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Effective patient grievance policy can be vital tool for improvement

Every facility is different; make sure policy fits your organization

They may not grab many headlines, but grievance policies and procedures are, nonetheless, a critical component of a thorough, effective quality improvement effort.

Furthermore, quality professionals say, all grievance policies are not created equal — it really *does* make a difference who sits on your committee or task force, how your policy is constructed, and whether it is adequately customized to your facility or system.

"There are a number of good reasons [for having patient grievance policies and procedures]," says **Matthew Rosenblum**, chief operations officer for privacy, quality management, and regulatory affairs with CPI Directions Inc., a New York City-based consulting firm that specializes in performance improvement and regulatory compliance functions.

One important consideration, he says, is the context within which care is provided. "By that, I mean when people come to the hospital they are usually hurt and scared in some way, and as a consequence, their complaints may be easily aroused."

For the provider, Rosenblum adds, it's important to be able to recognize when a complaint also is a grievance. "In medical terms, we generally refer to how patients say they were hurt as a complaint. True grievances can include neglect, abuse, payments, insurance, reimbursement matters, or privacy. When a complaint comes in writing or through a third-party organization, then it's official, and it should be responded to with very appropriate actions."

Key Points

- Even if it were not required, quality managers would implement patient grievance policy.
- Hurt, frightened patients may be more likely to complain.
- Know the difference between a complaint and a grievance.

An effective grievance policy can ensure consistent staff responses, Rosenblum continues.

"If you have designated steps to resolve complaints and mitigate any harmful effects that have occurred, hopefully, situations can be resolved before they become official," he adds. "So, for example, staff should engage patients in a calm manner and express concern about what the patient is saying. This way, the patient feels better about our potential response." A consistent staff response also helps ensure timely and complete responses, and a good policy keeps staff aware that they need to be faithful to their ethical and legal obligations — i.e., to treat every patient equally, with no retaliation for complaints.

Finally, such a policy can make an important contribution to your continuous performance improvement efforts, Rosenblum notes. "The level of satisfaction with the care we provide is a rich source of information for improving. We need processes and technologies in place to accurately capture what our patients tell us and to analyze it proactively."

For example, you might want to conduct a failure mode and effect analysis (FMEA) on what patients complain about, or you could study complaints retrospectively through root-cause analyses. "You may also use it to improve patient relations," he adds.

The bottom line: Many quality professionals would have such policies and procedures in place even if there were not a regulatory requirement to do so. "The no-brainer answer is you have to have one because it is a CMS [Centers for Medicare & Medicaid Services] requirement," says **Cathy S.C. Stouffer**, customer service/patient safety officer at Freeport (IL) Health Network. "But besides that, you need to be prepared for the times when patients are concerned that an organization may have made a decision they are not satisfied with," she points out.

"This has grown out of the patient rights movement; it started many years ago, and it has kept evolving," notes **Sue Wedemeyer**, RN, BSN, MBA, clinical manager for loss prevention for Catholic Health Initiatives in Erlanger, KY.

"We always depended on some sort of patient satisfaction survey, but we've gone beyond that. Now, there's a lot more emphasis on patients' rights, and because of regulatory requirements, it became much more formal," she says. **(From a legal perspective, disclosure of medical error may be the best policy when it comes to responding to patient complaints. See box, p. 39.)**

If you are creating a new set of policies and procedures or re-examining your existing ones, who should comprise your committee or task force? "No. 1, you have to have the customer relations person," Stouffer says. "Then include the quality department — they are the ones who will spearhead process improvement, and that's the goal, to improve processes. Medical directors also should be included." CMS suggests that it be structured very much like your ethics committee and include someone from the outside, she notes. "It might even be helpful to include the chair of the ethics committee," Stouffer suggests.

"It really depends on the institution," explains Wedemeyer. "Certainly, you must include whoever is designated as the point person. Then the risk manager, the quality manager, the compliance

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Editor: **Steve Lewis**, (770) 442-9805, (steve@wordmaninc.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russell Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

officer, and probably representatives from nursing administration and senior administration [should be included, too]. One of the things every policy needs is to have the governing body's blessing."

The composition of the group will depend on the size of the organization, Rosenblum says.

"In a hospital, the logical composition of such a task force would include a nurse, a doctor, a nutritionist — people who have direct contact with patients and are on the line being confronted on a daily basis," he continues. "You also need representatives from risk management and/or quality management or performance improvement committees, the legal counsel's office and now, under HIPAA [Health Insurance Portability and Accountability Act], from the privacy or security office and a patient relations official. Also, in intermediate or long-term care facilities, you'd want a patient representative."

When crafting your policy, there is ample help available for at least creating its foundation, notes Stouffer. "For the bare-bones skeleton of a policy, there are guidelines about timelines to responses, and so on, on both the CMS and Joint Commission [on Accreditation of Healthcare Organizations] web sites."

Three keys to optimal results: Disclose, disclose, disclose

Establish disclosure policies and procedures

Traditionally, medical error disclosures have not occurred due to fears of liability, as well as credentialing, sanctioning, and licensing concerns. However, new research suggests that *not* disclosing a medical error actually can leave a health care provider in a worse position than if the provider had disclosed the medical error, says **James W. Saxton**, JD, chairman of the health care litigation group for Stevens & Lee, PC in Lancaster, PA.

"For example, failure to disclose leads patients and their families to believe that a cover-up has occurred; and in order to learn what actually happened, they find that only by filing a lawsuit can they discover what occurred," he explains.

"Disclosing medical errors in the right way, by the right people, and at the right time is the better approach for all involved," Saxton continues. "The right way means that we empathize with the patients and their families and apologize for the circumstances without admitting liability." This is not the time to place blame or fault, either, he emphasizes.

"Determining who should be the person or people to speak with the family is very important," Saxton notes. "The primary responsibility lies with the physician, but quality and risk managers should always be involved. Their involvement could include the actual discussion with the patient and family but should also include the investigation of what occurred. By investigating what has occurred, we can move toward continuous quality improvement as we learn from the errors. Measures can then be taken to prevent such errors in the future."

For this reason, Saxton says, it would be beneficial if any policy and/or procedure established also would require that physicians report near misses to their quality managers. "Near misses are a tremendous resource from which we can learn and then prevent medical errors from occurring in the first place," he explains.

"Also, quality and risk managers should be involved in follow-up with the patient and/or the family. A contact person should be established to whom family can direct questions or concerns as they come up as well. Managers should also be instrumental in coordinating meetings with family, especially when more than one health care provider may be involved," he notes.

Saxton lists the following basic legal strategies of which quality managers should be aware:

- ✔ apologies without admission of liability;
- ✔ physician-patient confidentiality;
- ✔ the Health Insurance Portability and Accountability Act (HIPAA);
- ✔ particular state laws on privacy and confidentiality of health information that may be more stringent than HIPAA;
- ✔ peer-review protection.

When creating and implementing policies and procedures, Saxton recommends these do's and don'ts:

- ✔ Design your goal to increase patient safety and well-being.
- ✔ Create a nonpunitive reporting procedure with clearly delineated exceptions (for example, instances of intentional acts).
- ✔ Determine when and what errors need to be disclosed to the patient/family and/or reported to the hospital, and in doing so, clearly define what is to be disclosed and reported.
- ✔ Define who should speak to the patient and/or family and when.
- ✔ Define exceptions for reporting to the patient and or family (for example, when it might be more harmful to the patient to do so).
- ✔ Recognize that mistakes often occur as a result of the organization of the health care system generally and are not due to any deliberate actions of health care providers.
- ✔ Track errors to increase patient safety. ■

Wedemeyer lists these considerations:

- The governing body should have oversight of the process unless it is delegated to the grievance committee.
- When a patient is admitted, he or she should receive written information about the process — how it unfolds, the process for filing, and so on. "There should be a signed acknowledgement that the patient has received this," she advises.
- You should identify the individual within the organization whom the patient should contact with a complaint and how that contact should occur.
- The policy should include an expectation that grievances be investigated and resolved in a timely manner. It should address time for completion of the review and investigative process, and when the patient will be provided results.
- It should address timely referral of concerns about quality of care or premature discharge to the appropriate peer review body.

In creating your policy, Rosenblum says, special consideration must be given to certain issues that affect the hospital and staff, and to those that affect the patient and staff.

Concerning hospital and staff: "In our opinion, the provider must embrace and encourage a cultural change in staff that is similar to one that pervades all business success: The customer is always right." This should be altered slightly for health care to read: "The patient always has something useful to say," he notes.

"This should pervade good medicine," explains Rosenblum. "Every complaint represents their perception of the care they receive. This begins to preclude staff from getting their backs up. Provide workshops to help staff calmly approach patient complaints with more objective consideration for what patients have to say. This way, you help them resolve the issue or elicit their cooperation in resolving it."

Your approach should include educating and training staff on the importance of consistency, better patient relations, and mitigating harmful effects, he recommends. "Workshops that use the concept of root-cause analysis can encourage discussion of frequent complaints, their causes, and how to resolve them," Rosenblum says.

When you're planning significant changes in service — such as a new specialty or a rapid expansion, it's usually a good idea to perform an FMEA, he adds. "This way, you may be able to think about the potential for patient complaints and approach it proactively," he explains.

Your facility also should provide step-by-step guidance for staff on how to accept and process a complaint, identify the chain of command, and assign responsibilities.

As for patient/staff issues, the patient must know how to initiate a complaint to the provider and, when necessary and when the facility is legally obligated, how to contact a third party. There should be time restrictions for filing and an outline of what staff are responsible for doing when they receive a complaint.

"Staff could virtually be anybody — a guard at the door or someone in the medical records office," Rosenblum explains. The policy should include the forms or reports staff need to fill out and the time windows for each.

The policy also should provide patients with an explanation of their rights to appeal:

- the process, who does the review, and who participates;
- how to file a complaint to a third party;
- the time window;
- whether those authorities have the right to investigate a complaint;
- whether there is a finding of noncompliance, those third parties may have the obligation to provide written notice to the patient.

Once the policy is created, dissemination and implementation should be carried out "just like any other policy," Wedemeyer says. "For dissemination, normally your facility has a designated method — i.e., give it to the managers, who

Need More Information?

For more information, contact:

- **Matthew Rosenblum**, Chief Operations Officer, Privacy, Quality Management, and Regulatory Affairs, CPI Directions Inc., 10 W. 15th St., Suite 1922, New York, NY 10011. Phone: (212) 675-6367. E-mail: MRosenblum@att.net. Web: www.CPIdirections.com.
- **James W. Saxton**, JD, Chairman, Healthcare Litigation Group, Stevens & Lee, PC, Lancaster, PA. Phone: (717) 399-6639. E-mail: JWS@stevenslee.com.
- **Cathy S.C. Stouffer**, Customer Service/Patient Safety Officer, Freeport (IL) Health Network. Phone: (815) 599-6356. E-mail: cstouffer@fhn.org.
- **Sue Wedemeyer**, RN, BSN, MBA, Clinical Manager, Loss Prevention, Catholic Health Initiatives, Erlanger, KY. Phone: (859) 594-3076. E-mail: SueWedemeyer@CatholicHealth.net.

review it with staff, who then sign a document to the effect that they have read it. The follow-up problem lies in the hands of the point person, the quality person, and possibly the compliance officer," she adds.

"You've got to use the existing QI staff to disseminate the information and continuously improve the process," Rosenblum stresses. "But the most important thing a provider can do is to embrace and encourage cultural change in the staff," he adds.

"We have 1,500 employees, and everyone is really an advocate for patients, so the most difficult part is getting educational information out for all of them," Stouffer says. "We cannot ignore grievances, and our response has to follow a more particular process, so we have a learning charter — a patient advocate course that talks about the service recovery program and educates employees about our grievance policy."

Every employee is required to take this course, she notes. "We also have an opportunity for online learning, and our policy is always available on our intranet." Just having a policy in place can have a positive effect on patient attitudes and avoid costly problems. "Primarily, it's the perception that we have established a process that allows a patient to have a second voice with a more neutral party, if necessary," Stouffer says.

Wedemeyer agrees. "Patients are sometimes reluctant to talk about their health care, or they don't know where to go to do it. This process gives them an avenue to do this. Also, it gives the facility a means to measure service. You can go back retrospectively or look at it concurrently, to see if it's being followed," she says.

"Your grievance policy is just as important as a fire policy," Stouffer adds. "So if you can put policies and procedures somewhere inside mandatory training, this should be one of them." ■

Second time's the charm for open-visiting effort

Proactive communications make the difference

Breaking with tradition is never easy, especially when it comes to such sensitive areas as the intensive care unit (ICU). But at Geisinger Medical Center in Danville, PA, a second attempt at instituting open visiting in the adult ICU is working so well that is has become official policy.

Key Points

- First attempt at instituting open visiting lacked adequate planning and defined processes.
- Including, not excluding, family from the intensive care unit is a growing trend.
- The two-month pilot ultimately led to adoption of a new policy.

Geisinger tried open visiting a few years earlier, but with little success. "What happened was we basically said, 'We're open.' We did not create any guidelines; we didn't look at processes. We didn't plan," explains **Lani Kishbaugh**, CCRN, clinical nurse educator for adult intensive care. "We also didn't understand how to communicate what we needed to do for the patients; failures came from family members who became disruptive — and from staff who didn't know how to ask them to leave when necessary. There were big communication issues."

In addition, such a concept runs counter to the traditional restricted visiting hours in the ICU. "In the past, this has been done in large part for the convenience of the caregiver," Kishbaugh explains. "Physicians always found it difficult to get work done, nurses felt they had a lot to do with the patients. And with the critical nature of the patients in the ICU, there was a tendency to limit the amount of stimulation."

Today, however, there is increasing evidence that having family more involved can improve outcomes and give staff access to somebody who knows a great deal about the patient. "The trend is to include as opposed to excluding," observes Kishbaugh.

This latest effort by Geisinger grew out of a challenge issued by **Don Berwick**, MD, MPP, president and CEO for the Institute for Healthcare Improvement (IHI) in Boston.

"He issued a challenge to all hospitals involved in the critical care collaborative of the IMPACT project at IHI," Kishbaugh recalls. "To my knowledge, we were the only hospital to accept."

According to IHI, IMPACT is "a network of health care organizations that are ready to join the improvement movement at a new level of ambition, scale, persistence, and transparency. The IMPACT vision is to make dramatic change in a specific area and improvements in multiple levels of the organization for overall transformation."

Berwick's challenge called for the hospital to conduct a two-month test of open visiting.

"Because we had had a failure, we met with a lot of resistance from staff," Kishbaugh notes. "However, since we were involved in a pilot project, and they understood we could actually test small changes, they were willing to try it." The staff were more comfortable that the test would be performed on a small basis within limits, as opposed to the free-for-all it was before, she adds.

Geisinger was better positioned for success because it already had in place a family satisfaction group. "We started with that group, because we felt it was part of the IMPACT project and would be most affected by open visiting," notes **Jennifer Donavan**, RN, CCRN, the staff nurse who had been working closely with the group.

"We had already been working with them in terms of improved communication," Donavan adds, noting that they only had a few days to prepare for the program. "We kind of went cold turkey," she says. "It was like, 'OK. On Aug. 13, [2003], we'll be starting.'"

Communication was a critical component of the program, with several important vehicles and strategies employed. One, ironically, was to set limitations, despite — or perhaps because of — the fact that there would be open visiting. "We created an information pamphlet that included what you could and couldn't do," Donavan says.

"This eased family and staff satisfaction." They sat down with the previous introduction to the unit, asked other staff about nuisance problems, and changed the publication accordingly. "We came up with a list and posted it over the door to the unit. We also posted a letter in the waiting room, saying basically, 'This is a trial, please bear with us while we do this test,'" she explains.

Staff were an important audience in the communications program as well. "We started with staff in group meetings, telling them what was coming and asking them what they felt the key issues would be," Kishbaugh points out. Several concerns centered on safety; for example, the fact that there could not be an unlimited number of people at bedside. Other issues involved age minimums and health department regulations.

"Another thing we focused on was, who will represent the family?" she adds. "The group created the position of family spokesperson — someone who gets updates from the doctor all the time and who has the responsibility of communicating to the family when they are not there." Because of Health Insurance Portability and Accountability Act (HIPAA) requirements, this individual is given a password so he or she can receive basic information over the phone.

Another effective strategy involved the use of beepers. "Before, we had families camping out, which was a big dissatisfier for nurses," Kishbaugh adds.

"We went to beepers so we could offer them to families who were reluctant to leave, so they could be in constant contact." These beepers have a messaging function, so the screen actually can say things such as, "Not an emergency." Beepers are now being tested in the cardiac ICU with open-heart surgery patients, she notes.

A bulletin board for family members also helped communicate important messages. It includes pictures that explain what they will see when they go into the ICU. "One big issue when we started was sterile procedures," Donavan recalls. "We'd shut down half the unit with a privacy screen, and other family members couldn't get in. So we put up pictures on the board and explained why they were not able to visit — that we needed to prevent infection, that there were privacy concerns, and so on."

Surveys conducted with family members and staff showed positive results, Kishbaugh says. "Because we had already been working on communicating with families, the responses were pretty positive before, and there was not much room for dramatic improvement," she notes. "But the numbers did improve slightly." As for staff, the attitudes at the beginning were negative.

"At the end of two or three months, they had trended up to more positive responses," Kishbaugh reports. "By the first of the year, it had became second nature. Last month, we voted to change our policy to open visiting with guidelines, and we're trying to spread it to other areas."

Of all the positive changes achieved by the program, perhaps the most critical, she says, was the establishment of trust between families and staff. "You would expect families to be here all the time because they can be, but actually since we've created a degree of trust, they're not. When we used to try to limit access, they came sooner

Need More Information?

For more information, contact:

- **Lani Kishbaugh**, RN, BSN, CCRN, Clinical Nurse Educator, Adult Intensive Care, Geisinger Medical Center, 100 N. Academy Ave., Danville, PA 17822. Phone: (570) 214-9529. E-mail: llkishbaugh@geisinger.edu.

and sooner to try to get in; now, they base their decisions more on their own needs and how the patient is doing. If you can trust that caregiver, this is a very positive improvement." ■

National model begun at regional level

IHI's model improves care of diabetes patients

The Breakthrough Series Collaborative model effectively employed by the Institute for Healthcare Improvement (IHI) on a national level has been translated successfully to the regional level in the state of Washington, achieving significant improvement in the self-care efforts of diabetes patients and clinical improvements in areas such as blood sugar and cholesterol.

The initiative, whose accomplishments were reported in two articles in the February 2004 *Joint Commission Journal on Quality and Safety,* was co-sponsored by Qualis Health of Seattle, the Washington State Department of Health, and the MacColl Institute for Healthcare Innovation at Group Health Cooperative of Puget Sound. One article reported on statewide diabetes collaboratives, while the other focused on two participating clinic teams.

In the statewide collaborative report, there was a 50% improvement in the number of diabetes patients who received foot exams; a 49% improvement in the number of patients who received blood pressure readings; and a 35% improvement in the number of patients who received blood cholesterol tests. Outcome measures showed improvement of 12% among patients whose blood sugar dropped; 13% in the number who lowered their LDL; and a 7% improvement in the number who lowered their blood pressure readings.

"Most collaboratives have been done nationally by IHI, and only by people with heavy financial resources," notes **Connie Davis**, ARNP, MN, associate director for clinical improvement/ improving chronic illness care at the Center for Health Studies, part of the Puget Sound Cooperative. The Center also directs the MacColl Institute.

The group worked with state health plans and developed a statewide support system for the chronic disease self-management program. It also brought rural clinics into the effort.

Just what was this IHI-inspired model the state groups implemented? "It's a learning model that uses what is known about how adults learn best," Davis explains.

"You bring people together four times over the course of a year with experts who teach you how to make changes, and between meetings you have calls, monthly reporting, ways of sharing information, and a web site with downloadable tools."

This approach, she says, keeps everyone in the cohort engaged. "It's very complicated to try to do this, but clearly there were improvements, and we're very definitely pleased with the results."

There were several keys to success, Davis says.

"You teach the teams they can't just add on to the system; they have to redesign it, and we teach them how to do it," she explains. They are taught, she says, to be efficient, plan ahead, and reach out and not wait for disaster to happen. "This is a whole different way of thinking."

The teams were provided with a structure; each of the clinic settings had teams comprised of representatives from administration, physicians, and nurses. Implementation was based on a chronic care model with evidence-based principals. "The team members did not have to grope around; we gave them something that would work for them," Davis notes. The approach is based on incremental improvement, she explains. "You try it with one patient; if it works, you go, and so on. All the while, you are measuring."

A learning collaborative, she emphasizes, "is a very powerful implementation tool." Peer pressure and peer support are key. "You know you will see them again in three months, and they'll ask you how you did," she observes. This "all teach, all learn" approach uses a number of creative techniques, such as story boards, to share information.

The final ingredient for success, she says, was "great clinical expertise." The top endocrinologists passed on their knowledge to family physicians, and in this manner, she says, "raised all the boats."

The two participating teams highlighted in the

Key Points

- Improvements were seen both in self-care efforts and clinical numbers.
- The model has been copied by other states and quality improvement organizations.
- The program is based on evidence of how adults learn best.

second article — Olympic Physicians, a rural clinic in Shelton, WA, and The Polyclinic, a large urban specialty clinic in Seattle, also achieved impressive results, but perhaps just as important was the recognition that "You don't treat every clinic like they're all the same," says **Donna M. Daniel**, PhD, epidemiologist and project director for the process improvement support center at Qualis Health, and lead author of the article.

"You must recognize that each has a local environment that is so powerful, and a basic tool kit will not meet all needs," she adds.

At Olympic, the keys to success included understanding the importance of the chronic care model provided by Davis' group.

"It's an incredible framework for directing and guiding health care professionals who want to create the best care for their patients," Daniel says. "It's very easy to grasp and to use to guide their work, and the small-scale test of change can work for any improvement you create in an organization."

The team also attributed its success to the ability to provide routine feedback. "By integrating the clinical information systems of the various organizations [through the Diabetes Electronic Management System, or DEMS], we were now able to give reports to the caring team — we could identify those patients whose hemoglobin A_{1c} [rates] are unacceptable, who has had heart failure, and so on," Daniel says.

In addition, Olympic was able to hook up with a local hospital that had a diabetes wellness center, and shared resources. "Community linkages and resources are part of the chronic care model," Daniel notes.

The other collaborative had an entirely different set of success keys. One, for example, was "an extremely vocal medical director."

"One of the things that does not get written down enough is personalities. If you have a strong — but not necessarily aggressive — individual who commands incredible respect and passion, and who demands that care be the best it can be, they can be an incredibly powerful key to an intervention like this moving forward," Daniel says.

The promotion of collaborative methods also was considered critical. "This started with one or two docs and their patients; then, we rolled it out to the other docs who had not been so enthusiastic," she notes. "This spread of practitioners can be very motivating."

The partnership with a health plan provided significant financial and staff support. "DEMS is one of the resources that needs to be provided," Daniel adds. "But for it to be a viable option, you need to have someone enter the data in for the patient — from paper to electronic — and this can be time-consuming. Many clinics got creative; they used reception staff when times were slow to enter chart information. They used folks from local colleges; nurses would come in on weekends, as well as physicians. In this situation, the health plan partnering with the clinics ponied up the necessary funds." Later, she explains, the clinics figured out ways to get grants from pharmaceutical companies to fund data extraction.

Strong on model

Daniel also is a strong supporter of the collaborative model. "The face-to-face meetings provide opportunities for people to develop trusting relationships," she says. "During these meetings, teleconferences, and e-mails on a daily basis, and creating story boards — all these modalities for sharing create a situation where the most change and improvement can occur."

Is this model replicable anywhere else? "That's the overall message," she says. "It's hard to participate in national collaboratives, but we did it on our level with minimal registration fees, much less travel, and we tried to minimize time out of the office by having meetings on Mondays and Tuesdays. We were able to realize results similar to those of the national collaborative, and we believe it can be replicated."

In fact, she says, the Washington group went to the Centers for Medicare & Medicaid Services and told it they thought the model could be replicated in a quality improvement organization (QIO) program. "Currently, over 100 IHI-like collaboratives are being reported from the QIO community on statewide and regional levels," Daniel reports. ■

Need More Information?

For more information, contact:

- **Donna M. Daniel**, PhD, Qualis Health, P.O. Box 33400, Seattle, WA 98133. Phone: (206) 364-9700 #2376. E-mail: donnad@qualishealth.org.
- **Connie Davis**, ARNP, MN, Associate Director, Clinical Improvement/Improving Chronic Illness Care, Center for Health Studies, 1730 Minor Ave., Suite 1600, Seattle, WA 98101. Phone: (206) 287-2900. E-mail: davis.cl@ghc.org. Web site: www.improvingchroniccare.org.

Collaborative starts 2nd phase of connectivity push

Incremental road map part of continuing efforts

Connecting for Health, a collaborative of public and private stakeholders, will be launching a new phase of its effort to promote electronic connectivity in health care. The project's steering group, comprising more than 50 leaders and decision makers in the health care industry is committed to creating an incremental road map to achieving electronic connectivity.

The road map is necessary, they say, for prioritizing actions, fostering innovation, and leveraging efforts across the public and private sector.

"Patients deserve to have a safe and reliable health care system that provides quality care. The only way we're going to get there is if public and private sectors come together to create an interoperable electronic infrastructure for health care," says **John Lumpkin**, MD, MPH, senior vice president of the Robert Wood Johnson Foundation in Princeton, NJ, and chair of the National Committee on Vital and Health Statistics.

The Robert Wood Johnson Foundation will be joining the Markle Foundation, which established Connecting for Health, as a funding partner.

Since Connecting for Health began its work in September 2002, it has:

- built consensus on an initial set of health care data standards;
- developed case studies of places where privacy and security practices may provide a model for others;
- advanced understanding of the consumer's role in an interconnected health care system by defining the personal health record and its use.

Ongoing efforts of Connecting for Health are accomplished by the following working groups:

- Working Group on Electronic Health and Personal Health Record
- Working Group on Accurately Linking Health Information for Safety and Quality
- Expert Panel on Organizational Models and Financial Sustainability of Community-Based Health Information Exchange
- Expert Panel on Data Exchange Standards

(For more detail on the working groups, go to: www.connectingforhealth.org.)

Why did the Robert Wood Johnson Foundation, well known for its efforts to promote health care interests, become involved with this group? "I think the foundation has a number of areas of focus relating to improving the health care of America, and an underlying component of that is the strength of the information infrastructure," Lumpkin says. "We see this initiative as being a key player in accelerating the information transformation of health care."

Lumpkin, who served as vice chair of the initial phase, says he has been impressed "first and foremost with the breadth of the coalition, the fact that it brought to the table leaders from providers, vendors, consumer advocates, and government — really all the key players you need to talk about key issues."

The first phase was a $2 million initiative supported by the Markle Foundation. How much the next phase will cost is not yet clear. "As we're rolling out this phase, we will initially kick in $350,000, but that's not the total amount we will kick in; we will continue to support this," he explains. "I will also continue in a leadership role, so we will be committing our personal resources as well."

There are several key goals for the second phase of this collaborative:

- A road map detailing an action agenda of achievable objectives over the next 12 months will leverage activities between public and private health care sectors toward a health information infrastructure that fosters innovation, encourages information sharing, and provides exchange of necessary health information in a private and secure manner.
- Barriers will be challenged that impede patient-centered information sharing within a series of working groups. Specific areas of focus will be on understanding the business and organizational issues of community-based information exchange, the issues relevant to sharing electronic information with patients, and certain aspects of technical interoperability.
- A demonstration project is planned to test and evaluate the working groups' products in real-world settings.

Key Points

- The Robert Wood Johnson Foundation gives financial boost to next phase of work.
- Incremental road map needed to prioritize actions and foster innovation.
- Demonstration project is planned to test products in real-world settings.

Need More Information?

For more information, contact:

- **John Lumpkin**, MD, MPH, Senior Vice President, Robert Wood Johnson Foundation, Princeton, NJ. Phone: (609) 627-5724.
- **Center for Information Technology Leadership**, Partners HealthCare, 93 Worcester St., Wellesley, MA 02481. Phone: (781) 416-9200. Fax: (781) 416-8913. E-mail: info@citl.org.
- **Connecting for Health.** Web: www.connectingforhealth.org or www.markle.org.

While the elements of the road map remain to be determined, Lumpkin expects it to progress rapidly. "This will not be duplicative of other road maps being developed — such as the one at the National Committee for Vital Health Statistics." He says he anticipates it will take one to three years for the road map to be developed.

"This whole phase will be relatively short," says Lumpkin, noting that the other work may be completed by the end this year. "We need a little hedge factor, because we may be looking at a demonstration project as a result of some decisions made by the steering committee, so it could go on longer."

When asked to cite the most glaring problems in the information infrastructure today, his reply basically was that since there really is *no* infrastructure, no glaring problems could be identified.

"Less than 15% of all physicians have electronic health records; people who travel can't have their health records travel with them; lab tests that have already been done are often repeated. The savings for this kind of infrastructure are *huge,"* Lumpkin explains.

Just how huge was illustrated during a presentation at the recently held meeting of the Chicago-based Healthcare Information and Management Systems Society (HIMSS). "Bill Yasnoff [William Yasnoff, MD, PhD, senior advisor for the national health information infrastructure at the Department of Health and Human Services] gave a talk in which he said the savings for implementing connectivity would be somewhere around $120 billion a year net," he adds.

Connecting for Health also cites the following statistic from the Wellesley, MA-based Center for Information Technology Leadership:

Nationwide adoption of advanced computerized order-entry systems in ambulatory care could eliminate up to 2 million adverse drug events and 190,000 hospitalizations per year and could save up to $44 billion annually in reduced medication, radiology, laboratory, and hospitalization expenditures. (Go to: www.citl.org/research/ACPOE.htm.)

"We cannot achieve a safe, effective, efficient, and high-quality health care system without significant transformation of our information infrastructure," Lumpkin concludes. ■

Quality gap found between award winners and others

Facilities compared across 26 procedures, diagnoses

A substantial difference in clinical quality was found between the winners of the Health Grades Inc./J.D. Power & Associates Distinguished Hospital Award for Clinical Excellence winners and all other hospitals, Health Grades Inc. reports.

What is more difficult to determine is whether this represents a significant change over last year's report — the first conducted. "Every year, we go through a rating summit, because medicine changes so frequently and we want to make sure to account for changes from year to year," explains **Samantha Collier**, MD, vice president of medical affairs for Health Grades Inc. in Lakewood, CO.

She adds, however, that there was "a lot of overlap between last year's winners and this year's winners." (The list of winners is available on Health Grades Inc.' web site, www.healthgrades.com.) "Maybe three years from now, we'll be better able to compare winners from previous years."

The Distinguished Hospital Award for Clinical Excellence is part of the larger Distinguished

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Hospital Program established between J.D. Power and Associates and Health Grades Inc. in February 2003 to recognize hospitals for both service and clinical excellence. J.D. Power and Associates, which measures patient satisfaction and perceptions of the hospital stay experience, recognizes qualifying hospitals for providing an outstanding patient experience.

According to Health Grades, The Distinguished Hospital Award for Clinical Excellence is the first award of its kind to focus exclusively on clinical quality. The award winners fall among the top 3.4% of all hospitals in the country in seven major clinical specialties: cardiac surgery, cardiology, orthopedic surgery, neurosciences, gastroenterology, pulmonary, and vascular surgery. The award was designed to highlight the best hospitals in the nation and to encourage consumers to research the quality of their local hospitals before undergoing a procedure.

Health Grades bases the awards on a detailed study of each hospital's risk-adjusted mortality and complication rates of Medicare patients as reported to the federal government.

"We looked at either vast mortality or complications across 26 procedures and diagnoses," Collier explains. "Then each hospital is ranked for every single cohort." **(See example, below.)**

For a facility to even qualify, it had to not only be an open-heart hospital, but it also had to have a minimum number of diagnoses and procedures. "We wanted to show that those facilities had a breadth of procedures; right away, that got us down to 800," Collier notes. "They also had to do 22 out of the 26 procedures and diagnoses, and a minimum of 30 cases."

Why were these specific service line areas chosen? "Frankly, those are the highest volume areas to hospitals — coronary artery disease, heart failure, heart attack," she continues. "The same thing with community-acquired pneumonia, COPD, and so on."

Health Grades uses the most recent three years of data from the U.S. Department of Health and Human Service's Centers for Medicare & Medicaid Services (CMS) and risk adjusts it to create accurate and fair comparisons between hospitals.

Of the award winners, 73% are part of larger hospital systems. They also tended to be larger hospitals, with an average of 504 beds compared with an average of 181 beds for those that did not receive the designation. In addition, 77.44% are in the eastern third of the United States.

Need More Information?

For more information, contact:

- **Samantha Collier**, MD, Vice President, Medical Affairs, Health Grades Inc., 44 Union Blvd., Suite 600, Lakewood, CO 80228. Phone: (303) 716-6548. Web site: www.healthgrades.com

Health Grades Study Sample Table

Comparison of mortality rates between distinguished hospitals and all others for 3 of 26 procedures Included in study

Procedure	Distinguished Hospitals		All Other Hospitals		Results
	actual mortality	predicted mortality (based on risk adjustment)	actual mortality	predicted mortality (based on risk adjustment)	percent lower mortality rate in distinguished hospitals
Bypass	2.91%	3.59%	3.74%	3.52%	22.14%
Stroke	11.15%	13.30%	12.45%	12.22%	10.45%
Coronary Intervention (e.g., stent, angioplasty)	1.79%	2.17%	2.29%	2.17%	21.76%

Source: Health Grades Inc., Lakewood, CO.

Taken as a whole, Distinguished Hospitals have mortality rates that are 19.09% lower than those that did not qualify for the awards. Complication rates were 5.38% lower.

There are a total of 164 winners from the starting number of 869, or essentially the top 20%. However, that represents 3.4% of the 4,773 acute care hospitals in the country.

This does *not* mean, Collier is quick to point out, that only large facilities can provide high-quality care.

"Some of our partnerships [Health Grades is a quality information company with an advisory services component] are with hospitals that promote good quality outcomes but are smaller and may not meet the criteria," she explains.

The term distinguished implies more than quality, however; it also employs breadth of service. "For example, if you broke your hip and went to hospital A and then had a heart attack, as a consumer, you'd want a hospital that is good at everything," Collier says.

Health Grades' web site includes quality outcomes information on every hospital in the United States, and it is free to consumers. It seems they are taking advantage of the service: In the past two years, total users increased from 650,000 in 2002 to 4.31 million in 2003; total visits increased from 0.80 million in 2002 to 5.07 million in 2003; and total page views increased from 6.71 million in 2002 to 30.62 million in 2003. ■