AMERICAN HEALTH CONSULTANTS®

HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR JCAHO, CREDENTIALING, AND QUALITY INFORMATION

CELEBRATING 28 YEARS OF SERVING THE HEALTH CARE QUALITY PROFESSIONAL

28

IN THIS ISSUE

MARCH 2003

VOL. 28, NO. 3 (pages 29-44)

U.S. congressman calls for OIG investigation of Joint Commission

JCAHO says it doesn't fear inquiry; confident work is beyond reproach

An influential congressman is calling for a broad investigation of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), alleging that the accrediting body is ineffective, torn by conflicts of interest, and rife with financial improprieties. The best solution, he says, would be to make JCAHO a federal contractor answering to the government, not to its member hospitals.

The agency responds by saying it welcomes an investigation even though the congressman is wildly misinformed. Rep. **Pete Stark** (D-CA) is no stranger to JCAHO, having criticized the organization in the past. He tells *Hospital Peer Review* that he wants the Health and Human Services Office of the Inspector General (OIG) to investigate what he calls fundamental flaws in the way JCAHO oversees health care quality. While there is some doubt as to how quickly the OIG will act on his request, if at all, the congressman's request is noteworthy because of his stature.

Stark has served in Congress since 1973 and is a senior member of the powerful Committee on Ways and Means. He was chairman of its Health Subcommittee between 1985 and 1994 and currently is ranking minority member on that subcommittee. Stark was a successful businessman and banker before being elected to Congress in 1972.

If the congressman gets his way, or if even a few of his suggestions are taken seriously, health care providers could face a much tougher accreditation process. Stark tells *HPR* that his latest call for an investigation is his way of keeping JCAHO on its toes.

"I've been fighting with them for 15 or 20 years," he says. "They get sloppy, and you threaten to no longer make them the certifying agent, so they get a little tougher. They've got such a sweetheart deal."

Stark says he has never liked the whole concept of JCAHO as an accrediting body that must please its customers, accredited health care providers, while also inspecting them and holding them accountable for deficiencies.

"The incentives are wrong. They work for the hospitals; they don't work for the government," he says. "That's not to say that they couldn't do the right job, but the focus of their attention is to keep their members happy."

Stark called for the OIG investigation in a recent letter to Inspector General Janet Rehnquist in Washington, DC. In his letter, Stark noted that Rehnquist has pledged to focus on hospital quality oversight this year. She recently stated that she will revisit areas of concern highlighted in the 1999 OIG report, *The External Review of Hospital Quality, A Call for Greater Accountability*, which included an investigation of the Joint Commission.

Stark explains in his letter that he has additional concerns not addressed in the 1999 report, "that take on added significance given Medicare's extensive reliance on [JCAHO] to assure quality of care and patient safety in our hospitals. I request that you address these issues during your upcoming review of the hospital quality oversight issue."

Stark is particularly critical of the agency's new survey process called Shared Visions — New Pathways, which will go into effect in 2004 and require hospitals and other providers to conduct their own self-assessments before surveyors show up. In his letter, Stark says, "This protocol appears even more collegial and less regulatory in nature than the current survey." The congressman says the quest for improved health care quality would be better served by a system in which the accrediting body took a stronger approach to surveys and then let the chips fall where they may.

"I've been in a hospital recently and saw stickers on doors saying, 'JCAHO is coming next week, so get your records in order,'" he says. "I used to be a banker, and the bank examiner didn't let us know what day they'd be sitting outside our door. They just showed up; and either we were in compliance, or we weren't."

Stark's letter notes that in the most recent Center for Medicare & Medicaid Services (CMS) Report to Congress, validation studies indicated that, "JCAHO was least reliable in assessing Medicare Conditions of Participation [CoPs] when self-assessment activities were a primary component of the monitoring process. Now, it will be the predominant component of the entire survey! I am requesting that you investigate whether the proposed new procedure can effectively assess compliance with the Medicare CoPs and assure quality and safety in Medicare participating hospitals."

Stark also goes after the Joint Commission's business practices, saying they appear "fraught with potential for conflict of interest." His concerns in this area focus on JCAHO's subsidiary Joint Commission Resources (JCR), which Stark says "has been aggressively pursuing and obtaining consulting contracts with the very institutions that they are surveying. According to the most recent financial information available, this consulting entity had a $5 million excess on $16 million of revenue — an exceedingly good 'profit margin' for a not-for-profit entity." While noting that the agency has attempted to establish a "firewall" between its surveying and consulting entities, Stark points out that half the JCR board members also are members of the Joint Commission board of directors.

"It is difficult for me to understand how this

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10 to 20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.
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**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

consulting business cannot have a negative influence on the surveying activities," he says. "I hope we don't have to see the equivalent of the cataclysmic events that occurred in the financial arena with Arthur Anderson, Enron, Global Crossing, and others to realize the problems of mixing regulatory and consulting functions."

Stark says he also is troubled by recent JCAHO financial reports that show more than $750,000 in contributions from unidentified sources. Without knowing the identity of these sources, he says, there is a specter of undue influence eroding the impartiality of the surveying process. "I am requesting that you investigate these business practices, determine whether there is a conflict of interest between competing functions that interferes with JCAHO effectively fulfilling its quality oversight duties, and make any necessary recommendations for change," Stark's letter says.

Many of the problems, Stark alleges, could be solved by making the government responsible for overseeing health care quality and making the Joint Commission a federal contractor, he says. **(See related article, below.)**

In its official response to Stark's letter, the Joint Commission says it "welcomes an evaluation by the [OIG] at any time. The Joint Commission cooperated fully with an OIG evaluation in 1999. That report found significant value in the accreditation process, and noted that 'JCAHO standards . . . promote the delivery of quality health care and are widely considered to be state-of-the-art.' The report also identified opportunities for improvement, most of which had been fully implemented prior to the issuance of the OIG's final report."

Margaret VanAmringe, vice president for external relations with the Joint Commission, tells *HPR* that Stark is "woefully ill-informed," his staff never asked for a briefing on Shared Visions — New Pathways, and the congressman appears to be under the misconception that the Joint Commission will start relying entirely on self-assessments in 2004. That is not the case.

The new accreditation process includes provision for a self-assessment by the organization at the approximate midpoint of the accreditation cycle, the JCAHO letter notes. "The self-assessment is an additional accreditation requirement and does not in any fashion substitute for the on-site evaluation by the survey team; neither the survey length nor the size of the survey team are to be reduced." The agency goes on to note that self-assessment methods have long been used successfully by other accrediting bodies and evaluators, including government agencies.

VanAmringe says Stark's charges about conflict of interest also are off-base. "We have never let the fact that we might lose a hospital's business be a determinant factor in how we score a

Congressman says, 'Make JCAHO a federal contractor'

Conflict of interest is such an inherent flaw in the Joint Commission on Accreditation of Healthcare Organizations' structure that the federal government should take over the responsibility and make the accrediting body a contractor, says U.S. Rep. **Pete Stark** (D-CA).

Stark contends that the federal government should establish health care quality standards and then contract with appropriate professionals to ensure that providers comply. He says the Joint Commission would be the obvious choice to hire for the job, but that having them answer to the government would make a major difference.

"Their responsibility would be to us, and their pay would be from us," he says. "There would be absolutely no negative incentive as you find in the current system. Their responsibility would be to the federal government, and then we could say there have to be surprise visits and on down the line."

Stark also says providers should be charged more for Joint Commission surveys as an incentive to get things right the first time. The fees would be paid to the federal government, which then would pay the Joint Commission for its work.

"We should do what they did when I was in banking. I was charged for the examination," he says. "The better shape my records were in, the less they had to do, the quicker they could do it, and the less it would cost me. Others would have significant problems and pay a lot more."

Margaret VanAmringe, vice president for external relations with the Joint Commission, says this isn't the first time she's heard a suggestion that the Joint Commission's responsibilities be turned over to the federal government. She doesn't think it will happen.

"We obviously do have a very strong relationship with the federal government, and I think we are very accountable now," she says.

"Obviously, Congressman Stark would like to see a stronger structure, but we think that relationship works well now. I think he may not understand how much we do in terms of providing a very significant source of information to the government, free of charge," VanAmringe explains. ■

hospital. We're not in the business of giving scores to please people." Stark missed the point of the new survey process, she says. The self-assessment allows the surveyor to be more informed of the hospital's history and permits the surveyor's time on site to be better utilized for a rigorous, more pertinent survey. "This is in no way diluting the survey process," she says.

As for Stark's concerns about discrepancies between JCAHO surveys and CMS validation survey findings, the Joint Commission's response says those are regularly described in the CMS annual report to Congress. While some critics of the Joint Commission have pointed to these discrepancies as a cause for concern over the agency's oversight, the Joint Commission notes that the number of such discrepancies has varied significantly from year to year, and these discrepancies tend to relate primarily to the physical environment in which care is provided.

"An important confounding factor in assessing the significance of these discrepancies is the number of substantive differences in the versions of the Life Safety Code applied in the respective surveys," the response says. "This problem should now be resolved on a going-forward basis with CMS' recent adoption of the current version of the Life Safety Code. Joint Commission and CMS requirements in this area are now identical."

Regarding JCR, the Joint Commission's response asserts that "JCR operates in a completely separate fashion from JCAHO in accordance with strict guidelines that were first adopted in 1986 and have been updated periodically since then. The 'firewall' created by these guidelines meets current U.S. Securities and Exchange Commission separation criteria. No organization-specific information of any kind is shared between the entities."

However, the Joint Commission concedes that, "Mr. Stark raises an interesting question about the board structures of the two entities. That question is already the subject of review and discussion by the leaders of the two boards."

The Joint Commission's response says Stark's statements with respect to JCR's services "are at best misleading. In 2001, the subsidiary provided consulting services to fewer than 2% of all Joint Commission-accredited organizations. For this period, 88% of JCR's net revenues after expenses was generated by education programs, publications, and international activities. In fact, the net revenues generated by domestic consulting amounted to substantially less than $1 million."

As for profits and funds from unknown donors, the Joint Commission emphasizes that the Joint Commission is a 501(c)3 charitable, not-for-profit organization. "As such, it accepts donations in the form of unrestricted grants to subsidize JCR educational programs and publications offered to health care organizations to help them improve the safety and quality of care that they provide. At the same time, strict corporate guidelines prohibit JCAHO and JCR from accepting any contributions from accredited or accreditation-eligible organizations or their corporate owners."

The HHS OIG's office has not responded yet to Stark's request. VanAmringe says she doesn't expect the OIG to launch a full-scale investigation as it did in 1998, but that the Joint Commission is ready if it does.

"In 1998, we opened our books, and I think in general they were very satisfied with what they found," she says. "We obviously have nothing to hide."

[For more information, contact:

- ***Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*
- ***Rep. Pete Stark**, 239 Cannon HOB, Washington, DC 20515. Telephone: (202) 225-5065.]* ■

JCAHO issues alert on nosocomial infections

Organization changes sentinel event definitions

Several important changes were announced to Joint Commission on Accreditation of Healthcare Organizations surveyors at a recent training session in Chicago, including new definitions for some types of sentinel events.

The accrediting body also has issued a formal alert to health care providers about the danger of nosocomial infections.

In addition to emphasizing the newly intense focus on infection control, surveyors were told of changes to one sentinel event definition and a new sentinel event type. **Mark Forsteneger**, Joint Commission spokesman, confirms the announcements to *Hospital Peer Review*.

Rape already was a sentinel event, but the Joint Commission now has expanded the definition of rape to include "unconsented sexual contact,"

Forsteneger says. That definition broadens the type of sexual activity that could be considered a sentinel event so that sexual intercourse is not necessary to meet the threshold.

Also, the Joint Commission told surveyors that the "unanticipated death of a full-term infant" now is considered a sentinel event. This is a new addition to the list of events that are automatically considered sentinel events requiring a root-cause analysis and possible report to the agency. Other events are considered on a case-by-case basis using Joint Commission guidelines.

In addition, surveyors no longer will issue supplemental recommendations. Instead, the only options will be a Type I recommendation or what was described as "information finding," though the Joint Commission may end up calling it something else. Unlike supplemental recommendations, which must be addressed or hospitals will get a Type I, there will be no obligation to correct problems in the "information finding."

Surveyors also were told that they must stop the practice of handing out their own forms during the survey process. Many surveyors were in the habit of using their own forms to ask for certain types of information during a survey, just as a matter of expediency and personal preference, but were told during the meeting that they must use only Joint Commission forms to request information.

Alert issued after recent concerns

The Joint Commission also followed its recent statements about the need for improved infection control with a formal alert urging accredited providers to increase reporting of infection-related deaths. Its leaders recently stated that serious nosocomial infections should be considered sentinel events and thoroughly investigated, with **Paul Schyve**, MD, Joint Commission senior vice president, saying that "If a patient dies in a hospital or has a permanent disability as a result of a nosocomial infection, the hospital really should think about that as a sentinel event and treat it and evaluate as such. When the outcome is that serious, it is not the same as saying let's add these [infections] up and look for trends and patterns. It is, in fact, a sentinel event."

In response to the Joint Commission's new position, **Patrice Spath**, RHIT, a consultant in Forest Grove, OR, advises broadening your definition of what type of nosocomial infection is defined as a sentinel event.

She suggests including an infection control practitioner in the committee or ad hoc group that conducts the preliminary review of adverse events to determine whether a root-cause analysis is necessary. It also can be useful to have physicians to include a question on their mortality review forms about the need to review the nosocomial infection, she says.

To emphasize the Joint Commission's new approach, it issued a *Sentinel Event Alert* that says hospital-acquired infections are being "seriously underreported across America." In addition to calling for increased reporting, the Joint Commission is urging better infection control practices. In particular, the *Sentinel Event Alert* urges compliance with new guidelines from the Centers for Disease Control and Prevention (CDC) that advise health care professionals to use alcohol-based hand rubs (in conjunction with soap and water and sterile gloves) to prevent these acquired infections.

The CDC estimates that more than 2 million patients annually develop infections while hospitalized for other health problems and that nearly 90,000 die as a result of these infections. Despite these high figures, the Joint Commission's 7-year-old patient safety reporting database includes only 10 such reports that cover 53 patients.

In releasing the alert, **Dennis S. O'Leary**, MD, president of the Joint Commission, said, "We are receiving a disproportionately low volume of reports on the number of patient deaths from infections acquired in the health care setting, possibly because many health care organizations do not view these events as 'errors' under the definition of a sentinel event. However, in view of the importance and high visibility of such occurrences, we are urging health care organizations to share this information with the Joint Commission, just as they might share information about other types of sentinel events with us."

In addition to evaluating compliance with infection control standards during its regular triennial surveys, the Joint Commission has included infection control as a special focus area during random unannounced surveys for hospitals in 2003, he noted. The Joint Commission also is convening a new infection control panel with 20 experts to suggest ways in which current standards can be strengthened.

[For more information, contact:

- ***Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*

- ***Patrice Spath**, Brown-Spath & Associates, 2314 19th Ave., Forest Grove, OR 97116. Telephone: (503) 357-9185.]* ■

Diabetes QI program cuts complications by 60%

JCAHO honors program with Codman Award

Quality improvement projects can be especially challenging if you try to implement them on a systemwide basis across many health care institutions, but a diabetes project in Iowa shows that it can be done if you give people the tools and let individual organizations decide how best to use them.

The project to standardize and improve diabetes care grew out of the Des Moines-based Iowa Health Care System's overall effort to unify as a system, says **Tom Evans**, MD, vice president and chief medical officer. With 11 hospitals in the system, he says it was a challenge to standardize clinical care, but everyone knew it was the way to improve quality and probably could help lower costs as well.

"It's one thing to be together as a health care system, but what is our joint commitment to quality?" Evans asks. "In 1998, the system declared war on diabetes, singling out that area of care as one where we could see tremendous improvements if we all got together on what we should do. It's been a wonderful journey, but we had to figure out how to do it."

Five years later, the Joint Commission on Accreditation of Healthcare Organizations is recognizing the system for successfully bucking the trend in Type 2 diabetes — one of the fastest growing health problems in the United States.

Iowa Health System recently received the Ernest A. Codman Award for helping its diabetes patients successfully manage their diabetes. By collecting and using data to improve care for 58,000 diabetics, served through its 11 hospitals, Iowa Health was able to reduce hemoglobin A_{1c} (HbA_{1c}) levels — which are higher for diabetics — to near-normal levels in most patients. The Codman Award recognizes health care organizations for excellence in the use of results measurement to improve quality of care.

Iowa Health System is the state's first and largest integrated health care system. One of the state's largest employers, as well as its largest health care provider, Iowa Health employs more than 17,000 people statewide. Last year, it saw nearly 270,000 individuals in its emergency departments and had close to 100,000 admissions.

Leaders from Iowa Health decided that the way to provide the highest possible quality diabetes care was by recognizing that education, nutrition, and lifestyle management are the keys to controlling diabetes. The outcomes achieved over the course of three years have occurred as a result of the system working together from eight communities for its patients across Iowa and parts of Illinois and Nebraska, says **Sam Wallace**, president and CEO of Iowa Health System. The system's broad coverage meant that a diabetes quality improvement (QI) project could affect a huge number of patients, he says. Iowa Health serves about a third of all patients in Iowa. "We believed that as a health delivery system with statewide reach and broad-based clinical research capabilities, we could make a positive difference to those in our service area suffering from diabetes," he says.

Standardization was a key part of the initiative. Each hospital had diabetic teaching centers that, judged individually, were doing a fine job with their patients, Evans says. But the quality improvement team knew that standardizing the care would result in improvements across the board.

"Each teaching center had a lead diabetic educator or coordinator, so we recruited them to create a work team," he says. "We planned for three meetings. In the first, everyone talks about the wonderful things they're doing. That's sort of an inventory to get things out on the table and let people establish that they're already doing good work. It's important for them to establish that so that no one feels like they're being dragged in because they're substandard."

In the second meeting, the work team looked at what is standard in the industry for diabetes education, and what best practices are available. At that meeting, the work team also created a "joint-envisioned future" that detailed where Iowa Health wanted to be in the future regarding diabetes education.

"That was the ideal situation, the way we would handle diabetes education if nothing stood in our way. Then we came back with a third meeting to discuss the joint commitments that we will all use to get to that future," Evans says. "We distilled that into bullet points we could use to get to that future."

(Continued on page 39)

PATIENT SATISFACTION PLANNER™

Employee-centered focus sets this system apart

'The best health system in America!'

The lofty vision of Baptist Health Care Corp. of Pensacola, FL, is to be "the best health system in America." It may well be on its way. According to one authoritative source, Baptist Health may at the very least be the best health care employer in the entire country.

In *Fortune* magazine's most recent listing of the "100 Best Companies to Work For," Baptist — with six hospitals and 742 beds — ranked 15th on the list.

The next-highest health care employer — there were four in all — ranked 76th.

What sets Baptist apart? For one thing, the system provides an unbelievable range of programs that recognize, reward, support, and involve employees, including recognition of significant anniversary dates and numerous opportunities to present new ideas.

"*Fortune* said that the No. 1 factor that separates us is that we celebrate so much," says **Celeste Norris**, human resource director. "We have hospitalwide celebrations when we do well, and we thank everyone. We have a sense of pride about our work."

An atmosphere of celebration

It wasn't too long ago that Baptist didn't have much to celebrate at all.

"In 1995, we needed a boost — a big one," she recalls. "We had just been through merger mania, growing from 2,500 to 5,000 employees. We had tried re-engineering, and in the process, destroyed morale by shaking up middle management. Our leaders knew we couldn't compete by outspending the competition on equipment, so we decided to compete on service."

Leadership recognized early on that it couldn't deliver world-class service consistently unless the work force was behind it and every employee was engaged, says Norris.

"We had high turnover, patient satisfaction was in the teens as rated by Press Ganey Associates, and employee morale also was low as measured by a tool we use from Sperduto & Associates," she notes.

As it so often does with successful change, the process began at the top with the Baptist CEO.

"We made a concerted and sustained effort to change the corporate culture," says Norris. "We republished our values and mission and committed to being No. 1 in patient and employee satisfaction."

Employees were involved from the start in the visioning process. "One of the first things we did was share the news with employees and ask for their input on how to accomplish our goals," adds Norris.

A number of employee teams were formed, including the standards team, which was charged with outlining the behaviors every employee should exhibit to provide world-class service.

"As a result of this process, the employees exhibited a sense of ownership and felt free to express themselves," Norris notes.

At the same time, the CEO sent teams across the country to benchmark other workplaces, a number of which were then approved by the CEO and implemented.

The programs at Baptist not only make sense on paper, but they produce results.

"We have a very open culture when it comes to information sharing," says **Sharon Gaubert**, MPH, program director for occupational health and urgent care.

"Every day, we review the patients seen and the revenue from the previous day. We also look at month-to-date figures and benchmark them against our revenue goals," she says.

When those goals are exceeded, the department receives a free, catered lunch in the office.

"This helps us keep them fired up," Gaubert says. "It's actually easy to minimize loss of charges and increase accuracy."

Service teams are essential to success

Service teams are another key to Baptist's success. Through these teams, frontline employees and leaders work together at enhancing care to

all customers. "For example, one team deals with employee loyalty," Norris notes.

That particular team includes employees from the pharmacy, the wound center, human resources, marketing, and nursing. One project involved one-year certificates given to each employee who reached that milestone.

"We celebrate that because we know employees are still at risk for leaving until they've been with an employer for about two years," she explains.

However, the certificates cost about $2.95 each to produce, and one coordinator found several of them strewn about.

"The team realized many of these people did not have offices in which to post the certificates, so they didn't value them as highly as they might," Norris explains. "So, they suggested making pins."

The cost of the pins was $1 apiece. The recommendation has now been implemented.

The daily huddle, which was benchmarked from Ritz-Carlton Hotels, has impressed **Summer Jimmerson**, marketing representative for occupational health.

"I've been here for seven years and never worked on an actual campus," she explains. "With this many employees, its important to continuity to make sure the messages go out. Through the daily huddles, we know where we are, and where we are going."

Cascade learning is another important process, Norris says. "When leaders go off site to have instructional training, they are given the tools to waterfall that new knowledge to the staff when they return," she says. "They basically say, 'Thanks for covering for me. Here's what I learned.' With training budgets being cut so only a few people can go, this is a valuable way of extending training dollars."

Engaging employees with 'Bright Ideas'

The 'Bright Ideas' program has impressed Gaubert. It provides a mechanism by which employees' suggestions are taken to appropriate leaders at any level of the organization. "It's really great," she says. "Employees can generate their ideas, take ownership of them, and make them happen."

"When employees submit their ideas and they are implemented, it gets them engaged in the business," Norris adds. "It's great for their self-esteem."

Today, the changes initiated over the past several years have become part of the culture and of everyday procedures at Baptist. For example, the vice president of patient care and the COO meet weekly with the leaders of the service teams.

"That's their forum to get approval," Norris notes.

The numbers don't lie.

"We've been in the top percentile in inpatient surveys for four years in a row; and in employee satisfaction surveys, we have been ranked 'best-in-class' in terms of morale," she reports.

Improved morale

From an occupational health perspective, the improved morale also has been a plus, Gaubert says.

"From our end of the business, we know injury rates tend be lower when employees are happier. When unions are about to go on strike, for example, injuries are higher," she explains.

Norris confirms the positive impact on injuries. "Our workers' comp injuries have declined, and our risk management costs have also declined," she reports.

"It's also reflected in employee turnover, where the numbers are also down," Jimmerson adds.

In fact, Baptist Health Care has been so successful that other organizations now are benchmarking *them.*

"We now offer a leadership training institute. We have had so many requests from executives around the country we have opened it up to the public through our web site [www.ebaptisthealthcare.org], she points out.

Once there, people can visit our leadership institute site and learn about the opportunities they have to come here and benchmark," says Jimmerson.

[For more information, contact:

- ***Celeste Norris**, Human Resource Director, Baptist Health Care, 1000 W. Moreno St., Pensacola, FL 32501. Telephone: (850) 434-4011. cnnorris@bhcpns.org.*
- ***Sharon Gaubert**, MPH, Program Director for Occupational Health and Urgent Care, Baptist Health Care, 1000 W. Moreno St., Pensacola, FL 32501. Telephone: (850) 434-4011.*
- ***Summer Jimmerson**, Marketing Representative for Occupational Health, Baptist Health Care, 1000 W. Moreno St., Pensacola, FL 32501. Telephone: (850) 434-4011.]* ■

EDs report success with service guarantees

Free visits and movie passes pay off

Imagine promising that every patient who walks through the door of your emergency department (ED) will be seen in 15 minutes.

Does this sound like an invitation for a public relations nightmare? You may be surprised to learn that an increasing number of EDs are offering patients similar service guarantees.

At Northern Nevada Medical Center in Sparks, ED patients are guaranteed they will be seen within 15 minutes or the visit is free. The guarantee is posted in the ED and advertised via newspapers, radio stations, notices in telephone directories, and billboards.

If the time limit is not met, the patient complains to the nurse, who reports it to the nurse manager, who then instructs the business services manager not to bill the patient for the ED visit, says **Jean Lyon**, RN, chief nurse executive at the medical center.

"With a designated triage nurse, the only way the guarantee is not met is if several patients arrive in the ED at the same time and can't all be triaged within 15 minutes," she says. "This does not happen very often."

30-minute guarantee

ED patients at Oakwood Hospital Medical Center in Dearborn, MI, are guaranteed that they will be seen by an ED physician and care will begin within 30 minutes of arrival.

"If we do not meet this, the patient receives a letter of apology signed by myself and the ED medical director, along with two movie passes," says **Corinne G. Victor**, RN, CEN, administrator for emergency services.

Each patient's arrival time is entered into the computer by a greeter at the front desk, and if the 30-minute guarantee isn't met, the staff will inform the patient, she explains.

If for some reason this delay is overlooked by the staff, it will be caught when the charts are reviewed by the ED billing department, Victor says.

"If we missed the guarantee, those charts are copied and given to the ED clinical manager," she points out. "She will call the patient and send out the tickets and letter of apology at that time."

The guarantee is in place for all five EDs in the Oakwood Healthcare System and is heavily advertised, with a prominent sign posted in the ED's waiting rooms, says Victor.

"We have also done postcard mailings to our market share, which could be as many as 150,000 for one ED at a given time," she says.

ED managers report that the service guarantees have succeeded in their goal: to set their department apart from competitors. "Our 15-minute guarantee has become Northern Nevada Medical Center's brand in the market," Lyon says.

Here is what EDs offering service guarantees have experienced:

- **Not many patients were dissatisfied.**

Victor reports that from the start of the program in July 2000 through September 2002, all five EDs in the Oakwood Healthcare System have collectively given out movie tickets to only 638 patients out of 361,234 patients seen.

"Star Theatres gave us the first 200 tickets at no cost, which was wonderful,"she says. "We have had to pay for 438 tickets at $6 each, for a total of $2,628."

Likewise, Lyon reports that the ED has written off just a single visit over a two-month period. "The average is five or six a year, in a volume of 1,750 to 1,850 visits a month," she adds.

- **Patient satisfaction has increased.**

Lyon attributes high patient satisfaction in large part to the guarantee program.

"Letters, telephone calls, and patient and family comments show that many people come to our ED not because it is closest, but because they have heard from friends and neighbors that they will receive fast and high-quality treatment," she says.

Making an impact

"It had an incredible impact on our patient satisfaction," Victor reports. In fact, patient satisfaction scores rose from 70% to 96% after the service guarantee program was implemented, she says.

- **Most staff responded positively.**

The majority of ED staff were enthusiastic about the guarantee, but not everyone, Victor says.

"In the beginning of the guarantee, we lost some staff," she acknowledges. "These were folks who for one reason or another just couldn't change their way of thinking."

Overall, the guarantee program resulted in greater staff satisfaction, she says. "The staff are happier because patients aren't always upset with the wait," she explains.

- **Census increased significantly.**

Lyon says the ED's volume has increased steadily over the past five years, which made it harder to meet the 15-minute guarantee. As a result, she says additional nurses were hired, including a designated triage nurse.

"This change in the staffing pattern ensures that the guarantee is achieved," she says.

In addition, an ED expansion is under way that will increase the number of beds from eight to 18.

"If the volume continues to increase, we will add more ED nursing staff to make sure we meet the guarantee," she says.

Because of the program, the ED's volume has outgrown its capacity, Victor says.

"Be careful what you ask for! We have experienced a 45% increase in volume since 1999," she reports. "We wanted an increase in market share, but this was phenomenal." ■

Patients want quality, quantity time with PTs

Research shows patients care less about waits

Conventional wisdom — and indeed, much literature — supports the idea that satisfied patients are impressed with short waiting times, good parking, convenient locations, and sophisticated equipment.

But a new study looking at patient satisfaction with physical therapy clinics found that what patients really care about is the quality and quantity of time they spend with their therapist.

According to the study, recently published in the journal *Physical Therapy*, patients rate first in importance the amount of time the therapist spends with them, along with the therapist's listening and communication skills and the therapist's willingness to give clear explanations of treatment.[1]

The quality of patient-therapist interaction counts for much more than high-tech medical hardware, accessible parking, and convenient location and office hours.

Researchers surveyed a sample of 1,868 workers' compensation patients from clinics in 17 states in an effort to measure the effectiveness of a patient satisfaction survey instrument the authors developed.

"Based on the current literature regarding customer satisfaction, as well as conventional wisdom, we asked questions about things like parking, location, equipment quality — things that arguably would be of interest to a consumer," says **Paul Beattie**, PhD, PT, OCS, clinical associate professor in the department of exercise science at the University of South Carolina's School of Public Health in Columbia.

"We found that none of those things correlated significantly with the overall satisfaction with care," he says. "The big things were that they wanted to have quality time with the therapist and to have that person answer their questions, provide information, and spend adequate time with them.

High quality is worth the wait

"Our primary objective was to develop an instrument and determine its measurement properties," Beattie says, "but when I saw these results, it was almost astonishing. It was a very strong relationship, and I think it's significant in terms of practice."

The waiting time issue might be the most surprising. "As a patient, you may say that a lengthy waiting time was worth it if the therapist really paid attention to you, answered all your questions, and provided high-quality care," Beattie says.

"On the other hand, you could go to a palatial clinic where you are quickly moved through without adequate time or attention from your therapist, and you're going to be dissatisfied with that experience," he adds.

Reference

1. Beattie P, Pinto MB, et al. Patient satisfaction with outpatient physical therapy care: Instrument validation and identification of important components. *Phys Ther* 2002; 82:557. ■

(Continued from page 34)

To reduce HbA_{1c} levels and control chronic diabetes, the team took these steps:

- It adopted a standardized education curriculum for type 2 diabetes for patients and caregivers.
- The team adopted uniform standards of care based on national quality standards.
- Iowa Health committed to providing staff training in patient education, data collection, chart abstraction, data entry, and behavior evaluation.
- The system introduced the use of reminder calls to patients for return appointments.

"The most important steps were using common metrics, common data collection techniques, and common definitions," Evans says. "We achieved most of that in the first year, making sure we were all using the same information and playing the same song."

Iowa Health's new approach has been in place for about three years. As a result of this initiative, the average HbA_{1c}, which measures blood sugar in diabetic patients, fell from 9.2% to 7% during the most recent six-month data analysis, Evans says. The reduction in HbA_{1c} is estimated to reduce the risk of further patient complications by 30% to 60%. The work of the multidisciplinary team has paved the way for implementing other disease-specific quality improvement programs, including programs for asthma, congestive heart failure, community-acquired pneumonia, total joint replacement, and acute myocardial infarction, he says.

According to Evans, the rapid success of the program is the result of utilizing a consistent curricula along with a strategic plan implemented consistently across the system's hospitals. Diabetes education centers at each of the hospitals have met the strict requirements for recognition from the American Diabetes Association, and they have implemented treatment standards consistent with those developed by the respected Minneapolis-based International Diabetes Centers.

In addition, Iowa Health realized some financial benefits. All of the diabetic teaching centers had been operating as loss leaders, so Evans challenged the QI team in 2001 with a new goal: remain open in 2002. The work team looked at cost per hour and exactly how each site was delivering the education to patients, with an eye toward improving efficiency. The biggest change to grow out of that focus was a switch to group sessions rather than individual patient education. In the first six months of 2002, that change and other improvements in efficiency lowered the operational costs of the clinics by 20% per hour.

Evans says an important part of the team's work was standardizing expectations and methods while still leaving some degree of autonomy to each individual clinic.

"Consistency in how we treat diabetes and how we measure the results allows us to determine which are the best practices and share them among all our hospitals and doctors," he says. "But health care is local, so you can't just give everyone a recipe and tell them follow it. We tried to focus on identifying a common destination and then give them the tools to get there. We helped them figure out the route to get there, but we didn't tell them the route."

[For more information, contact:

- ***Iowa Health System**, 1200 Pleasant St., Des Moines, IA 50309. Telephone: (515) 241-6161.]* ■

JCAHO, NCQA form human research quality group

Partnership to offer new accreditation program

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) have announced the formation of the Partnership for Human Research Protection (PHRP) to offer a new accreditation program that will seek to protect the safety and rights of participants in clinical trials and research programs in public and private hospitals, academic medical centers, and other research facilities in the United States and abroad.

The PHRP Accreditation Program will invite organizations to demonstrate their commitment to safeguarding the interests of human research participants through engagement in the new accreditation process. Standards are to be released in April 2003, and accreditation reviews will begin shortly thereafter, says **Margaret E. O'Kane**, NCQA president. "We need to ensure that the invaluable efforts of researchers are matched with robust processes for protecting the volunteers that make progress possible," she says.

"By applying one set of standards across many different biomedical research settings, NCQA and JCAHO will bring their decades of expertise to bear in ensuring that protection of volunteers

is paramount," O'Kane adds.

The rapid expansion of medical research, drug trials, and other studies involving human subjects is placing increased demand on existing HRP programs to ensure that studies' risks and benefits are thoroughly weighed, volunteers are properly informed, adverse events are carefully monitored, and research risks are minimized, says **Paul Gelsinger**, vice president of Citizens for Responsible Care and Research (CIRCARE) in Baltimore and a noted advocate for improving clinical trial oversight processes.

"Study participants need to be able to trust the research system," he says. "This joint accreditation program will go a long way toward assuring research participants that they will be well protected and thoroughly informed of any risks."

NCQA developed the nation's first HRP accreditation program in 2001 for the Department of Veterans Affairs (VA). Both the federal Office of Human Research Protections and the Food and Drug Administration have supported private accreditation, such as the new PHRP Accreditation Program, as a critical component of an overall national strategy to better protect human research participants and promote greater accountability.

The NCQA and JCAHO collaboration will provide a national set of standards and a voluntary oversight process that complements current regulatory efforts. The new accreditation program will seek to optimize performance and promote continuous improvement, rather than simply accept compliance with minimum standards.

The new PHRP Accreditation Program specifically addresses the principal issues identified in the 2001 Institute of Medicine report, *Preserving Public Trust: Accreditation and Human Research Protection Programs.* The draft standards address organization responsibilities, institutional review board structure and operations, consideration of risks and benefits, and informed consent. The accreditation process will feature use of a web-based self-assessment tool, which organizations will use both to evaluate themselves against the standards and to determine their readiness for a full review. The self-assessment results will be reported to the PHRP Accreditation Program.

The actual accreditation review will be conducted in two parts: 1) an off-site review of the self-assessment results and supporting documentation; 2) an on-site review, during which a team of PHRP surveyors — research clinicians and others experienced in biomedical research — will validate performance against the standards.

The on-site component of the review is expected to be two to three days long and will include interviews with organization leaders. The program will offer an accreditation award for a maximum of three years and will include annual reporting requirements to assess continued standards compliance. Accreditation decisions will be publicly reported.

[For more information, contact:

- ***National Committee for Quality Assurance**, 2000 L St. N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-3500.*
- ***CIRCARE**, 24 Indian Lane, Baltimore, MD 21210. Telephone: (410) 435-4895.]* ■

THE QUALITY - CO$T CONNECTION

Prevent communication breakdowns

Errors can occur during information transfer

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

Patient safety can be jeopardized when the transitions or "handoffs" that occur during patient care are not managed effectively. Many errors come from slips that occur during the exchange of materials, people, and/or supplies.

Transfer of information — oral, written, or electronic exchanges — is critical. To minimize the risk of unintended patient harm, caregivers must ensure that information exchanges are timely, complete, and accurate. These exchanges can occur between caregivers within the same setting, between services or departments within the same setting, or between caregivers in different settings.

Each component within the patient care continuum must be adequately linked with every other component to enable unimpeded and timely flow of information. When information is effectively exchanged, quality of care is positively affected and there is less chance of an untoward outcome. Communication breakdowns can occur at any

point within the continuum of care. When the information necessary for meeting a patient's care needs is not effectively transferred, the patient can be exposed to unnecessary risk of harm. What might happen if the evening shift nurse in the hospital forgets to tell the night shift staff that a depressed patient has just started expressing suicidal ideation? Or suppose the radiology technician does not document that a patient has had a previous allergic reaction to contrast agents?

Continuity of patient information is essential to safe care. Clinicians must have knowledge of or ready access to relevant facts about a patient at all times. Complete and pertinent information must be available to all caregivers. Effective information sharing must occur among the practitioners caring for a patient, whether in the same institution, between institutions, or between care settings. Information continuity depends on data being up to date, accurate, retrievable, understood, and used. In transitions between settings of care, information is at risk of not being transferred, of being transferred but not read, of being read but misunderstood, or of being understood but discounted.

It is important to identify the barriers to effective

Where Does Information Exchange Need Strengthening?

Important Information Exchanges	Frequency of Occurrence		
	Often	Occasionally	Rarely
All relevant information about the patient's previous care and services is available to caregivers at the time of the patient's entry to the setting or service.	☐	☐	☐
Patients and their families are informed about proposed care and associated risks and costs.	☐	☐	☐
Care is planned collaboratively, involving all responsible caregivers, patients, and patients' families.	☐	☐	☐
Patient records from all care settings within the organization can be quickly assembled when needed.	☐	☐	☐
Information is well communicated among care providers during different phases of care and across different settings.	☐	☐	☐
Everybody providing care to a patient uses the same treatment plan.	☐	☐	☐
Communication problems do not result in patient incidents.	☐	☐	☐
Diagnostic test results are accurate and communicated to practitioners in a timely manner.	☐	☐	☐
Translator services are available for non-English-speaking patients.	☐	☐	☐
Caregivers have ready access to critical patient information (e.g., allergies, condition, current status, etc.).	☐	☐	☐
Caregivers follow a consistent procedure for communicating pertinent patient information during shift changes.	☐	☐	☐
Physician-to-physician communication is adequate in situations in which more than one physician is caring for the same patient.	☐	☐	☐
A concise picture of the patient's continuing care needs is provided when he/she is transferred to another provider.	☐	☐	☐
Caregivers consistently follow the organization's patient transfer policy and procedure.	☐	☐	☐
Patients and their families are educated about the patients' conditions and issues affecting self-care.	☐	☐	☐
Patients and their families are involved in discharge planning.	☐	☐	☐
Patients are contacted following an unexplained missed appointment for a clinic visit, diagnostic test, or elective hospital admission.	☐	☐	☐
The people caring for a hospitalized patient talk with the people who will care for the patient after discharge.	☐	☐	☐

Source: Patrice Spath, RHIT, Brown-Spath & Associates, Forest Grove, OR.

communication during the process of patient care. **Use the assessment tool on page 41** to examine the important information exchanges throughout the continuum of care. By evaluating the communication linkages, you'll have a better understanding of the capability of your systems to support consistently safe, high-quality patient care. The statements shown in the tool are designed to stimulate your thinking about how information flows among caregivers, patients, and families. The assessment tool prompts you to identify less than optimal practices, those actions or activities that only occasionally or rarely occur. By completing the assessment, you should have a snapshot of the strengths and weakness of the information exchanges in your organization. This knowledge can be used to initiate appropriate improvement plans.

Once the barriers are recognized, steps can be taken to eliminate them. For example, misinterpretation on the part of the listener is a common barrier to successful oral communication. When oral communication is a vital component of the patient care experience (for example, exchange of verbal orders), a "repeat-back" system should be used to prevent miscommunications. Illegible handwriting is a common barrier to effective written communication. A computer-based ordering system removes the potential for errors caused by misread handwriting.

Caregivers should have ready access to critical information relative to patient care when it is needed. Techniques for ensuring ready access to information might include using color-coded wrist ID bands on patients with known drug allergies, or putting patient allergy information automatically on all medication order forms. A color-coded seat belt or flag attached to a wheelchair also can be used to denote patient status and supervision guidelines. This type of system communicates the patient's status to all caregivers.

Ineffective transfer of information during patient care can create a dangerous situation that increases the risk of patient harm. For example, timely and reliable communication of critical abnormal test results to the clinician who needs to take action is important. Improving hospital communication procedures can make a significant contribution to patient safety.

A safety factor of particular concern is the role of interpersonal communications — between the clinician and patient, and between clinicians — in diagnosis and treatment. Previous studies have shown that communication failure is a contributor to adverse events. As patients become more diverse, their language and cultural differences will increase the likelihood of communication problems that result in errors or unintended injuries. It is important to understand that there are many contributors to an adverse event and that each must be addressed to provide patients with the utmost safety.

It's time to begin analyzing one of the primary contributors, our information exchange processes, so that effective solutions can be found. ■

AHRQ: Autopsies helpful in improving quality

They also can reveal diagnostic discrepancies

Autopsies can detect clinically important diagnostic discrepancies and help an organization improve the quality of care, according to a new report released by the Agency for Healthcare Research and Quality (AHRQ).

Based on an analysis of more than 50 studies spanning 40 years, researchers estimate that, in U.S. hospitals in the year 2000, the correct cause of death escaped clinical detection in between 8% and 23% of cases, with as many as 4% to 8% of all deaths having a diagnostic discrepancy that may have harmed the patient. In addition to clinically missed diagnoses, up to 5% of autopsies disclosed clinically unsuspected complications of care.

These diagnostic discrepancy rates do not simply reflect selection by clinicians of diagnostically challenging cases, according to the AHRQ. In fact, considerable evidence suggests that clinicians have trouble predicting which autopsies are likely to yield important new information. The researchers note that, although often referred to as "diagnostic errors," these findings refer to discrepancies between clinical diagnoses and autopsy diagnoses and not necessarily to medical mistakes. While diagnostic discrepancies can result from a clinician's failure to consider an appropriately broad listing of alternative diagnoses or misinterpretation of test results, there also are situations with atypical symptoms or limited diagnostic test information, they explained. These discrepancies, regardless of source, create inaccuracies in death certificates and hospital discharge data, both of which play important roles in epidemiologic research and health care policy decisions, the study authors said.

The evidence report examined the benefits of

the autopsy as a tool in health care performance measurement and improvement. However, the researchers did not attempt to address other roles of the autopsy in medical education, furthering medical research, quality control within the medical specialty of pathology, verification of second opinion consultations and legal documentation of findings, or the bereavement process for surviving family members. The focus of the report on the autopsy's role in detecting quality problems reflected an objectively quantifiable area to evaluate the potential negative effects of the trend toward fewer autopsies during the past 40 years.

In 1994, the last year for which national data exist, the autopsy rate for all nonforensic deaths fell below 6%, from a high of 50% in the 1960s. This decline is probably due to lack of reimbursement for autopsies, the attitudes of clinicians regarding the utility of autopsies in light of other diagnostic advances, and general unfamiliarity with the autopsy and techniques for requesting one, especially among physicians in medical training, according to the study authors.

The report was requested by the College of American Pathologists. A summary of the report can be found on-line at www.ahrq.gov/clinic/epcsums/autopsum.htm. ■

CE *questions*

9. Under changes to sentinel event definitions, the Joint Commission now considers the unanticipated death of a full-term infant a sentinel event.
   A. true
   B. false

10. According to estimates from the CDC, how many patients per year develop infections while hospitalized for other health problems?
   A. 200,000
   B. 800,000
   C. 1.4 million
   D. more than 2 million

11. As a result of the diabetes quality improvement initiative at Iowa Health Care System, the average HbA_{1c} for the program's diabetic patients fell by what percentage during the most recent six-month data analysis?
   A. 1.7%
   B. 2.2%
   C. 3.1%
   D. 4.3%

12. The draft standards of the new Partnership for Human Research Protection address which of the following issues?
   A. institutional review board structure and operations
   B. organization responsibilities
   C. informed consent
   D. all of the above

Answer Key: 9. A; 10. D; 11. B; 12. D

Stroke care improved with use of clot busters

Quality of care is improved significantly when emergency department (ED) physicians are allowed to deliver clot-busting drugs to appropriate stroke patients without waiting for dedicated stroke teams, according to a new study.

Current wisdom calls for judicial use of special thrombolytic drugs called tissue plasminogen activators (tPA) that can break up a clot and cut the risk of brain damage, with many hospitals restricting their use to special teams trained to use them. That may not be necessary, according to findings from a four-hospital retrospective study of tPA treatment for ischemic stroke led by researchers from the University of Michigan (U-M) Health System in Ann Arbor. The study results were presented recently at the annual meeting of the Society for Academic Emergency Medicine in St. Louis.

Phillip Scott, MD, FAAEM, director of the UMHS Emergency Stroke Team and assistant professor in the U-M Department of Emergency Medicine, was the lead author. He says some patients who could benefit from tPA have to wait too long before the special team arrives. "Despite all the proof that tPA works, emergency physicians have hesitated to use it because of concerns about achieving results similar to centers with specialized

COMING IN FUTURE MONTHS

- ■ Infection control professionals skeptical of JCAHO plan
- ■ Hospital implements 60 pathways with 90% adherence rate
- ■ QI project leads to 36% drop in mortality from myocardial infarction
- ■ Using dashboard reports to monitor quality, spot problems
- ■ Complying with spiritual assessment standard

stroke teams, and the perceived liability they might face if it causes the patient to hemorrhage. But what we have shown is that with diligent use of stroke treatment protocols, and specialty neurologist consultation as needed, the complication rate for patients treated by an ED team is the same as for those treated by specialized stroke teams."

The study looked at data from 140 patients treated with tPA from 1996 to 2001 by emergency physicians at community, university, and urban teaching hospitals, and a community nonteaching hospital. All the hospitals used acute stroke treatment guidelines, and patients were treated by board-certified or board-eligible emergency physicians. The rate of serious bleeding complications (intracranial hemorrhage) in patients treated in the four EDs was 7%: the same as in previous studies of tPA use by dedicated stroke teams. That kind of bleeding is a known risk of tPA use, but despite the risk, treatment within three hours of symptom onset improved clinical outcomes at three months.

The U-M study looked at the records of the 140 patients to see how they fared before and after tPA treatment by what Scott calls a "distributed stroke team." Forty-four percent of the patients entered the ED with mild to moderately severe neurological impairment, as measured by the National Institutes of Health stroke scale, and another 32% had severe impairment.

The tPA did its job in most cases; 59% of the patients left the ED in better condition than they went in, and an additional 9% left the ED feeling like their normal selves. This positive result is probably due to the fact that the ED teams treated the patients with proper speed, giving tPA within an hour and a half of the patient's arrival at the ED, on average.

Most patients were treated within the recommended three-hour window from stroke onset; 22 patients were treated despite having gone past the three-hour mark, though the median number of minutes over the deadline was 12. Some patients asked for tPA despite being over the time limit.

Even if they don't have a stroke team at their hospital, ED physicians don't have to go it alone when making the decision about whether a patient is a candidate for tPA, Scott says.

"In 65% of the patients in our study, the ED physician consulted with a neurologist before giving tPA, and half of those consultations took place over the phone. Making the call about stroke diagnosis and tPA treatment can be tough, but with the proper support, an ED physician can do it with confidence." ■

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. ■