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Study reveals benchmarking flaws of many report cards, quality rankings

Medical centers with high transfer rates are at a disadvantage

Hospital rankings and report cards are growing in number and importance, but a new University of Michigan study suggests these measures may be inaccurate if they don't take into account the high number of very sick patients that large hospitals receive as transfers from other hospitals.

This study, which focused on medical intensive care unit (MICU) patients, was as much about benchmarking as it was about the MICU, says **Andrew L. Rosenberg**, MD, assistant professor of anesthesiology and internal medicine at the University of Michigan Health System (UMHS) in Ann Arbor, and lead author of the study.

"The idea of this study was to try to quantify something that most physicians intuitively know: Transfer patients are sicker," says Rosenberg. "However, this is difficult to quantify because the type of precise data needed are often lacking; they are expensive and hard to get at. In fact, much of [the quality rating] benchmarking deals with administrative databases, not clinical databases."

The UMHS study results were published in the June 3, 2003, issue of the *Annals of Internal Medicine*, in an article titled, "Accepting critically ill transfer patients: Adverse effect on a referral center's outcome and benchmark measures."

"We used a very detailed clinical database [APACHE III for Acute Physiology and Chronic Health Evaluation]," Rosenberg notes.

Key Points

- Transferred patients have 38% longer ICU stays and 41% longer hospital stays.
- Many databases used for report cards are administrative, not clinical.
- Active awards are seen as more valid than passive ones.

The study examined 4,579 consecutive admissions for 4,208 patients from Jan. 1, 1994, to April 1, 1998. A full 25% were transfer patients. Its measurements were MICU length of stay, hospital length of stay, MICU readmission, and hospital mortality rates. "We reasoned, why not study the place [MICU] where the most valid benchmarking tools are used?" says Rosenberg. "If we still can't adjust for the ICU, how can we possibly do it at another level?"

Even using tools to account for differences in diagnoses, severity of illness, and other predictors of outcome, the transferred patients had 38% longer ICU stays and 41% longer hospital stays compared with patients who were admitted to the ICU directly, and were twice as likely to die in the hospital. As a result, the authors report, a hospital that gets 25% of its ICU patients as transfers from other hospitals would show an extra 14 deaths for every 1,000 admissions, as compared with a hospital that accepts no ICU transfer patients and provides exactly the same quality of care. This seemingly small 1.4% difference would be enough to drive down the hospital's score. The transferred patients also had higher Acute Physiology Scores at admission and discharge than did directly admitted patients, and they were more likely to have complex problems, such as severe infections and upper gastrointestinal bleeding.

Study makes valid point, experts say

Benchmarking and health care experts contacted by *HBQI* generally agree that Rosenberg and his research team make a valid point.

"If someone is not adjusting for severity or acuity, it's back to the proverbial 'apples and oranges,'" says **Robert G. Gift**, MS, president of Systems Management Associates in Omaha. "You are not looking at data that are truly comparable."

"The distinction between administrative data and clinical data is a good point," adds **Sharon Lau**, a consultant with Medical Management Planning in Los Angeles. "Clinical data are very difficult to get."

Lau finds the whole issue of transfer patients interesting. Early in her career, she was the administrative staffer for a neonatal intensive care unit. "This was an issue every day," she recalls. "Because we did not have a maternity unit, every patient we had was transferred in. Of course, we'd get the sickest of the sickest, and no inborns to balance that out. If our morbidity and mortality had been measured [against other hospitals], it would have been horrible, but if you had a sick newborn, ours was the place it would have been sent."

"I think what he [Rosenberg] says is technically and scientifically valid," says **Philip A. Newbold**, MBA, chief executive officer of Memorial Hospital and Health System in South Bend, IN.

What this means, says Rosenberg, is that when "Top Hospital" rankings are issued, some of the best hospitals may not be included. Yet many consumers use these rankings to determine which hospitals deliver the best care.

"It's the referral centers, the big urban systems, that are often the centers of last resort and are mandated and built to take care of highly

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complex patient cases," he notes. "But if the benchmarks don't account for that, these centers are at risk for being compared negatively to other hospitals."

This is not a case of sour grapes on the part of UMHS, Rosenberg says, because UMHS often does well in such rankings. "But do you really think those 100 hospitals are the only 'best' hospitals in the country? A lot of them are relatively small community hospitals. If you are really ill in Atlanta, you'll go to Emory. In Cleveland, it's the Cleveland Clinic. But generally, those are not the hospitals that show up on those lists."

Newbold agrees. "Generally speaking, places like the Mayo Clinic and the Cleveland Clinic don't even apply for awards," he says. "Yet some of them are highly recognized for excellent care."

Nevertheless, says Gift, these rankings do carry a good deal of weight. "The problem with report cards is that the general public looks at the data and they do not know what they are looking at," he says. "What often tends to be missing is the quality of the data, and when that is the case, they absolutely do not tell the patient what he needs to know. Frankly, even some insurance companies and regulatory agencies may not be fully versed in the quality of that data; they may take it at face value with no caveats about its limitations. In other words, people are making decisions on data that are less than perfect."

Gift is quick to add that he doesn't believe anyone is intentionally or maliciously misleading consumers, but rather that some of these folks are just uninformed. "But if I use poor data to make decisions about my family, that can be kind of scary," he says.

Rankings not all created equal

It's important to note, says Newbold, that some sponsoring organizations do better than others — particularly those that do employ clinical data or that give active awards as opposed to passive ones. An active award is one for which the criteria are posted in advance, and organizations can literally spend several years working toward a designation.

"The value of the active awards is that they make you such a better organization in terms of performing for your patients and staff," Newbold says. "If it's an active award, that is the most valuable goal and outcome for patient care you could want. If it's passive, and we're doing what we always do and someone writes us and says 'You won,' there's not the same sort of attraction for improvement of clinical care."

Clinical care is the key, he notes. "That's definitely a good way to go," says Newbold. "We all can get much, much better in patient safety, outcomes, and service excellence — and we need to."

Report cards are where things really get problematic, says Rosenberg. "The majority of web sites that grade health care organizations use administrative databases," he says. "There's a lot of literature that has looked at the quality of that kind of data, and it just isn't good enough."

But these sites are still "better than nothing," he says. "Their intentions are absolutely spot-on, and their goals are what we all want: to evaluate and improve performance and quality. Fortunately, we do well on those sites, but we're just concerned that the growth of the quality-rating industry may be outpacing the techniques for valid benchmarking."

The bottom line, says Newbold, is if you are going to use these consumer report cards, you should do so with a sense of perspective. "Certainly these benchmarks are valuable, but they are one piece of the puzzle," he notes. "They should not be considered definitive."

Making things better

Much can be done to improve the quality of the comparative data available, observers say. For one thing, there should be a greater opportunity to share information — which is, after all, the foundation of benchmarking.

"Some of the methodology is proprietary," says Rosenberg. "Take APACHE III, for example. In order to do their study, they created a company and used the company to collect the data. That became a big controversy, because then your model is in a 'black box.' They counter by saying, 'This our business.' I can understand both sides, but if you want the best quality measures, you want to know how they do it."

Lau agrees. "This is a real issue; we're dealing with it now with the Joint Commission [on Accreditation of Healthcare Organizations] on pediatrics core measures," she says. "The children's hospitals with which we work have requested a waiver because the core measures are not at all appropriate for pediatrics."

Lau says her firm is working with the Joint Commission and several major pediatric groups that lobby for child health care to develop good

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core measures. "But if you go to risk-adjust for conditions like asthma, all risk-adjustment methods are proprietary," she complains. "So, either everybody buys the same thing, or you can't risk-adjust."

Not all standards are in a black box, notes Newbold. "With Baldrige, you are required to share your data," he says. "Press-Ganey has an annual conference, and everyone shares what they do. There are lots of forums where the information is almost in the public domain, and that's where we want to get it, so everyone can get better at what they do."

Data-gathering presents challenges

Another challenge, says Rosenberg, is simply gathering all the data you need. "There's a huge amount of information that's not available because it's not collected, and we have six people who do nothing but collect data."

For example, he notes, there are aspects of quality that have to do with the effect of teaching programs, the number and quality of nurses, ancillary support, the census, how busy a hospital is, the volume of cases a hospital has, and so on.

"Then there are things having to do with the patient himself that we are just starting to get at," Rosenberg says. "We think of transfer patients as those who failed to respond to therapy, but what was the quality and intensity of care at the caring hospital? We're not studying psychological factors at all. Physiologic reserve is another variable. If you're young and healthy, you have a better chance of getting better. Kids, especially, have such reserves, while 90-year-olds do not, but we don't have measures for this. These are all part of risk-adjusting patients in order to benchmark."

"It would be wonderful if there were some kind of way to score patients at admission, so that if they were very sick, you'd get 'credit' for it, while the others take the cream," says Lau. "It's the same with kids; adult hospitals hold onto the tonsillectomies and send out cystic fibrosis.

"But the bottom-line message is, don't avoid benchmarking; get together with these other hospitals. Try to join collaboratives, get together with your associations, and come up with standardized methods to monitor specific issues that need to be benchmarked. Line up as close as you can, and look for improvement." ■

ADA, Kaiser using modeling in DM efforts

Web site will recommend customized treatments

A new web site designed by the American Diabetes Association (ADA) in Alexandria, VA, and Kaiser Permanente in Oakland, CA, will recommend customized treatment plans for diabetes patients. The plan uses a complex software program called Archimedes to model health care outcomes.

ADA officials say physicians with a patient, or the patient alone, could go to the web site, enter health information, and get back an optimized program of steps for treatment within 10 minutes.

Archimedes is a complex model of the American

Key Points

- Program predicted results of studies before data were even analyzed.
- Results of Archimedes program will be in public domain.
- Predictive modeling will be used to address most chronic diseases.

health care system that medical researchers use to study questions about costs and best-treatment recommendations. The Gateway computer company will help run the massive program, which can take hundreds of hours on a single computer, by donating the use of "idle" computers in its retail stores.

The advantages of modeling

Medical modeling is a superior approach to disease management, says **Richard Kahn**, PhD, the ADA's chief scientific and medical officer.

"Modeling in general means being able to simulate the real world so we can predict events to come," notes Kahn. "In the medical arena, that means medical events, particularly outcomes like heart attacks, strokes, and other untoward events." Much human thinking is actually a form of modeling, he explains. "Thinking about a trip to the drug store, considering how much time you have and whether you can make it back home by a certain time — that's a way of modeling," Kahn says.

What are the benefits of medical modeling? "For many reasons, individual physicians and patients present with unique circumstances, conditions or situations; they do not neatly fit into [broad conclusions reached in] clinical trials that have been done. If they did, one could say these are the exact odds of things happening to you if you do X, Y, or Z."

For example, he notes, there have never been clinical trials on smoking that randomized people to different smoking habits and then examined the outcomes. "From a lot of different studies, people have pulled together 'predictive' information," he says.

"The question is the degree to which you can accurately predict what will happen given the known variables," Kahn continues. "When you have a half-hour to get to the drug store, you may consider what the weather is like and the type of transportation are you taking, but you might discount whether you could have an accident, if there's enough gasoline, if the hoses and fan belts are in good shape, whether there will be a line, or even whether the store will have your product."

Modeling, math, and computers, says Kahn, allow medical researchers to take into account a much larger number of such variables than a single human mind can and factor them into the equation to give a much more accurate picture.

Kaiser Permanente uses other methods of modeling in addition to Archimedes, says **Jed Weissberg**, MD, associate executive director for quality at Kaiser Permanente.

"We have access to a number of tools, such as DxCG [Diagnostic Care Groups]," he notes. "As opposed to just being controlled for age and sex, which can predict only 5% of subsequent utilization, this can boost it to 20%-30%."

He says since Kaiser Permanente already has a wealth of information about individuals, this type of modeling is being used instead to help determine risk-adjusted premiums for groups. "Since we are an integrated delivery system, we already know who's not doing well and who needs more intensive work," he explains.

Not there yet

Modeling is still in its infancy, Kahn concedes, and much of it leaves a lot to be desired.

"When modeling takes into account as many factors as it does, the person who wants the information wants to know if you are right and wants to see some testing that shows you have been right in the past," he observes. "Unfortunately, all models up to now don't have independent validation that they have weighed all the relevant factors."

Archimedes, however, does all of that, and it weighs more factors than any other model by far, says Kahn.

"Equally important, we see that it is really accurately predictive," he says.

"Archimedes uses bio-mathematical simulation employing differential equations and complex mathematics to project a virtual population based on evidence from clinical trials," adds Weissberg. "Its great strength has been starting with that information and then prospectively predicting outcomes of trials that have not yet been input."

Weissberg calls this "quite a remarkable test" of such a program.

A program like Archimedes can contribute to improved outcomes in two ways, says Kahn. "First, we can use it to design our clinical practice recommendations, because we can confidently predict the right results. Clinicians have been asking for this type of information, but up till now, our recommendations have come from a bunch of people sitting around a table and modeling."

The second thing Archimedes does is to allow users to enter a patient's individual circumstances, conditions, and history and then to obtain predictions of likely health outcomes, both with and without possible interventions.

"Archimedes is used primarily for up-front information for clinicians trying to weigh interventions," Weissberg explains. "It helps give a richness to our clinical practice guidelines. It can also be a very powerful motivator for behavior change."

The seed money for the initial efforts on Archimedes was provided by Kaiser, says Kahn. "More recently, the money to enhance it and make it more robust was provided by Bristol-Myers Squibb."

"At present, Archimedes has been mostly developed for diabetes, but we are working on other modules for cardiovascular disease," Weissberg notes. "Our intent is to develop it to the point where it covers the bulk of chronic illnesses."

While Kaiser Permanente's primary goal is naturally to benefit the health of its patients, it also has more far-ranging goals. "This information will be in the public domain," Weissberg says. "Our intent is to really advance scientific modeling and chronic care management."

The ADA hopes the Archimedes web site will start offering the free customized service during the first half of 2004. ■

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Hotel shows health system keys to service excellence

Focus on respect, attention, courtesy

As part of a major ongoing effort to pursue service excellence, The Great Neck, NY-based North Shore-Long Island Jewish (LIJ) Health System has entered into an agreement with The Ritz-Carlton Hotel Company, LLC, of Atlanta, on a program aimed at fostering a corporate culture in which patients are given the same respect, attention, and courtesy as guests at a luxury hotel.

"To meet the demands and expectations of today's health care consumers, we not only must provide them with high-quality medical care, we must gain their trust and loyalty by making sure that every aspect of their visit meets or exceeds their expectation, whether it be the courtesy of staff or the quality of the food they are served," says **Michael J. Dowling**, LIJ's president and CEO and the person who provided the initial impetus for the partnership with Ritz-Carlton.

"This comes under the strategic dashboard of what we are focusing on — work force development, service excellence, and other quality issues at a strategic level," explains **Kathleen Gallo**, PhD, LIJ's chief learning officer. "Bringing service excellence up to the level of our clinical excellence is what we are working for."

The partnership with Ritz-Carlton fits comfortably within an overall strategy exemplified by the system's Center for Learning and Innovation, which was rolled out in January 2002. As chief learning officer, Gallo's responsibility is to enhance the learning capacity of the organization, and this effort is a significant component of that endeavor. It involves a strategic partnership with the General Electric Leadership Institute and the Harvard School of Public Health.

Key Points

- Ritz-Carlton partnership part of broader program pursuing service excellence.
- Nearly 600 system leaders will participate in day-long seminars.
- GE, Harvard serve as strategic partners for ongoing educational efforts.

Initial seminars under way

Under the umbrella of the Center for Learning and Innovation, faculty from The Ritz-Carlton Leadership Center are instructing key health system employees in a range of corporate practices and processes. The first seminar took place in December 2002 and will be run monthly until the end of this year, by which time 600 leaders throughout the system will have received the training.

"The Ritz people come once a month and take

the staff through an eight-hour session," Gallo explains. "They tell their stories and share their strategies." These include:

- **Lateral service:** Anyone who finds a customer problem owns it. "If they can't fix it — for example, if a security guard cannot leave his post — his colleagues will do it for him," says Gallo.
- **Anticipating customers' needs:** When a patient is admitted to a room, they should have everything they need already there. "They should not have to ask for a warm blanket or extra pillows," says Gallo.
- **Scripting:** This involves a predetermined set of words employees use to send clear messages to patients. For example, before leaving the patient, every employee is to ask, "Is there anything else I can do for you?"
- **Treat employees like customers:** "Research shows this has the highest correlation with customer satisfaction," Gallo explains.

Behavioral job interviewing is another Ritz-Carlton concept LIJ has adopted. "It builds the interview questions around the core competencies of the job, and service needs to be at the top," says Gallo. "So, for example, the candidate is asked about their past experience in terms of how well they delivered service in their other jobs. This way, you bring in people who already have an affinity for service."

After that, new employees enter the orientation program, called "Foundations." "They meet our CEO, who goes through the strategic plan with them. They discuss how important service is, what our expectations are, and how they are linked to our overall strategic plan for being an excellent company," says Gallo. "Then they go to the Ritz class."

Building on each other

Even without the Ritz-Carlton effort, the Center for Learning and Innovation is an impressive undertaking. For example, LIJ claims to be the largest health care system to develop a "corporate university." The concept, pioneered by General Electric, "helps give rise to excellence and provides the foundation for any culture transformation," says Gallo. Faculty who teach learning initiatives at the Center come not only from LIJ, but from Harvard and GE Medical Systems as well.

One GE-inspired effort, the Six Sigma initiative, already has borne fruit, with documented net savings to LIJ of more than $800,000.

Top Ten Ingredients of Service Excellence

1. Employee satisfaction.
2. Leadership involvement.
3. Determination, commitment, and accountability.
4. Attend to "voice of the customers."
5. Two-way communication.
6. Freedom to act.
7. Employees as ambassadors.
8. Adapt service recovery model (L.A.S.T.: Listen, Apologize, Solve, and Thank You.)
9. Anticipate needs.
10. Scripting to convey the right message.

Source: North Shore-Long Island Jewish Health System, Great Neck, NY.

All these initiatives are intertwined with, not separate from, the Ritz-Carlton partnership. "In our core management classes, the first class out of the box is service — how we can provide a better experience around our clinical excellence," says Gallo. "What we do in those classes reinforces Ritz-Carlton, and vice-versa."

Another Ritz-Carlton concept adopted by LIJ is the employee input survey, which enables all 32,000 employees to share their thoughts on how close the organization is coming to its vision of excellence. "This converts again into improved patient satisfaction," Gallo asserts.

Gallo already is noting improvement in the hospital areas that have been exposed to the Ritz-Carlton principles the longest. "Service is all about culture, which you can't supervise," she explains, asserting that these principles are directly transferable to health care. "The high-performance organizations all have similar basic principles, and applying those principles to whatever business you are in gets results." ■

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Nurses and pharmacists partner for patient safety

Collaboration, teamwork emphasized

Seeking a shared vision for safe medication use in hospitals in the face of continuing work force shortages, leaders of five nursing and pharmaceutical organizations recently gathered in Washington, DC, to discuss how they could work together to achieve this common goal.

The meeting was convened by the American Association of Colleges of Nursing, the American Association of Colleges of Pharmacy, the American Nurses Association, the American Organization of Nurse Executives, and the American Society of Health-System Pharmacists (ASHP).

"The ideal construct in improving patient safety in the hospital setting should be a multi-stakeholder one," notes **Kasey K. Thompson**, PharmD, the ASHP's director of patient safety.

The objectives of the session were to:

- develop a shared vision of ideal medication distribution and administration in hospitals, including better utilization of nursing and pharmacy work forces;
- recommend approaches to improve medication use in hospitals so as to ensure patient safety and therapy effectiveness.

Shortages shape vision

The overarching issue was patient safety and how nurses and pharmacists could collectively improve it, but the nagging issue of work force shortages was a strong presence. "We recognized that these are two professions with work force challenges," notes Thompson. "We also recognized that while, yes, we have a short supply, we also may not be using staff optimally."

For example, he offers, pharmacists may be performing too many technical functions and not enough patient care functions. "It may be the same with nurses," Thompson says. "Among the things we discussed was a model for redeployment."

Another charge the organizations placed on themselves at the beginning of the session, says Thompson, was to talk about revolutionary changes — as opposed to quick fixes — to better improve patient care.

"The thinking went in very diverse directions, such as a broader framework around better deployment and advocating for more effective use of information technology; not just better use, but more logical design that takes into consideration how we do our work and how patients require care," Thompson observes. "For example, my organization is a strong supporter of bar-coding. Logically designed systems are effective almost 100% of the time; they increase nurse satisfaction and they decrease patient harm. But in some cases, nurses have not been involved in the decision-making processes of bar-coding, and you can end up with devices with fonts that are too small or a battery life that is too short."

Systems approach recommended

Based on his impressions of the executive session, Thompson came away with this possible model for a vision statement: "Hospitals will function as high-reliability organizations in which nurses, pharmacists, and other health professionals collaborate on teams to provide systems-oriented, evidence-based patient care to ensure the safe and effective use of medications."

While the statement has yet to be edited and finalized, Thompson identified these common themes from the executive session as steps that need to be taken to achieve that vision:

- All hospitals should adopt a systems approach to medication use.
- Health care professionals must be given the opportunity to practice in a safe, collaborative, and information-rich culture.
- Hospitals should maintain an ongoing feedback system for quality improvement.
- Hospitals must be appropriately staffed.
- Decision-making must be evidence-based and standards-driven.
- Caregiving must be supported by verified technology.
- Health care professionals must have access to the resources necessary to deliver highly reliable, safe, and effective care.

While conceding that many of these points are

Key Points

- Professions face serious challenge of work force shortages.
- Leaders of five organizations come together in first step of ambitious journey.
- Revolutionary changes, not quick fixes, seen as solution.

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obvious, Thompson is quick to emphasize that doesn't mean they are universally practiced. "In many cases, we do not now have safe, collaborative, team-based systems," he says. "These are system issues that impact the whole industry. In order to help us get to specific problems, we have to achieve these goals."

Nor, he adds, does evidence-based, standards-driven decision-making occur consistently. "Not every stakeholder in health care would agree this is the best way to go," he says, "but this group did. From a clinician's standpoint, and from the standpoint of hospitals and accrediting bodies, this is big news."

Thompson emphasizes that the Washington, DC, meeting was just a first step. The next steps, he says, will be to continue to meet and to broaden the list of stakeholders. "Broadly, we are looking to involve physicians and major accrediting bodies," Thompson says. "We are already involved, for example, with JCAHO [the Joint Commission on Accreditation of Healthcare Organizations] in the development of patient safety goals." ■

JCAHO OKs alternative safety goal approaches

How to learn about acceptable alternatives

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, has published examples of acceptable alternative approaches to complying with its 2003 National Patient Safety Goal recommendations. In July 2002, the Joint Commission's Board of Commissioners approved the 2003 National Patient Safety Goals — the first to be issued by JCAHO.

Each goal includes no more than two succinct evidence- or expert-based recommendations. To ensure a stronger focus on high-priority safe practices, no more than six goals are established for any given year. Each year, the goals and associated recommendations are re-evaluated; some may continue, while others will be replaced because of emerging new priorities. New goals and recommendations are announced in July and become effective on Jan. 1 of the following year.

As of Jan. 1, 2003, all JCAHO-accredited health care organizations were to be surveyed for implementation of the following recommendations (or acceptable alternatives) as appropriate to the services the organization provides:

1. Improve accuracy of patient identification.

— Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.

— Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure, and site, using active — not passive — communication techniques.

2. Improve the effectiveness of communication among caregivers.

— Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.

— Standardize the abbreviations, acronyms, and symbols used throughout the organization, including a list of abbreviations, acronyms, and symbols not to use.

3. Improve the safety of the use of high-alert medications.

— Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, and sodium chloride >0.9%) from patient care units.

— Standardize and limit the number of drug concentrations available in the organization.

4. Eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

— Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

— Implement a process for marking the surgical site, and involve the patient in the marking process.

5. Improve the safety of the use of infusion pumps.

— Ensure free-flow protection on all general-use and patient-controlled analgesia intravenous infusion pumps used in the organization.

6. Improve the effectiveness of clinical alarm systems.

— Implement regular preventive maintenance and testing of alarm systems.

— Ensure alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

Alternatives must be at least as effective as the published recommendations in achieving the goals, says JCAHO. "Failure by an organization to implement any of the applicable recommendations (or an acceptable alternative) will result in a special Type I recommendation," says the JCAHO web site (www.jcaho.org).

Organizations that wish to submit alternative approaches can do so by filling out a "Request for Review of an Alternative Approach to a NPSG (National Patient Safety Goal) Recommendation" form. The form is available on the JCAHO web site and can be submitted electronically, by fax, or by mail. A separate form must be submitted for each alternative and must be submitted by the accredited organization or health care system — not by consultants — and should be submitted to JCAHO no fewer than 60 days prior to a scheduled survey.

Acceptable alternatives published on web site

The organization will be told whether its alternative is acceptable prior to its scheduled survey. If the alternative isn't accepted, the organization will be told why and will need to either revise the alternative until it is approved or implement the recommendation issued by JCAHO.

Acceptable alternatives to the NPSG-related recommendations, if potentially relevant to other organizations, will be published in *Joint Commission Perspectives* and will be posted on the JCAHO web site for other organizations to consider, says the Joint Commission. During the survey, the organization can tell the surveyor it is using a published alternative, and the surveyor can verify that the organization is doing what the acceptable alternative says.

(Editor's note: A list of sample alternatives may be found at: www.jcaho.org/accredited+organizations/patient+safety/npsg/. Click on "Samples of Alternative Approaches to the Recommendations.") ■

QI project cuts patients' chronic pain dramatically

Facility earns Codman Award from JCAHO

A quality improvement project at a Michigan long-term care facility resulted in a decrease in the prevalence of chronic pain among its residents from 33% in March 2000 to 18% now.

The reduction is even more significant given that the assessment of an individual's pain is a highly complex procedure, particularly among the elderly, who may experience cognitive or communication difficulties.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, recently presented Marwood Nursing & Rehab in Port Huron, MI, with the Ernest A. Codman Award, which recognizes excellence in the use of outcomes measurement by health care organizations to achieve improvements in the quality and safety of health care.

Assessment tool meets CMS requirements

Marwood's nursing team focused on the potential benefits of better pain management by developing a resident assessment protocol tool consistent with the Minimum Data Set requirements of the Centers for Medicare & Medicaid Services.

Individual resident care plans then were revised to address the specific pain issues identified by using the new tool, in addition to other pain assessment and medication management tools developed through the initiative.

One of the first steps was the formation of two pain management teams. The first, which worked together on the overall program, comprised 30 members from all disciplines, including Marwood's medical director.

Suzanne Walker, RN, unit coordinator and leader of the clinical pain management team, says the team's large size and varied backgrounds proved to be helpful.

Another important component of the program was the revision of forms that now call for more specific information about the physical and emotional conditions of residents being assessed.

Originally built as a 50-bed nursing home in 1963, today Marwood Nursing & Rehab is a 240-bed not-for-profit skilled nursing facility that has

been affiliated with Port Huron Hospital since 1987.

The focus on pain management began in 1999, Walker says. The first efforts involved education of staff, residents, and family. Using research showing that pain is not a normal part of aging and often not a result of the patient's diagnosis, Walker and her colleagues sought to change the way people look at pain.

"The cause could be spiritual, psychosocial, or emotional. It's broader than we really thought it was," she says. "We educated our housekeeping staff, maintenance staff, office staff, and all nonnursing staff in basic pain assessment. So a housekeeper who goes into a patient room to sweep can listen when the patient says she has a headache, or can notice that she is different from yesterday. Maybe the housekeeper can't explain why the patient is different, but the housekeeper knows something is wrong."

Pain management is 'everybody's job'

That nonclinical staffer is expected to report the observation to a nurse or physician, who can make a more thorough assessment. The idea is to empower the ancillary staff by educating them, Walker says, and the staff take this idea very seriously.

"They know it's not just the nurse's job. It's everybody's job," she says. "It's the job of the activity person walking down the hall who sees a resident who is restless or agitated. They know it's their responsibility to notify the nursing staff."

This type of shared responsibility didn't come easily, Walker says. It never would have worked previously, because the nonclinical staff didn't know what to look for, and the nursing staff didn't respect their concerns if they did speak up. But now, she says, the ancillary staff feel confident while still knowing their limitations, and the nursing staff know everyone has been trained in the basics of recognizing pain.

And the education didn't stop with the ancillary staff. There still was plenty to teach the nurses about pain management, she says.

As in most health care settings, medication always had been the No. 1 defense against pain, but now Marwood looks for nonpharmacological approaches — back rubs, quiet environments, soft music, music therapy, pet therapy, or just someone to sit and talk with the resident.

Walker and her colleagues used proven quality improvement processes for the project, first collecting data and conducting audits to get baseline information.

One immediate revelation was that the facility's documentation could be better. The existing documentation was "fair, but it wasn't great," she says, which made follow-up difficult. The pain management teams also quickly saw the need to improve forms.

"There were lots of form changes, and the input on form changes came from the nursing staff because they use the forms," she says. "Then we went back and audited it to see if the changes were effective."

Baseline data collection started with 25 residents who were monitored over a two-year period. The QI team also did a staff survey. The survey revealed that staff were very frustrated over poor communication related to pain management.

"We had complaints that some people would hear of a resident's pain and blow it off, saying an 85-year-old patient is going to be in pain," Walker says. "That clearly had to change."

Staff can make referrals to team

In addition to the overall pain management team with 30 members, Marwood developed a clinical pain management team with two registered nurses, a social worker, and a pastor. If staff feel frustrated with their own attempts to help a resident in pain, they can make a referral to the team, which Walker heads.

If a staff member has notified clinical staff but still thinks the resident is not being helped, he or she can contact the pain management team for help. Then the team will conduct a chart audit,

review the case history, and look at what the current recommended practices are and what the nurses are doing. Then the team makes recommendations to the nurses and physicians if changes are needed to manage the person's pain.

The QI project has led to a much more collaborative atmosphere at the facility, she says. It used to be that if the physician made a decision, the nurse followed instructions and the family went along with it. Now, Walker says, staff may decide with the family what they want for the resident and go to the physician with their suggestion.

Less pain, better outcomes

The results are convincing. When the program first started in 2000, the prevalence of pain was 33%. Now it's at 18%. The effort to better control pain had a direct impact on the facility's quality indicators: weight loss, decline in activities of daily living activity, behaviors affecting others, and decrease in range of motion. Walker found that as pain issues were handled better, residents ate better and weight became more stable. Residents got out of bed and felt better.

One of the best aspects of the project was that it didn't cost much. When Marwood presented the project description to the Joint Commission, the accrediting body didn't understand Marwood's claim that it had an open-ended budget.

"What that meant was that our biggest expense was time, and we were willing to put in as much time as it needed," Walker says. "We didn't have to go out and buy equipment. We had to invest time to research and educate our staff, family, and doctors, so everyone has the same focus and the same information. Our time was our biggest expense, and the administration made it easy to spend time on this."

The administration approved multiple teleconferences for staff, and the pain management teams used the in-house pharmacist as a key resource.

Walker offers this advice for any health care provider seeking to improve pain management and affect quality indicators: Set a goal and be prepared to refocus your goal. "It's a three-steps-forward, two-steps-back process," she says. "You have to be prepared for that."

You must have buy-in from staff. It's not enough to get managers and administration on board. Tap into nurses' desire to help people, the real reason they went into nursing in the first place.

Give staff the education they need to help the residents. Pain management is more complex than most people realize, and strategies have evolved significantly in recent years. ■