose the core measure set based on the services it provides, and surveyors will assess a hospital's use of its selected core measure sets in its performance improvement activities during the on-site survey process. Eventually, the Joint Commission will use core measure data for focusing on-site survey evaluation activities.

Long-term care, home care, and behavioral health care organizations can put off the whole question for a while. The Joint Commission announced recently that those organizations will be permitted to defer the reporting of data from their ORYX measures until applicable core measures are identified. "However, these organizations will continue to be expected to meet standards-based requirements for performance measurement, and to present relevant performance data and actions taken in response to these data during the Joint Commission's on-site surveys," according to the accrediting body.

The announcement doesn't mean you can't report ORYX data if you want. Accredited long-term care, home care, and behavioral health care organizations that wish to continue to report measurement data to the Joint Commission may continue to do so.

In addition, the Joint Commission is developing and will offer an extranet option beginning in mid-2003 that will permit accredited long-term care and home care organizations to use the same data to satisfy both federal performance reporting requirements and ORYX requirements.

This option is expected to appeal to the approximately 93% of accredited long-term care organizations and 60% of accredited home health agencies that are already required to gather and report Minimum Data Set (long-term care) and Outcome and Assessment Information Set (OASIS) data (home health care).

The modified ORYX refinements "acknowledge the slow pace at which national consensus is being reached on appropriate performance measures for nonhospital settings of care," the Joint Commission says. The modifications also will eliminate what some organizations have seen as duplicative federal and private accrediting body requirements.

The Joint Commission plans to continue to work with the Centers for Medicare & Medicaid Services, the National Quality Forum, and other stakeholders in the long-term care, home care, and behavioral health care fields to identify appropriate core measure sets.

Once suitable core measures have been identified for organizations in any or all of the three accreditation programs, the Joint Commission will require accredited organizations to transmit core measure data to the Joint Commission via its extranet site or through a JCAHO-listed performance measurement system.

The Joint Commission reports that core measures will be identified for the long-term care

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Editor: **Greg Freeman**, (770) 645-0702.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Greg Freeman** at (770) 645-0702.

field by mid-2003. A timeline for final development of core measures for the other two fields is "highly speculative," the Joint Commission reports.

[For more information, contact:
*• **Jarod M. Loeb**, PhD, Vice President, Research and Performance Measurement, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.]* ■

No more surveyors as consultants after 2003

By March, surveyors must indicate intentions

Surveyors from the Joint Commission on Accreditation of Healthcare Organizations no longer will be allowed to work as survey readiness consultants on the side after Jan. 1, 2004, according to a new rule. Working both sides of the fence created too much opportunity for a conflict of interest, or at least the appearance of it, the Joint Commission says.

Surveyors long have worked as consultants, offering advice to health care providers on the best way to comply with standards from the Joint Commission and get ready for a survey.

Though many people thought the practice was questionable, the Joint Commission allowed the arrangements as long as certain criteria were met to avoid a conflict of interest. Joint Commission spokeswoman **Charlene Hill** tells *Hospital Peer Review* that a tougher stance will be taken after this year. "The perception of a conflict of interest is an unacceptable risk," she says.

In March 2003, surveyors must indicate their intention to act either as a Joint Commission surveyor or a consultant. As of Jan. 1, 2004, they can't do both. Until then, surveyors and health care providers are free to continue with consulting agreements under the same provisions that already were in place.

Harold Bressler, JD, general counsel for the Joint Commission, says surveyors always have known the rules, but the Joint Commission never publicized them to accredited providers. He provides *HPR* with this summary of the rules about surveyors acting as consultants:

- Only part-time Joint Commission surveyors may work as consultants. Full-time Joint Commission surveyors are strictly prohibited from consulting on the side.
- A surveyor cannot consult with an organization that he or she surveyed in the past three years.
- A surveyor cannot survey an organization that it consulted within the past three years.
- The surveyor cannot suggest in any way that the accredited organization would benefit from the consulting "other than doing a better job at standards compliance. There can be no suggestion that there will be favored status of any kind."
- The surveyor, or any consulting firm with which he or she works, must not have any financial interest in the accredited organization.
- Surveyors are restricted in how they may solicit consulting business. In short, Bressler says, they may not solicit business during the survey process or use their association with the Joint Commission to pressure potential clients.

[For more information, contact:
*• **Charlene Hill** and **Harold Bressler**, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.]* ■

Groups join to offer lab accreditation services

Also, a new method for custom proficiency testing

Clinical laboratories will have a new method for measuring proficiency and demonstrating that they have met quality standards, under a new accreditation plan announced recently by the American Proficiency Institute (API) in Traverse City, MI; the American Society for Clinical Pathology (ASCP) in Chicago; and the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

API is a nonprofit corporation providing proficiency testing services to more than 11,000 laboratories nationwide, including hospital-based, clinical, and physician-office laboratories. ASCP is a nonprofit medical specialty society representing 151,000 members, including board-certified pathologists, other physicians, clinical scientists

(PhDs), medical technologists, and technicians. It is the world's largest organization representing pathology and laboratory medicine.

The three groups announced a collaborative relationship to offer, as an option, a combined package of laboratory accreditation services, customized proficiency testing, and technological and scientific educational services.

Laboratories will be able to integrate menu-driven, web-based API proficiency testing that meets Joint Commission accreditation requirements and participate in ASCP technological and scientific educational programs that are uniquely designed for customer needs.

Through this collaborative effort, the expertise of pathologists, skilled medical technologist surveyors, and an experienced proficiency testing provider will be integrated into the Joint Commission survey process, says **Daniel Edson**, president of API.

Such collaboration would meet the needs of laboratories by offering reduced costs, improved service, new educational opportunities and enhanced surveyor expertise in a one-stop, coordinated fashion, he says.

"With this new accreditation program, laboratory professionals are able to customize and pay for only the proficiency testing services they need," Edson says. "They could then report and access the proficiency testing results from a secure web site when it is convenient for them."

Laboratories also would be enrolled in a portfolio of technological and scientific education programs that are tailored to the relevant needs of accredited laboratories, says **E. Eugene Baillie**, MD, FASCP, president of ASCP.

Baillie says the leaders of the three groups hope that in the future, Joint Commission surveyors could review the API proficiency testing results prior to survey, instead of searching for them on-site. That method would save time and enable more on-site discussion and education, he says. ■

Reader Question

Tabletop drills not enough for testing disaster plan

But paper patients can suffice

Question: Our facility is not an acute-care hospital and does not provide emergency services, so we don't expect to provide care in any community disaster. Do we still have to conduct the emergency preparedness drills that are required by the Joint Commission on Accreditation of Healthcare Organizations? Can we get by with doing just tabletop drills or using "paper patients" instead of people acting as victims?

Answer: Emergency preparedness plans and drills are getting more attention because of terrorist threats and recent revisions to accreditation requirements, raising questions about exactly what the Joint Commission requires, says **Britton Berek**, MBA, CCE, associate director in standards interpretation with the Joint Commission. The Joint Commission's requirements for emergency planning are found in the "Environment of Care" chapter under EC.1.4, and the required drills are found in EC.2.9.1.

The emergency preparedness requirements were revised in 2001. Among other changes, the term "emergency preparedness" was changed to "emergency management" to focus more on the overall effects of an emergency rather than just what the health care provider does on the day of a disaster.

"Providers used to put all their effort into planning how they would respond on the day the disaster struck, planning how they would handle the influx of patients and the other problems that come with a hurricane or a snowstorm," Berek says.

"Under the revised standard, we want to see more focus on anticipating emergencies that could strike, and how you handle the long-term problems they bring. We're thinking about problems like breaks in your supply chain and staffing issues when the flood goes on for days and people need to go home and take care of their own family," he says.

Health care providers are considering more types of possible emergencies than they might have before, which will please Joint Commission surveyors. Prior to Sept. 11, 2001, hospitals typically planned for bus crashes, severe storms, and similar emergencies that were considered likely. Now Berek says hospitals are broadening their scope to include terrorist acts such as bioterrorism and weapons of mass destruction.

How much you need to plan and drill for those emergencies will depend on your facility's circumstances. No accredited facility is exempt from

the requirement for emergency preparedness, Berek explains, but the Joint Commission expects your plans to be commensurate with the way in which you actually would be involved in an emergency.

A small outpatient clinic with no emergency services can get by with a relatively compact emergency preparedness plan, possibly a few paragraphs that detail how the clinic will shut down for the duration of the emergency or how the clinic will switch to cell phones when phone service is lost. But a larger facility providing emergency services must have a more complex plan, he adds.

Determining factor

A major determining factor is whether your facility is a "designated disaster receiving station." If you have an emergency department, you are. Even without an emergency department, you can declare yourself a receiving station if you think victims might seek help at your facility. But beware: Some facilities that might not normally be considered a receiving station still can be designated in times of emergency, Berek explains.

"If you're a nursing home and have an arrangement with the hospital next door to offload less acute patients at your facility during an emergency, you're a designated receiving station," he says.

Disaster receiving stations must plan for the influx of patients, which greatly increases the need for emergency planning and drills, Berek says. The Joint Commission requires two emergency preparedness drills per year — unless your organization meets certain standards that indicate you would have very little involvement in a community disaster, he points out.

The standard explains that if your facility provides only outpatient care, is not a designated disaster receiving center, and is "equivalent to business occupancy" as defined in the Life Safety Code, the Joint Commission requires only one drill per year. A physician's office, for instance, probably would meet those criteria, he adds.

For all other health care providers, the Joint Commission requires two drills per year. If the facility is a designated receiving station, at least one of the drills must include rehearsing the influx of patients, he explains. The other drill may, if you choose, involve only an "internal" emergency such as the loss of utilities.

"The idea of the drills is to work out any kind of weaknesses in the plan," Berek says. "You have to force the stress on the organization to see if plans need to be changed or improvements can be made."

One source of confusion involves the use of tabletop drills instead of full-scale drills. Tabletop drills, in which you play out an emergency scenario by discussing it among involved parties, do not meet the requirements for twice-yearly testing of the emergency preparedness plan, Berek says. The two required drills must be actual physical drills involving all the necessary staff and departments. However, the Joint Commission allows a tabletop drill to suffice for one *component* of the required drills.

"If you're designated as a receiving station, one of the drills must include interaction with community responders, such as your local fire department or civil defense," Berek says. "That can be difficult for some communities, especially if they have a lot of hospitals in the area that have to do that. So for this component, a tabletop drill meets the requirement. You can even get four or five hospitals together to do a tabletop drill with community responders in a conference room if you like."

The paper chase

Another common question concerns the use of paper patients — a packet of symptoms, vital signs, and similar information presented for care — instead of volunteers who pretend to be disaster victims. It used to be more common to enlist Boy Scouts or other groups to aid in drills, but some hospitals have found that liability concerns and other issues make that more difficult now. Berek says the Joint Commission accepts paper patients as an alternative.

"It still has to be an actual drill, even if you use paper patients," he says.

"You have to actually put the packet on a gurney and wheel it through the system just as you would a real patient, take it to X-ray to simulate the care a person would receive, and find it an available bed when the patient would get a bed," Berek concludes.

[For more information, contact:

*• **Britton Berek**, MBA, CCE, Associate Director in Standards Interpretation, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.]* ■

VA's surgical QI program could be available to all

Using data to find best practices, problem areas

The innovative quality improvement program that greatly improved patient care in the Department of Veterans Affairs (VA) health care system could be available to all hospitals within a year, according to program leaders who say the system could revolutionize health care quality.

Known as the National Surgical Quality Improvement Program (NSQIP), the program is the first national, validated, outcome-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care. Currently, the NSQIP incorporates 128 VA medical centers (VAMCs) and 14 beta sites in the private sector, but the VA is working on a plan that could make it possible for any health care provider in the United States to adopt the same system of data collection and quality improvement.

The chairman of the NSQIP tells *Hospital Peer Review* that the VA is working with the American College of Surgeons (ACS) to request congressional authority for making the VA's program available nationwide by turning the NSQIP into a nonprofit agency under the oversight of the VA and the ACS.

Shukri Khuri, MD, chief of surgical service at the VA Boston Healthcare System and professor of surgery at Harvard Medical School, says he and the other NSQIP leaders are confident that Congress will grant permission to turn the NSQIP into a nonprofit agency. The effort is aided by a $6 million grant from the Agency for Healthcare Research and Quality.

"The nonprofit will be an umbrella for all the other medical centers in the country to participate," Khuri says. "This could all happen within a year if things go well. We fully expect to see NSQIP made available to everyone very soon."

NSQIP tracks surgical outcomes

If that plan comes to fruition, NSQIP could be a major resource for quality improvement. VA medical centers already have benefited in significant ways.

The system got its start in 1991, prompted by the need to assess comparatively the quality of surgical care in 133 VA hospitals. The VA conducted the National VA Surgical Risk Study (NVASRS) between 1991 and 1993 in 44 VA medical centers. The study developed and validated models for risk adjustment of 30-day morbidity and 30-day mortality after major surgery in eight noncardiac surgical specialties. Similar models were developed for cardiac surgery by the VA's Continuous Improvement in Cardiac Surgery Program (CICSP).

Based on the results of the NVASRS and the CICSP, the VA established the NSQIP in 1994 in all the medical centers performing major surgery. An NSQIP nurse at each center oversees the prospective collection of data and their electronic transmission for analysis at one of two data coordinating centers, says **Jonathan Perlin**, MD, PhD, deputy undersecretary of health at the VA.

Feedback to the providers and managers is aimed at achieving continuous quality improvement. It consists of comparative, site-specific, and outcome-based annual reports; periodic assessment of performance; self-assessment tools; structured site visits; and dissemination of best practices.

A gold mine of QI data

The NSQIP also provides an infrastructure for the VA investigators to query the database and produce scientific presentations and publications. Since the inception of the NSQIP data collection process, the 30-day postoperative mortality after major surgery in the VA has decreased by 27%, and the 30-day morbidity has decreased by 45%.

"The program is based on our compulsiveness for collecting reliable data," Khuri says.

"What differentiates us from other programs is that we have been very consistent about the need to collect data in a reliable way," he explains. Most importantly, we assigned a clinical nurse in each of our VA centers to collect data in accordance with a very structured, standardized protocol."

Those data regarding surgical outcomes are transmitted to VA coordinating centers in Denver, where they are checked for reliability and then entered in the NSQIP database.

An executive committee reviews the information quarterly, and then each year generates the annual NSQIP report. This report is a gold mine of quality improvement data, Khuri says. Each

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VA medical center receives a copy of the report, showing the surgical outcomes data for each hospital in the system.

All of the data are blinded, except for the recipient hospital's own data. That way, the chief of surgery and the quality improvement director can compare the hospital's performance to the overall quality measures in the VA system.

Best and worst scores

A key measure of outcomes in the NSQIP is the "outcomes to expected" or "O/E" ratio for certain procedures and patients. That ratio is determined by comparing the actual outcome of a surgical procedure to what would be expected when considering various factors, including the patient's severity.

If a hospital's outcome data are considerably worse than the average, the hospital is deemed a "high outlier." A hospital with surgical outcome data that is considerably better than the system average is called a "low outlier." The whole NSQIP system is intended to help the high outliers learn from the low outliers.

"When the data show that a hospital is a high outlier, that obviously implies that there may be a problem with the quality of care in that institution," Khuri says. "On the other hand, if the hospital's O/E ratio is low, that implies that there is superior performance and a higher quality of care. In both cases, we want to go in and look at why."

Site visits may result from NSQIP data, either to help a hospital determine why its surgical outcomes are unusually high or to see how an especially good program achieved such good results. The annual report in January includes lists of problems that were identified in the high outliers and best practices that were found in the low outliers.

All VA hospitals can benefit from the list of potential problems and best practices, even if their own hospitals' quality ratings are average, Perlin says.

Substantial improvements achieved

"NSQIP has led to substantial improvements in the VA system," Perlin says. "Early on when we started this program, there were some real concerns about morbidity and mortality in the VA, but now the observed mortality is lower than what would normally be expected for the patient. The NSQIP data provide managers in the system a rational basis for comparison, a means for sharing best practices and improvement."

Khuri says the NSQIP analyses have led to dramatic improvements in some VA medical centers. In one case, a high outlier's data prompted an in-depth investigation that revealed a rampant infection control problem in the surgery unit. Until the NSQIP data prompted the investigation, the infection was completely unnoticed. Once the problem was corrected, the hospital became a low outlier.

In addition to the annual reports, the NSQIP is amassing a large database on surgical outcomes. The database now has information on more than 1 million surgical cases from the past 10 years.

Data system expanding beyond VA

Initial efforts at expanding the NSQIP beyond the VA have been encouraging, Khuri and Perlin say. Three medical centers initially tried the system, with good results, and now the trial has been extended to a total of 14 hospitals across the country.

Initially, there was some concern over whether the VA's success could be replicated in more typical hospitals that treat a wider array of patients, including children and procedures not often seen in the VA system.

Those concerns were dispelled in the early testing and the ongoing experience affirms that the system can be used by any hospital, Khuri points out.

Making the VA's NSQIP available to all hospitals could revolutionize quality improvement in the surgical arena, Perlin says, and the next step is to expand the system beyond surgery. In the future, the NSQIP could include data on other forms of clinical care as well as issues such as patient satisfaction.

"One of the exciting things is that the NSQIP allows hospitals to measure quality systematically," Perlin says. "It's the measurement that has led to better outcomes."

[For more information, contact:

- ***Shukri Khuri**, MD, Chief of Surgical Service, VA Boston Healthcare System, 940 Belmont St., Brockton, MA 02301. Phone: (508) 583-4500.*
- ***Jonathan Perlin**, MD, PhD, Deputy Undersecretary of Health, Department of Veterans Affairs, Washington, DC 20011. Telephone: (800) 827-1000.]* ■

THE QUALITY - CO$T CONNECTION

Part 2 of 2

Improve performance by taking outsiders' view

Patients want health care to be 'customer-shaped'

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

What is the purpose of your health care organization? To survive and prosper, of course. But the question is, by what method? What you need is everybody working to improve performance, and to do that, you need the means to determine how well processes are working for patients. Patients and families can only take their view of your organization from the interactions they have with you. If those interactions are positive, people are likely to return for more services and tell friends about the high-quality experience. To achieve this goal, you must understand what matters to patients and families at every step in your patient care processes.

Take, for example, the process of getting a mammography examination. Looking at it from the point of view of the patient, the process resembles **the diagram on p. 13**. The manager, taking a top-down view, might think it wise to reduce staffing for the appointment desk or limit the hours in which appointments will be taken.

But go too far and prospective customers may call elsewhere for appointments. Similarly, if management focuses on increasing the number of exams that are performed each day, patients might find themselves with a long wait time in the reception area. Moving on to the post-exam steps: results reporting and billing; you often find enormous amounts of patient calls caused by "failures" of the organization to get it right the first time.

To improve performance, people must get inside the process from the patient's viewpoint. Patients want health care to be customer-shaped. They want to do business with organizations that respond to their particular needs in ways that suit their circumstances. Only by having intimate knowledge of customers, their attitudes, habits, their work, and so on, can one start to design services that are truly customer-driven. The best way to begin a customer-driven transformation is to know the nature of customer demands on the patient care process, know what "value" is associated with those demands, and know how the process works to meet those demands. Using the same diagram, ask yourself:

- What do you know about the patient's experience at each point?
- What type of demands do patients make at each point?
- What do you know about what matters to patients (the "value") at each point?

Now go to the points of patient-organization interaction. Listen and observe. Listen to telephone calls coming in. Observe the X-ray receptionist. Undress in the changing room, and put on the cover-up supplied to patients. Spend time with the technologist, the radiologist or anybody who personally interacts with patients. At each point, look at what's happening from the patient's point of view.

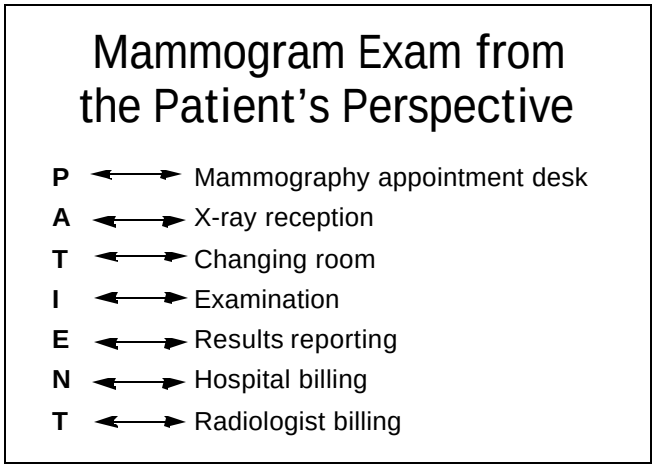
- What types of demand are patients making?
- What matters to patients with respect to each type of demand?
- Does "what matters to customers" differ by type of patient or by type of demand?
- Ask the people who work there what matters to patients?
- As you work on this activity, keep asking: "How do we know?"

To improve for the long term, you'll need more than opinion and anecdote. You'll need measures to help manage performance. These are called "capability measures" — tools for evaluating the continued success of customer-driven process changes.

Measure process capabilities

For every type of demand patients place on your organization, you'll need measures to tell you how well you are responding. In many health care organizations, measurement focuses on meeting internal standards.

The results reveal little or nothing about how well you are meeting patient expectations. If you take a systems approach to performance improvement, you'll want measures of how well the organization does things for patients and families. For example, time to send out reports, time to respond



to requests, percentage of bills that are accurate, percent of problems solved on first call and so on. Armed with a good understanding of what is happening at each point of interaction between your organization and patients, your improvement efforts can focus on enhancing customer service.

Measures of customer-driven expectations are very powerful analytic tools. People may disagree about what you should or should not do for patients, but they cannot argue over what is actually done. It is vital to get data on the capacity of your processes to meet customer expectations before taking a look at how work flows through your organization.

Think flow

Once you clearly understand what is happening between you and your customers, then people can begin to move from "what" to "why." Measures tell you the "what" of performance, and workflow tells you the "why." Many health care facilities claim to be working on improving processes or flows, but how have they decided on the focus of these improvement activities?

If the improvement team completes an analysis of the process from the customers' viewpoint, as illustrated by the mammography exam example, team members will have an effective starting place for actions. The core steps of the process are defined by interactions with patients and families. Performance measures tell the team how the process actually flows.

When selecting the actions intended to improve a process, the focal point for a systems view is always the customer. The process must be viewed from end to end — from the point that the patient makes the demand to the point where the patient's need is fully met. From the map of core steps, as defined by the customer, choose one that has a high impact on overall satisfaction.

For example, suppose the team chooses the step of mammogram results reporting. As the team examines this step, it will want to look for the causes of failure from the customers point of view by asking these questions:

- What is the purpose of this step from the patient's point of view?
- What matters to patients at this step?
- What are the activities involved in this step?
- What is the usual flow of activities in this step?
- What might go wrong during each activity?

As the team members discuss the step, have them make a list of all the things that could go wrong from the patient's standpoint and what might cause these failures. The objective of the team should be to change the flow and activities so that work of "value" to patients is performed. By conducting the activities analysis, the team will have a schema of the interactions with patients, and at each point of interaction, it will have data about what is currently happening. This leads to a better understanding of the flow and identification of suboptimal activities. Now the team can move on to discovering the system causes of current undesirable performance.

A better way to work

Health care organizations are facing fundamental challenges to traditional beliefs about how to design and manage patient care processes. By viewing health care services from the patient's perspective and applying systems thinking, improvement teams can discover the root causes of ineffective workflow and processes. Getting people to think about the "hands-on" experience of patients and their families provides an important systems view that leads to lasting changes and improved customer satisfaction. ■

HHS launches national nursing home QI

Launch follows six-state pilot project

The Department of Health and Human Services (HHS) Secretary **Tommy G. Thompson** has launched the national Nursing Home Quality Initiative in an effort to improve the quality of care

given to the millions of long-term care residents. The initiative combines new information for consumers about the quality of care provided in individual nursing homes with important resources available to nursing homes to improve the quality of care in their facilities.

The April 2002 pilot project launch follows the successful six-state pilot project, which involved nursing homes serving Medicare and Medicaid beneficiaries in Colorado, Florida, Maryland, Ohio, Rhode Island, and Washington.

Good for consumer — and nursing home

"The pilot demonstrated that these measures aren't just good for consumers — they're good for nursing homes as well," Thompson said in a press conference.

"More than half of the nursing homes in the six pilot states requested technical assistance to help them improve their care, and that is exactly the type of collaborative effort we envisioned — and what we want to continue to see happen," he pointed out.

The complete quality data are available at Medicare's consumer web site, www.medicare.gov. **Tom Scully**, administrator for the Centers for Medicare & Medicaid (CMS), explains that the National Nursing Home Quality Initiative is a four-pronged effort, consisting of CMS' continuing regulatory and enforcement efforts conducted by state survey agencies; improved consumer information on the quality of care in nursing homes; continual community-based quality improvement programs offered to nursing homes by Medicare's Quality Improvement Organizations (QIOs); and collaboration and partnership to leverage knowledge and resources.

"We know nursing homes are just as interested in improving the high-quality care they already give to their residents as we are," Scully says. "By making this information available to the nursing homes and consumers, we are seeing a collaborative effort to do even more to raise the bar on quality."

In support of the HHS effort, a National Quality Forum (NQF) steering committee recommended that nursing homes focus on 10 quality measures, six for chronic care patients (long-term stay residents) and four for post-acute care patients (short-term patients).

The six measures for long-stay residents are:

- percentage of residents with loss of ability in basic daily activities;
- percentage of residents with infections;
- percentage of residents with pain;
- percentage of residents with pressure sores;
- percentage of residents with pressure sores (with additional facility-level risk adjustment);
- percentage of residents in physical restraints.

The four measures for short-stay residents are:

- percentage of short-stay residents with delirium;
- percentage of short-stay residents with delirium (with additional facility-level risk adjustment);
- percentage of short-stay residents who walk as well or better;
- percentage of short-stay residents with pain.

CE *questions*

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveyors must declare their intention either to remain JCAHO surveyors or act as private consultants by what date?
   A. March 2003
   B. June 2003
   C. January 2004
   D. March 2004

2. Which of the following organizations did not participate in the announcement of a new accreditation plan for clinical laboratories?
   A. Joint Commission on Accreditation of Healthcare Organizations
   B. National Committee for Quality Assurance
   C. American Proficiency Institute
   D. American Society for Clinical Pathology

3. The Joint Commission on Accreditation of Healthcare Organization's requirements for emergency planning are detailed in what chapter of the standards?
   A. leadership
   B. human resources
   C. care of patients
   D. environment of care

4. Since the inception of the Department of Veterans Affairs National Surgical Quality Improvement Program data collection process, 30-day postoperative mortality after major surgery has decreased by what percentage?
   A. 14%
   B. 22%
   C. 27%
   D. 32%

Answers: 1. A; 2. B; 3. D; 4. C

Another key component of the initiative is the assistance that every QIO has available to improve quality of care in local nursing home facilities. QIOs are CMS contractors that have offered improvement assistance to hospitals, physician offices, and in some states, nursing homes over the past decade.

As part of the Quality Initiative, the QIOs are expanding their scope by providing information and consultation to skilled nursing facilities in all states. In addition, QIOs and state and local long-term care ombudsmen will use the new data, along with other information and personal visits, to help families make informed decisions about placement in nursing homes.

The ombudsmen primarily are volunteers who help nursing home residents and their families on a daily basis and are trained and funded through HHS' Administration on Aging. ■

JCAHO accreditation open to critical access hospitals

The Centers for Medicare & Medicaid Services (CMS) announced recently the granting of deeming authority for critical access hospitals to the Joint Commission on Accreditation of Healthcare Organizations, meaning these hospitals will be considered to have met Medicare certification requirements once the Joint Commission accredits them.

CMS found that Joint Commission standards for critical access hospitals meet or exceed those established by the Medicare program.

Critical access hospitals provide essential services to patients seeking care in underserved communities. Accreditation remains voluntary, and seeking deemed status through accreditation is an option, not a requirement for Medicare certification. The Joint Commission has had deeming authority for acute-care hospitals since the inception of the Medicare program in the 1965.

The Joint Commission launched its accreditation program for critical access hospitals late in 2001.

Critical access hospitals, as outlined in the Balanced Budget Act of 1997, provide limited but vital health services to rural communities. These facilities — which must have a patient census of less than 25 — are certified by the Department of Health and Human Services as eligible for cost-based reimbursement from the Medicare program.

More than 600 hospitals across the country already have converted to critical access hospital status; another 500 hospitals may be eligible for this designation.

Critical access hospitals are surveyed for compliance with Joint Commission standards that specifically have been adapted to the special services offered by these organizations. The Joint Commission also has developed a streamlined survey process for assessing compliance with the standards.

In addition to critical access hospitals and acute-care hospitals, deemed status options are available to Joint Commission-accredited home health agencies, hospices, clinical laboratories, ambulatory surgery centers, and Medicare+Choice HMOs and preferred providers organizations. ■

Guidelines can reduce in-hospital deaths

Results from an ongoing national quality improvement initiative examining adherence to American College of Cardiology (ACC) and American Heart Association (AHA) treatment guidelines for chest pain disorders, suggest that using a class of drugs known as glycoprotein (GP) IIb-IIIa inhibitors reduced in-hospital deaths by 46%.

The data, recently released from Duke University Medical Center in Durham, NC, also show that only 31% of eligible patients were treated with a GP IIb-IIIa inhibitor within 24 hours, as recommended by the guidelines.

The initiative, referred to as CRUSADE (Can Rapid Risk Stratification of Unstable Angina

COMING IN FUTURE MONTHS

- Lessons learned in VA's NSQIP
- How to comply with spiritual assessment standard
- Custom physician profiles help with recredentialing
- Hospital scores 90% adherence to 60 clinical pathways
- Measures of cost and quality lead to 36% drop in mortality

Patients Suppress Adverse Outcomes with Early Implementation of the ACC/AHA Guidelines), is designed to determine adherence to the ACC/AHA guidelines for patients with non-ST-segment elevation acute coronary syndromes, or high-risk chest pain disorders, and to improve clinical outcomes through the implementation of strategies to promote these guidelines.

Eric Peterson, MD, associate professor of medicine at Duke University Medical Center and principal investigator for the CRUSADE initiative, says the analysis presented looked at the outcomes of 27,786 patients treated at more than 300 hospitals in the United States.

"Our analysis of real-world practices confirms that following the ACC/AHA guidelines, which recommend early, aggressive treatment of high-risk patients, has the potential to save thousands of lives each year," Peterson says. "Our mission is to not only document guidelines nonadherence but to actually change the behavior of health care professionals and thus positively impact patients' lives."

Patients who did not receive a GP IIb-IIIa inhibitor within 24 hours of hospitalization had an in-hospital mortality rate of 4.5%, compared to 2.5% for patients receiving the drugs early, a reduction of 46%.

In other findings, only 42% of patients received a recommended procedure known as diagnostic catheterization within 48 hours, which also was shown to improve mortality. This diagnostic procedure reduced a patient's stay in the hospital following a chest pain disorder from 5.8 days to 4.8 days.

[For more information, contact:

*• **Eric Peterson**, MD, Associate Professor of Medicine, Duke University Medical Center, Trent Drive, Durham, NC 27710. Telephone: (919) 684-8111.]* ■

Correction

The November 2002 issue of *Hospital Peer Review* stated incorrectly that the national average score for hospitals surveyed by the Joint Commission on Accreditation of Healthcare Organizations is 89. The average score, according to the most recent analysis by the Joint Commission, is 91. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

• Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.

• Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.

• Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■

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'Everybody wins' as CM, home health join forces

Looming JCAHO survey prompts affiliation

A couple of years ago, **Lisa Zerull,** RN, MS, the force behind the dramatically successful community nurse case management (CNCM) program at Valley Health System in Winchester, VA, faced a new challenge: She was informed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that it would begin surveying the program based on the agency's home care standards, in conjunction with the health system's home health program.

"In the past, JCAHO hadn't really looked at us," she says, adding she believes that may be the case with other, similar programs that simply aren't on the accrediting body's radar screen.

Not wanting to reinvent the wheel, Zerull went to Valley Health's home health director and said, "How can we work with you to ensure a good survey?" Drawing on the policies and procedures and performance improvement process developed by director Patty Klinefelter during her 16 years in home health, Zerull says, "I just molded [them] to fit our program."

The home health program, Zerull notes, has received perfect scores in its two most recent JCAHO surveys.

The successful collaboration between the two entities, which for years had operated separately, began a discussion that ultimately led to a joining of forces, Zerull says, although that didn't happen immediately.

"We started a dialogue, with the thought that we have so much to share, the opportunity to educate both sides on what we do," she notes.

"But in the initial dialogue, there were some turf issues." Home health personnel had the perception that the CNCMs were caring for patients who should have been under home health and were in effect providing free care for those patients, she says.

Finally, Zerull adds, "I said, 'OK, why don't you screen, do the intake, and tell us who we can care for?'"

Because the two programs constituted "home and health services," it made sense to have one telephone number for physicians, emergency department clinicians, or hospital case managers to call to arrange care for their patients, she says.

Referrals to CNCM

"We drew upon one another's expertise to come up with a plan that worked for both sides. It was better for home health to handle the central intake process to assure that the appropriate level of community care was being offered," Zerull adds.

The central intake system began in October 2000, Zerull notes, and JCAHO surveyed the programs in March 2001. The joint score was 99, she says, adding with a laugh that the point subtracted "was not because of us." It had to do with the incorrect labeling of a bag being used in home-administered chemotherapy.

With the advent of the central intake process, she notes, the percentage of patients referred to CNCM by way of home health has gone from 6% to 80%.

When the patient's condition doesn't meet home health criteria, he or she can be referred to the CNCM program, Zerull explains. "Home health is the acute model, and we're the subacute model. We're just valuing the level of care that each [program] brings."

The CNCM nurses "do nothing invasive," she adds. "The only two instances where we obtain a physician order is if we're filling a pillbox and for pulse oximetry."

As patients' care needs change, they may be traded back and forth between the two programs, Zerull notes.

"[Home health] may follow a patient for six weeks and then refer the patient to us. We may see them for three or four months and then they're in the hospital and once again qualify for home health."

Future plans include having one nurse who can wear both hats, which would enhance the continuity of care, she says. "Relationship is one of the greatest predictors of wellness. If you have a socially isolated 80-year-old who is now dealing with a chronic illness, one of the bright spots in her life is that visit from a nurse case manager."

The idea is problematic from an administrative standpoint, however, she says. The CNCM nurses see their patients a maximum of once a week, and those visits are scheduled according to geographic area, she adds.

If a patient now needs to be seen three times a week, the nurse could find him- or herself driving back and forth between locations far removed from each other, Zerull says.

Combining the two programs has had many benefits, she points out. In addition to increased staff and patient satisfaction, physicians enjoy the advantage of being able to call only one telephone number or make one referral to arrange patient care, she adds.

Zerull was warned early on to "keep [the CNCM program] away from home health because it will confuse physicians," she says, but Valley Health staff take steps to make sure that is not a problem. "We educate them that when they write the order for home care, they write 'home and community services,' and we determine the best level of care. Everybody wins with this solution."

The home health program now can make use of a CNCM innovation whereby the computer system flags the names of patients who are admitted to the hospital, Zerull notes.

Outcomes

Indicator	Pre-CNCM	Post-CNCM
# Hospital Admissions	499	219
Avg. LOS	16	10
# ED Visits	70	48
# Critical Care Days	67	20

N = 182

Source: Lisa Zerull, Valley Health System, Winchester, VA.

CNCM Good Economic Sense

Salary, Benefits	$55,000
Travel Reimb.	$ 4,000
Supplies	$ 4,000
Misc.	$ 2,000
TOTAL	$65,000

Based on 1.0 FTE

Source: Lisa Zerull, Valley Health System, Winchester, VA.

One High-Cost Patient

Hospital $ Loss/Admission *DRG 127-- CHF*	$20,000
Avg. 5 Admissions/Year (5 x $20,000 =)	
TOTAL HOSPITAL COSTS	$100,000

*Avg. Caseload- 35 patients

Source: Lisa Zerull, Valley Health System, Winchester, VA.

"We get an automatic e-mail [regarding the admission], and we don't make a wasted visit." she says.

The affiliation also has made possible a contingency staffing plan, she says. When one of the CNCM nurses was dealing with the possibility of taking time off to have open-heart surgery, "[home health] had nurses who could fill in," Zerull adds. "Before, we were it. We had to cover our own time."

Valley Health's CNCM program began in 1992, when Zerull's job was to coordinate acute-care case management, she says.

"The 16 case managers from the hospitals would come together as a team and say, 'We're great at mobilizing patients through the system and doing discharge planning, but the chronic care patients keep coming back into the system.'"

Using as a model a Tucson, AZ, program that since has disbanded due to lack of funding, Zerull put together a proposal for CNCM and, to justify it, gathered data on patients who were high users of the system but weren't homebound and so didn't meet home health criteria.

After the program was in place, figures showed, and continue to show, around a 50% reduction in emergency department (ED) visits, length of stay (LOS), and critical-care days, she says.

The CNCM program has continued to save money for Valley Health, a two-hospital system with a rural, tri-state service area, she says.

Each year, outcomes illustrate that the cost of seven to 10 home visits equals the cost of just one day's hospital stay, Zerull says, not to mention the improvement in patients' quality of life.

Looking at an actual patient known as "Joe," for example, records show that after participation in the CNCM program, the number of annual hospital admissions went from five to one, with average LOS reduced from 12 days to four days, she explains. The cost of Joe's care went from about $120,000 to about $12,000. Noncompliant before, the patient now closely follows the prescribed regimen of care, including medications, diet, and exercise, Zerull adds.

Then there is the more intangible result of Joe changing from a "sick mindset" to the perception of a higher level of wellness, she says.

Despite such successes, Zerull reports little progress in her effort to have the Centers for Medicare & Medicaid Services — then known as HCFA — answer the question posed in the July 2000 issue of *Discharge Planning Advisor*: What if there were eight years of data (now 10 years of data) illustrating that it's cheaper to pay per visit for community nursing care for the chronically ill than to pay for periodic acute care episodes at the hospital — and that patient outcomes are better, too?

Because programs such as Valley Health's CNCM save money rather than make money, she points out, they probably will not get much support from chief executive officers.

If the nation's hospital CEOs "can see the benefit of keeping people out of the hospital," the dynamics of health care can change, Zerull adds. "It's a prevention mindset vs. an illness/treatment mindset."

If a chronically ill patient is in and out of the hospital, she says, "we're saying that it's too expensive to use critical care days. With Medicare, you get a set rate reimbursement, by DRG. That means, for example, for congestive heart failure, you're getting $6,300, no matter how long the patient stays in the hospital."

To continue with the example of the chronic patient named Joe, Zerull explains, "If Joe comes in, is put on a ventilator, has four or five critical care days, and then goes home in 12 days, the system has to absorb the cost of care for anything over that $6,000."

The aim of the CNCM program is to teach such patients to go to the physician's office or the ED before they're in crisis, she adds, so that hospital stay might only be four days.

(For more information, contact:

• ***Lisa Zerull**, Program Director, Community Nurse Case Management Program, Valley Health System, Winchester, VA. Web site: lzerull@valley healthlink.com.)* ■

Solutions needed for prescription drug problem

Making sure patients without an insurance plan for prescription drugs get the medications they need is an increasing challenge, case managers and discharge planners tell *Discharge Planning Advisor*.

Faced with a high-cost list of prescribed medications, "patients decide to take only some of the drugs or maybe some of the doses or none at all," says **Tina Davis**, RN, MS, CMAC, senior director for continuum of care at Arnot Ogden Medical

Center in Elmira, NY.

"This can lead to readmission to the hospital," Davis points out. Contributing to the problem is some physicians' tendency to prescribe "the latest and the greatest," which can cost much more than "the tried and true," she adds.

Case managers who are aware of the issue may try to put patients in touch with pharmaceutical companies that provide no-cost drugs to needy individuals, Davis notes, but sometimes it takes six weeks to obtain the medications.

Lisa Zerull, RN, MS, the program director for the Community Nurse Case Management Program at Valley Health System in Winchester, VA, points out that the philanthropic programs sponsored by drug companies all require different processes and forms, and may include restrictions that can make it difficult to obtain the help.

For instance, Zerull adds, some require that for a patient to qualify, the drug company's local sales representative must call on that patient's physician.

"The prescription drug problem is a very hot issue," agrees **Jackie Birmingham**, RN, MS, CMAC, a longtime case manager who now is managing director for Curaspan Inc., in Needham, MA. "It's especially a problem for those who are on pain medications and have traveled a far distance to a center for surgery," she notes.

"Patient satisfaction is a huge issue when you are unable to [obtain] the medications to get them started until they can go to their own pharmacy to get the prescriptions filled. The patient needs to go home, and the family needs to leave them to go get the medications," Birmingham adds.

*(*Discharge Planning Advisor *will look at possible solutions to the various problems associated with obtaining prescription drugs for patients in future issues. Please send any feedback on the issue to Lila Moore at lilamoore@mindspring.com.)* ■

Final outpatient PPS rule increases spending

The 1,000-page final outpatient prospective payment system (OPPS) rule, which takes effect this month, provides the congressionally mandated inflationary update and increases overall spending, but still pays hospitals only 83 cents for every dollar spent on outpatient care, the Chicago-based American Hospital Association (AHA) points out.

The rule gives the mandated 3.5% increase, but the net effect of all provisions in the rule is a 3.1% increase from last year for urban hospitals and a 6.2% increase for rural hospitals, according to a report in the on-line service *AHA News Now*.

The rule does not include a pro-rata reduction in pass-through payments for certain new and high-cost devices, drugs, and biologicals. It lowers the outlier threshold from 3.5 to 2.75 times the ambulatory payment classification amount, enabling hospitals to reach the outlier threshold sooner. However, outlier reimbursement will drop from 50% to 45% of costs above the threshold amount. ■

Patient records linked as part of warning system

Twenty million ambulatory care patient records will be connected as part of an early warning system for terrorism-related illness outbreaks.

The Centers for Disease Control and Prevention (CDC) has awarded $1.2 million to the Harvard Consortium to develop and pilot the early warning system.

The project will create a computer operating system that can link information from various types of medical systems and health departments so health professionals receive early warning of a terrorism attack, the CDC announced.

The system would scan managed care networks continually for clusters of illness. If successful, the platform would serve as a model for a syndromic surveillance system that would be one element of a national warning system.

Consortium members include the American Association of Health Plans, Harvard Pilgrim Health Care, HealthPartners Research Foundation, and Kaiser Permanente of Colorado. For more information, go to www.cdc.gov. ■