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PROs may spearhead error reporting initiative

Critics worry that federal regulators will use PROs to spy on provider operations

Lost in the controversy over President Clinton's plan to force hospitals to report serious adverse events has been the important question of who's likely to be in charge of the systematic, nationwide error reporting process. The administration says it wants to take a state-based approach to error reduction, but some experts wonder how the federal government can mandate state action. *Hospital Peer Review* has learned that the answer probably lies with the nation's existing network of peer review organizations (PROs).

Taking the lead on error reporting and reduction is a natural extension of the role PROs historically have played in health care, says **William Golden**, MD, president of the Washington, DC-based American Health Quality Association, which represents the nation's PROs. "You could look at it a couple of ways. One is that we're already doing quality improvement and performance measurement assessment. Sometimes, we have done root-cause analysis depending on the nature of what we're analyzing." Golden adds that, in the past, PROs were very active in performing case reviews, and because they were random, "we could uncover serious episodes of unusual character. That was part of our mission — to take a case review where something dramatic might be found and then work with the facility to ensure that it would not occur again."

But not everyone's likely to be enthusiastic about a return to the "good old days" of PRO case review.

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"I think it would be very much resisted," says **Sanford E. Feldman**, MD, a retired surgeon in Mill Valley, CA, who has published extensively on the subject of medical errors. Feldman also served for several years as medical director of the PRO California Medical Review.

Feldman notes that PROs stopped doing external case review in the first place because of opposition from medical and hospital associations. "The attitude about the PROs from the medical association viewpoint was that it was a police-state kind of thing," he says. The associations objected that not all of the physicians who performed case review on behalf of the PRO were qualified to judge whether a case was mishandled or not. "It got to be a fight over each and every case," he says. "Gradually, HCFA [the Health Care Financing Administration, which administers the PROs] basically gave in to that movement and first reduced the number of cases [the PROs] reviewed and then eventually lessened the pressure to see those cases at all."

Controversy stirred again in late 1998, when HCFA assigned the PROs responsibility for detecting billing errors and reporting those errors to the Health and Human Services' Office of Inspector General and other enforcement agencies. At the time, some providers contended that the plan would poison the relationship between providers and PROs, and even Golden's organization opposed the idea, contending that PROs should maintain their newfound focus on quality of care. With medical error reduction, however, Golden is convinced that PROs can maintain collegial relations with providers by putting their error reduction activities "more into a quality improvement kind of mode, rather than a 'gotcha' kind of mode."

Indeed, Golden says that PROs' generally positive relationship with hospitals is a big part of the argument in favor of allowing PROs to coordinate the national error reduction effort. "A lot of this in terms of error reduction is education, outreach, and communication," he says. "Obviously, if you go in there like a stern parent, people will be turned off. Over the past several years, because of our quality improvement activities, people have become used to how we've approached them. Most facilities and professionals want to do the right thing, and if they are given an environment where they are treated as professionals, to respond and then to make changes in safety systems, then I think that problem would not be a major issue."

Steven Shea, RHIA, MBA, senior consultant

The Clinton error reduction plan: Key points

In addition to its controversial mandatory error reporting provision, President Clinton's medical error reduction plan includes the following proposals:

• Establishing a new $20 million Center for Quality Improvement in Patient Safety, designed to develop national quality improvement goals, issue an annual report on the state of patient safety, and translate its research findings into better practices and policies for the health care industry.

• Forcing all hospitals that participate in Medicare's Prospective Payment System to have or institute patient safety programs to prevent medical errors. "These new systems save lives, and over time of course, also save money," Clinton noted.

• Working with the National Quality Forum, a public-private group of health care experts, to develop a set of patient safety measurements that would "lay the foundation for a uniform system of reporting errors."

• Supporting legislation designed to protect provider and patient confidentiality, as long as it doesn't "undermine individual rights to remedies." Clinton said, "People should have access to information about a preventable medical error that causes serious injury or death of a family member, and providers should have protections to encourage reporting and prevent mistakes from happening again."

• Charging the Food and Drug Administration to develop new standards to prevent medication errors caused by misleading packaging of drugs or sound-alike drug names. The administration also plans to develop new label standards that highlight common drug interactions and dosage errors. ■

with Sheasp Healthcare Consulting in Winchester, MA and sponsor of the World Wide Web site www.medicalerrorreduction.com, concedes that using PROs to spearhead error reduction and reporting activities represents "a logical model. Instead of creating another bureaucracy, it would be a reasonable thing to do." Nevertheless, he remains concerned about the issue of government control of the error reporting process. "Doctors and hospitals are going to say, 'Wait a minute, you guys are just another arm of HCFA. You're just going to send in the HCFA police if problems exist."

Golden argues, however, that PROs are the logical choice to handle error reporting activities because the PRO program has built-in peer review protections — something health care advocacy groups like the Chicago-based American Medical Association and American Hospital Association are strongly pushing for. "Right now, you can say very clearly that errors reported for Medicare patients to PROs would have peer review protection and would not be subject to Freedom of Information [requests] or subpoenas," Golden says. "That would fall under the Peer Review Protection Act."

Golden adds that "if you want to have a constructive program [that emphasizes] error reduction as opposed to punishment, then that's going to be an essential piece of the whole operation. And if other entities need to be doing this work, then you'd have to extend peer review protection to [them]. But the PRO program can do it right now."

Even peer review protections, however, won't necessarily protect all providers who report errors, Shea contends. He notes that even if such protections were in place, they would be easy enough for investigators to get around. "You can still get all the information you want about a case, about the events, and about the analysis, just by deposing people," he says. "You know a case occurred, you know Dr. X was involved, you get a copy of the medical record, and you just go through and start picking out some names and chatting to people. I don't think there are any protections that will keep [investigators] from deposing those people and getting the information on the case anyway. So the idea that peer review protection is going to give you an absolute barrier from people being aware of an event, it's just not true."

Shea says that no matter what structure the government devises to collect and analyze data on medical errors, hospitals' best defense is to set up a strong internal system to identify serious adverse events, conduct thorough root-cause analyses, and institute effective action plans that

result in true improvement in patient care and services — very much the approach hospitals already should be taking with regard to the sentinel event reporting policy of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

The larger issue, however, is whether the industry should be rushed into a mandatory error reporting system at all, says **Martin Merry**, MD, a health care quality consultant and associate professor of health management and policy at the University of New Hampshire in Exeter. Noting that the president's proposals came in response to a widely publicized report late last year by the Washington, DC-based Institute of Medicine, Merry says, "It's interesting that so much attention has focused on mandatory reporting, when another part of the report [advocated] creating a culture of safety. What we really need to do is to change the whole culture of health care to one of safety and excellence and get away from this kind of witch-hunting of the worst end of the quality [spectrum]."

Further, Merry says, the regulatory focus of the recent discussion of medical errors "represents a bankruptcy of more creative ideas about how to move the whole system forward." He adds, "I'm reminded of the old saying that if you're a hammer, everything looks like a nail. If you're a regulator, and [mandatory] reporting is the only thing you can think of, you pound a little harder on the reporting. My concern is that all this attention we're giving to regulatory processes might actually detract from the energy we should be putting in moving the whole quality curve forward." ■

Outpatient procedures may be costing you millions

How to prepare for new APCs

While hospitals wait for the Health Care Finance Administration (HCFA) to finalize its rules on Ambulatory Patient Classifications (APCs), they already could be losing huge dollars for outpatient services that Medicare reimburses at much high rates as inpatient procedures.

Deborah Hale, CCS, president of Administrative Consulting Services in Shawnee, OK, says that audits her company has conducted have found that some hospitals are losing millions of dollars because they're doing those procedures as outpatient.

How can so many hospitals be missing the boat on this? "Because they don't know," says Hale. "Many of the Medicaid commercial payers require these procedures be done as outpatient." Hospitals often assume that because the third-party payers are saying that it's appropriate, that means that Medicare is using the same standard. "And because it's necessary to read through so much Medicare fine print, the distinction is often lost," Hale says.

Some of the procedures affected include laparoscopic cholecystectomy, pacemakers, including replacements, angioplasties and stent placements. "Those are all on the list that will be paid only as inpatients [under the APC regulations]," says Hale. "And for most hospitals, reimbursement is a lot better if done as an inpatient."

Another startling fact, Hale says, is that when patients have these procedures done in the outpatient setting, such as an angioplasty with stent placement, their out-of-pocket expenses run between $3,000 and $4,000. "If they had done the procedure as an inpatient, it would only have cost the current deductible, which is less than $800. So we're talking about a huge difference in out-of-pocket expense," she says.

HCFA's reasoning for the inpatient emphasis is that many of these procedures are done for older patients, some with comorbid conditions, who aren't able to tolerate the procedures as well as a younger person would.

While providers may agree that some fragile patients need inpatient treatment, some wonder if it's necessary to provide inpatient care to stronger, healthier patients who would probably tolerate outpatient surgery nicely. "My response to that is that we're not talking about standard of care in this instance," says Hale. "We're talking about billing."

"From a quality-of-care and the patient's standpoint, these procedures should not be outpatient," says **Sue Prophet**, director of classification and coding for the American Health Information Management Association (AHIMA).

Meanwhile, speculation continues about what the APC regulations will mean procedurally and how hospitals can bring themselves into compliance by the implementation date of July 1.

"There isn't much time [to prepare]," says Prophet. "But on the other hand, there's certainly

nothing to prevent hospitals from looking at their current procedures for documentation, their chargemasters, and their outpatient coding procedures. They also should be looking at the skills of the people involved in coding."

"A big area where I think most hospitals are going to have an educational curve is interventional radiology, because radiology is paid by APC," says Hale. "So many hospitals don't know how to code these procedures. They're incorrect. A part of it comes from the chargemaster, a part of it comes from actually coding the medical record. One thing hospitals can do now is be sure that their chargemasters are correct and they know how to code interventional radiology. Appropriate use of modifiers is also something they can be learning. The modifiers are going to be critical to accurate payment."

"APCs are driven by what is provided — the medical visit, what services are performed and so forth," Prophet explains. "If you've miscoded something, it goes into the wrong APC. Everything has to be accurate down the line: The registration has to be accurate, the charges have to be accurate, and the billing has to be accurate.

"It's going to be a major challenge gearing up. Hospitals will need to look at things like the proposed rules and their own patient mix, which procedures account for the highest volume of patients, and current outpatient coding practices," she says.

Compliance by the expected implementation date of July 1 will be almost impossible, according to both Hale and Prophet. The implementation of a new coding system is just too complex. Hale notes that there already is a shortage of coders, and although training is available, the learning curve is fairly steep. It would take six months to a year to bring a trainee up to speed.

And how will hospitals deal with the billing dilemma? "Actually," says Hale, "The only way hospitals can cope with this is to put in some admissions screening strategies. A case manager or an access nurse can look at this as a procedure is placed on the surgery schedule for Medicare patients; then you should coordinate with the surgeon to determine whether this should be done as inpatient or outpatient. The hospital can't take that responsibility alone. It has to be a joint effort. Even the [rule in the] *Federal Register* says that it should be a collaborative effort between surgeon and hospital to determine the appropriate level of care for the patient."

She points out that there are some instances where even a hernia repair that is normally an outpatient procedure will become appropriate for inpatient if the patient has comorbid conditions. If the patient, for instance, had Class III heart failure, for example, outpatient care would be completely inappropriate.

Changes to accommodate the new billing procedures will have to be addressed on an individual basis by hospitals, Hale says. "Whether they have to add FTEs or just rearrange responsibilities will depend on what their current system is. But no one I know is anywhere near ready," she says. "Some hospitals have done more than others, but it's a huge learning process." Still, HCFA seems committed to it. "So I think it's here we go, ready or not," says Hale.

[Editor's note: When HPR *went to press, the Health Care Financing Administration's final rule on APCs had not yet been published. Look for complete coverage of the final rule in upcoming issues of* HPR.*]* ■

Achieve balance from your scorecard strategy

Scorecards can boost physician buy-in

The Balanced Scorecard — who uses it? Is it just another buzzword developed for corporate gurus trying to write a strategic plan? And what does it really have to do with health care?

Actually quite a lot, some health care experts claim. The concept, which started out as a business tool for corporate America, has found its way into some of the major hospital and health management organizations around the country. According to some of the players, it's a keeper.

The concept was initiated by R.S. Kaplan and D.P. Norton in their book *Translating Strategy Into Action: The Balanced Scorecard*.[1] According to the authors, "the Balanced Scorecard translates an organization's mission and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system."

Bruce Harber, now CEO and president of Northshore Health Board in Vancouver, BC, enthusiastically endorses his experience with the Balanced Scorecard when he was CEO and president of Peel Memorial Hospital in

Brampton, Ontario. "We gathered people from all levels of the organization and explained the importance of measuring performance to improve the underlying capability of the organization," he says. Harber's hospital managers then focused on identifying "the vital few" — the most critical elements of the business that required change. Teams were selected to monitor the vital areas. They developed action plans to achieve the necessary results.

"Selecting the vital few is part science and part art," Harber says. The hospital administrators brainstormed at the senior level toward the end of each fiscal year to determine which drivers would improve performance results. Typically, we selected at least four vital projects," he says. These were then measured against the hospital's strategic objectives with an emphasis on accountability, productivity and quality.

But he cautions about becoming enamored with using the same measure over and over again. "You must learn to reject those that don't initiate any change in performance — where it's unclear about what's being measured and how results should be interpreted, where there's no display of progress toward strategic objectives, or where there's no ownership for performance."

Beware of drawbacks

In their article[2] analyzing the effectiveness of scorecards, a group of researchers from Dartmouth Medical School in Hanover, NH, and Dartmouth Hitchcock Medical Center in Lebanon, NH, pointed to other potential drawbacks in using scorecards:

1. Some of the data being used are included more because they are available rather than because they provide quantifiable answers to questions.

2. A scorecard might show where improvements are needed, but fail to show how to make improvements.

3. If the data are not gathered and analyzed by third parties, there is the potential for manipulating data to the organization's advantage.

Staff involved in process improvement efforts at Johns Hopkins University Hospital in Baltimore began building their scorecard last spring.

"By October we were all set to put the draft scorecard out for approval," says **Daniel Wassilchalk**, director of performance improvement and utilization management at Johns Hopkins. "But then we reviewed some of our leader opinions and stopped to take a second look. Our scorecard was geared to clinical outcomes, financial goals, and patient satisfaction."

But in a teaching hospital like Johns Hopkins, the physicians are dedicated to other goals, like research. They needed to see their work in those areas recognized, too. So Wassilchalk and his colleagues pulled their scorecard from the pipeline and went back to work.

"We knew it was important to have physicians buy into this plan if it was going to work," he says. "So we're just now adding a fourth quadrant to our scorecard that addresses research and teaching outcomes. To reflect those results recognizes the hard work of our medical staff and brings us physician acceptance."

Connecting past, present, future

That angle of total organizational acceptance is underscored by Bruce Harber. "One of the most important aspects of implementing organizational change," he explains, "is the ability to sell the rationale to the organization. People must see the connection between the past, present and future. Before implementing any change, we communicated with those involved to explain what we were doing and why we were doing it, the timetables and the level of involvement we expected from staff."

Carolyn St. Charles, RN, MBA, of St. Charles Consulting Group in Issaquah, WA, has been developing and implementing balanced scorecards for health care clients for more than four years. She notes that the "health care environment is very complex, with unique characteristics that create the need for special considerations." In *The Balanced Scorecard Strategic Management System*, a resource guide she wrote with her colleague Dona Foth, RN, MBA, she itemizes several of these characteristics:

- The customer (patient) who receives the services is not directly responsible for the cost.
- Physicians practice in organizations providing medical care and are a major driver of resource consumption; yet, they are generally not accountable for the cost.
- There are multiple constituencies that must be involved in decision-making, including board members and physicians, with both formal and informal influence and decision-making authority.

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Discharge Planning Advisor®

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On-line reservation system brings DP into 21st century

Allows time with patient instead of fax machine

Discharge planners at several hospitals in the Northeast are arranging patients' post-acute care through an on-line reservations and booking system that promises to revolutionize the discharge process.

In several pilot projects with the recently founded Integrated Health Networks (IHN), based in Newton, MA, hospital discharge planners are using a new software tool to determine the availability of post-acute services, then request and schedule those services over the Internet, says **Ruth Fisk**, RN, MS, vice president of clinical operations for IHN.

The three-month pilot projects will be completed in mid-May, with the new system expected to be available commercially to other hospitals by the end of May.

The system works like this:

• Post-acute providers that take referrals from a hospital, including skilled nursing homes (SNFs), home health services, and rehabilitation facilities, complete a profile outlining the services they offer. Each day, the provider updates the bed or service availability.

• Case managers or discharge planners working on a discharge plan input the patient's care needs and the date the hospital would like to discharge the patient. At this point, the specific patient is not identified.

• The system matches the availability of facilities or services with the needs of the patient.

• The discharge planner sends a notice via e-mail to the matched provider, by way of a secure Internet server, that a bed or service is being sought.

• The provider's intake coordinator reviews the patient care needs on the Web and responds to the hospital discharge planner.

• The patient and/or family is consulted in the final selection of the post-acute provider.

• To protect patient confidentiality, identifying information on the patient is sent to the provider only after the final match is made.

Program sets 2-hour time limit

The entire communication between the levels of care is done through electronic messaging, and the time given to respond is limited in both directions, Fisk points out. "If providers don't respond within a specified time, they're no longer on the list. This arrangement is agreed upon before providers are enrolled in the system."

Based on information from focus groups, IHN recommends that the nursing home or home care service be given two hours to respond to the hospital regarding acceptance of the patient, says **Jackie Birmingham**, RN, MS, CMAC, a veteran discharge planning and case management consultant and IHN's director of network integration.

"The provider needs to make a decision, that it will either take the patient or not, or will send a nurse to the hospital to assess the patient," Birmingham adds.

If the provider sends a nurse, it will be given another two hours before the process goes to the

next step, she says. "In fairness to both sides, the provider should either do an assessment of the patient within two hours or respond to the hospital and let them know a liaison will be there in three hours."

Whatever happens, Birmingham points out, the case manager or discharge planner can always override one choice and go on to the next.

System eliminates distractions

Some nurse liaisons who do preadmission assessments have expressed concern that the on-line discharge system will prevent patient screening, but that is not the case, Birmingham emphasizes.

"We want the patient to be screened for appropriateness to the nursing facility or home care service," Birmingham says. "We believe that once discharge planners and post-acute providers gain experience with the system, the appropriateness rate will improve significantly and only a few patients — in cases where the patient's needs are complex or where the destination isn't sure because of the complexity — will need to be screened."

At the alpha test pilot site, Fisk says, the patient populations targeted will be a selected group of those being discharged at any one time. Half the discharge planners involved in the pilot work with patients enrolled in a risk-based Medicare program, and the other half work with traditionally insured patients, she adds. These discharge planners will work with patients only on selected units, which allows a built-in comparison group.

One big advantage of the IHN system is that "there is a considerable reduction in the amount of time that has to be expended in making discharge arrangements," Fisk says, "not just elapsed time, but time spent communicating with providers. Who has a bed? Who will accommodate certain requirements? We hear from case managers who now can spend an hour or two on the phone just determining who has a bed available and the appropriate services for the patient."

The system eliminates such distractions as busy signals, multiple faxes and the need to leave and respond to voice messages, she adds.

"It has been reported that the typical hospital discharge conducted via telephone and supported by paper, on average, may take more than four hours to complete," Fisk says. "The same transaction conducted electronically is estimated to take less than 45 minutes to complete."

High-tech becomes high-touch

Ironically, this high-tech discharge solution actually can facilitate closer communication among families, Fisk points out, particularly when family members are spread out in different parts of the country.

"The general perception is that high-tech is more impersonal," she says, "but in this instance it really does expand the circle to include family, even if distant, and allows them to know the options and advantages of one facility or service vs. another."

A feature of the IHN system, adds Birmingham, will offer "patients and distant families access to what we're doing. We can e-mail the Web sites of nursing facilities to the families, where they can see a review of the nursing homes. They will have a unique code or password that will give them access to designated information they need to make a decision."

Patients matched to providers

Many patients go to two or three levels of post-acute care before finding the level that fits their needs, Birmingham points out, often because they don't go to the right place the first time. The IHN system will make a difference, she predicts, "because the discharge planner will have a work flow tool and the patient is matched to the provider based on needs and availability. Discharge planners also will have more time to work with the complex patient to develop a more precise discharge plan."

Response to the idea has been "phenomenal," Birmingham adds. "There is communication only when there is a piece of information and discharge planners don't have to wait for a phone call. I call it the 'virtual discharge plan.' Payers are also very excited about the work flow tool, since it will allow more real-time information and collaboration with hospital-based staff and post-acute providers."

[*Editor's note:* For more information on Integrated Health Networks, contact Ruth Fisk at (617) 630-1335, e-mail:ruthfisk@ihn.com; Jackie Birmingham at (617) 290-3365, e-mail:jbirmingham@ihn.com; or Mike Quilty at mquilty@ihn.com.] ■

'Cultural competency tool' aimed at reducing barriers

Staff sensitivity, awareness evaluated

A growing immigrant and refugee population in the United States is placing increasing demands on health care practitioners, who seek to make sure patients and family members understand and consent to the medical care being proposed.

"The hallmark for the 21st century is diversity and pluralism," says **Alice Kitchen**, LCSW, MPA, president of the Chicago-based Society for Social Work Leadership in Healthcare. "When providers of health care don't look like the patient, there is a distance right away. It is for us, the provider, to overcome that distance, to make the leap forward.

"We don't always have the luxury of time, so we must be attentive and aware, and reduce barriers until the patient is willing to participate in his or her own health care," says Kitchen, who is director of social work and community service at Children's Mercy Hospital in Kansas City.

With that in mind, the Society for Social Work Leadership has developed a Cultural Competency Evaluation Tool that organizations can use as part of employees' performance appraisal, adds **Olivia Hester**, MSW, ACSW, chairwoman of the society's work group on the cultural competency tool. That work group, comprising social work professionals from throughout the country, is an offshoot of the organization's multicultural coalition, says Hester, who is director of social services and utilization management at Miami Valley Hospital in Dayton, OH.

"This competency tool will serve as a mechanism to evaluate an employee's ability to demonstrate the skills and knowledge necessary to work with a diverse staff, community and client base," she adds. The Society plans to unveil the tool, which eventually will be available for widespread use, at its national convention, to be held May 31 to June 4 in Orlando, FL, Hester notes.

The tool is "somewhat open-ended" so that organizations can adapt it to their own policies and procedures, and is designed so that it can be used by any company, not just in the health care environment, Hester says. "It covers self-awareness, professional growth and development, and interpersonal relationships."

The tool addresses "the types of standards or criteria we should develop to manage staff competency, being able to verbalize the meaning of cultural diversity," she adds.

Coming from a culture with the religious belief that the body must be kept intact, for example, a diabetic patient will be extremely reluctant to accept amputation, Hester points out. "[Cultural competency] is being aware of that issue. It's asking how we can help the patient work around his or her illness [in view of] the religious implications and the family's belief system."

In a culture with a strong respect for the elderly, a family may insist on keeping the patient in the home, even though the medical needs are overwhelming, she adds. "It's hard for them to reconcile their beliefs with the idea of the individual going to a nursing home."

Hospital sponsors diversity grand rounds

Promoting cultural awareness must be done "across the health care setting," says Kitchen. "It's not just for physicians, nurses, and social workers, but also for secretaries, receptionists, and cleaning personnel. It's for all of us to be more sensitive and aware."

At her own hospital in Kansas City, Kitchen points out, Arabic interpreters are now the third most frequently requested, with Spanish number one, and Vietnamese second. There is no substitute for an in-depth knowledge of ethnographic interviewing, she says, but practitioners should at least be mindful of the following:

- Not all interpreters are equally qualified. Seek those familiar with medical terms or teach them the terms.
- Interpreters have to translate on three different levels within each language — technical, standard and slang.
- Health care providers need to decide whether they want a line-by-line or a summary translation and convey that to the interpreter.
- Untrained interpreters may not be aware of the ethical standards in health care settings and the inappropriateness of injecting their own words, opinions, or conclusions.
- Many words in English do not have equivalents in other languages, and many concepts and phrases are not translatable. Inflection and directness or indirectness also play a part in communication.
- Language and behavior are closely related. The way a culture uses language is often an

expression of a cultural value or orientation.

The advocacy committee at Children's Mercy Hospital, which meets every month, consistently seeks ways to enhance the hospital's commitment to cultural diversity in practice and behaviors, Kitchen says.

For the past three years, for example, the committee has sponsored "diversity grand rounds" four times annually, with a focus on one particular culture at each session, she notes. "There's an emphasis on education, with a patient or another individual representing that culture. Often a medical person from that culture speaks. We have had a case manager speak."

The entire hospital staff is invited, Kitchen says, including physicians, nurses and even environmental services employees. Questions at the session focus on how the patient wants to be treated, and the cultural values and traditions health care providers should be aware of, she adds.

Check nonverbal preferences

At Miami Valley Hospital, Hester says, all new employees are given a written statement outlining the organization's expectations in the area of cultural diversity, and required to participate in a half-day diversity orientation.

"The workshop covers handling differences with colleagues, being accepting of others' differences, and what diversity is," she adds. "We use vignettes to demonstrate ways to apply these policies and procedures."

Individuals often use stereotyping, for example, without even realizing it, Hester says. "We talk about how harmful it is, and about what the hospital will and won't tolerate." Ethnic jokes, or any jokes that may hurt people based on race, religion or origin, are not allowed, she notes.

Health care providers seeking to achieve cultural competency need to remember that, based on prior negative experience, patients often assume the practitioner lacks appreciation for their culture, Kitchen says. "A starting place for the face-to-face encounter with patients begins with asking what their previous experience has been with health care providers and what they expect from them at this visit."

"Ask the patient how he or she wants to be addressed — by last name, first name, title, etc.," she advises. "Check nonverbal preferences — eye contact, physical closeness, touch. Pay attention to body movements, hand motions, emotional expressiveness, silence. All of these expressions convey cultural values and norms."

[*Editor's note:* For more information on the cultural competency tool or the Society for Social Work Leadership in Healthcare conference, call (312) 422-3777.] ■

Discharge planning process identified as 'area of need'

CMSA gears workshop to hospital case manager

Hospital case managers involved in discharge planning are desperately seeking help in the area of education and professional support, says **Kathleen Moreo**, president of the Little Rock, AR-based Case Management Society of America (CMSA).

CMSA has learned from its acute-care special interest group (SIG) that "many hospital case managers don't feel we're addressing some of their most burning education and professional needs," adds Moreo, an independent case manager based in Fort Lauderdale, FL.

"Our SIG continues to identify the discharge planning process as the area where help is most needed," she says. "It involves so much of the [case managers'] days, and they need better ways to do plans, track outcomes — all the things that the Joint Commission on Accreditation of Healthcare Organizations expects them to do while also working with the patient."

In response to that need, Moreo says, CMSA plans to offer a one-day workshop geared to the hospital case manager in conjunction with the Utilization Management / Case Management Best Practice Conference and Expo, set for November in San Diego. That conference is sponsored jointly by CMSA and the Washington, DC-based Utilization Review Accreditation Commission (URAC).

"We want hospital case managers to know we are acutely aware of this need and are trying to address it," she adds.

[*Editor's note:* For more information on the UM / CM Best Practice Conference and Expo, call the Case Management Society of America at (501) 225-2229 or log onto its Web site at www.cmsa.org.] ■

(Continued from page 46)

St. Charles adds that "most hospitals lack information systems that allow easy access to critical information such as cost, process and outcome data. Even if the data are available, they usually reside in multiple sites without an adequate interface," she says. She also notes the difficulty in defining meaningful outcome measures and targets in areas such as clinical quality and community benefit. "These challenges," she warns, "must be taken into consideration to ensure a successful development and implementation of the balanced scorecard."

In developing a strategy, it's important to look at the hospital from all angles. It's also important to develop the scorecard around the individual organization. Depending on the size of the hospital, its requirements and its mission, scorecards can be adapted to areas where they are most needed and effective.

Identifying high-value care

At Denver's Craig Rehabilitation Center, for example, **Vi Griffin**, director of quality management, typically doesn't outline evaluation processes for each area. Instead, she says, Craig's scorecard is an ongoing evaluation of critical processes and outcomes. "We identify the critical areas and monitor for any adverse events," she explains. "Things like unplanned discharges to acute care facilities or surgical complications are significant concerns for us. I trend this sort of thing quarterly and write a report. Then on a report-to-report basis, I can key into the areas that require attention."

Dartmouth Medical School's Nelson and Batalden found that, among other things, a well-done scorecard could help consumers identify high-value care, hold providers accountable for outcomes and costs, and offer positive measures of recently provided care. But to be used constructively, scorecards must be reliable and relevant, predict future needs, and define what is being measured.

It's important to develop the scorecard around what works for your organization.

"While this was a major undertaking for us, the return on investment has exceeded our expectations," says Harber.

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1. Kaplan RS, Norton DP. *Translating Strategy Into Action: The Balanced Scorecard*. Boston: Harvard Business School Press; 1996.

2. Report cards or instrument panels: Who needs what? *The Joint Commission Journal on Quality Improvement* 1995; 21:4. ■

Tips on implementing a Balanced Scorecard

If you're considering using a Balanced Scorecard approach at your facility, consider the following advice from **Bruce Harber**, CEO and president of Northshore Health Board in Vancouver, BC:

- Conduct an environmental assessment to evaluate the state of readiness, strengths and weaknesses, critical success factors and implementation challenges.
- Take a top down-bottom up approach, allowing teams to create their own performance indicators, ensuring ownership of the process.
- Don't pass off accountability for the scorecard project to a single person. The scorecard is a core management tool that should be "owned" by the entire leadership team.
- Conduct regular team meetings to compare performance measures and progress against the corporate goals.
- Be prepared to change what you measure — especially the "soft," non-financial measures that are the drivers of all the other performance results.
- Start looking at the cause-and-effect relationships between the data elements to ensure that resources are being correctly allocated.
- Use a packaged, user-friendly software solution where programs are loaded from a server.
- Commit to a periodic, organizationwide assessment of your performance against all the data elements.
- Balanced Scorecard structures succeed when they provide relevant facts and data about current performance and show what needs to be improved, either immediately or in the future.
- Team-based environments are best equipped for effective roll-out of the scorecard. ■

Making sense of HCFA's restraint rules

'Anything done unilaterally is a problem'

Probably nothing in recent memory has raised eyebrows and elevated administrative blood pressure quite like the Health Care Financing Administration's (HCFA) Conditions of Participation (CoP) regarding seclusion and restraints. Even now, months after the CoP's release, many health care professionals remain frustrated by its inherent ambiguities and unanswered questions: What exactly constitutes a restraint? Who can order them? What about chemical restraints?

Particularly vexing to most clinicians and hospital administrators is the requirement from both HCFA and the Joint Commission that a physician do a face-to-face assessment with the patient within an hour of implementation of restraint or seclusion. **(See "Hospitals cry foul over ambiguity in HCFA's new restraint standards," *Hospital Peer Review*, November 1999, p. 165.)** "This new requirement is not clinically necessary because competent caregivers on the scene already are in constant dialogue with physicians about the patient's condition," said **Jonathan T. Lord**, MD, chief operating officer of the Chicago-based American Hospital Association (AHA). "Given the short notice of this unexpected provision, most hospitals would not be able to hire enough staff to fulfill these requirements."

What can a small rural hospital do with an out-of-control patient and no physician standing by to do an assessment? For that matter, what can be done in a medically underserved urban area or a residential setting?

"It's going to add expense at best and be difficult to comply with at worst," says **Michael H. Allen**, MD, immediate past president of the American Association of Emergency Psychiatry in Medford, MA. Allen is also associate director of behavioral health at Denver Health Medical Center, a large public hospital. "Some people will just get out of the business," he says. "Others will have to charge more. But we must improve staffing patterns to make this work."

Yet Allen agrees that where seclusions and restraints are involved, "whenever possible there should be a dialogue and choices about how the patient will be treated. It's important to involve the consumer and discuss the treatment options. Anything done unilaterally is a problem," he maintains.

HCFA's rules require the assessment by a physician or independent licensed practitioner within an hour of restraining the patient, a provision that caretakers argue is often impossible. The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) claims it wants to learn more about solutions to this dilemma. "Based on the review research, should the Joint Commission ultimately adopt a time frame that differs from HCFA's requirement, the Joint Commission still would hold organizations that are subject to the HCFA regulations to whichever standard or regulation had the shorter time frame," it states in its written response to concerns raised by the National Alliance for the Mentally Ill (NAMI) in Arlington, VA.

What constitutes competency?

The Joint Commission's draft also would require that "only competent, trained staff are involved in the use of restraint and seclusion" the JCAHO adds in the NAMI response. This means the organization would have to train and assess the competency of all staff, including physicians and midlevel providers, who are authorized to be involved in the use of restraint and seclusion.

But just how trained must staff be to qualify as competent?

According to the Joint Commission's draft restraint standards, staff must have competence in:

- an understanding of how their own behavior can affect the behavior of the people being served;
- the use of de-escalation, mediation, and other non-physical intervention techniques;
- the safe use of restraint and seclusion, including physical holding techniques;
- recognizing and appropriately responding to signs of physical distress in individuals who are restrained and secluded.

Allen is not entirely opposed to this. "We could cut the rates of seclusion and restraint dramatically by training staff in de-escalation skills, offering food, toileting, oral medications, and helping people get into a better frame of mind," he says.

Currently, HCFA is exempting emergency

rooms from the rules, and the Joint Commission has yet to make up its mind on this issue. So in some situations, a patient could be restrained by order of an ER physician. "However, we wouldn't want to make a habit of classifying these patients as emergencies where reimbursements may be higher," says Allen. "We don't want that to become an incentive for making restraints more attractive."

Vagaries in the standards persist and complicate the issue of compliance. What exactly constitutes a restraint — a raised bed rail? A shot of Valium? A prisoner in handcuffs?

HCFA has tried to address some of the more persistent questions on the definition of restraints in its Q&A paper related to "Hospital CoP for Patients' Rights." The Q&A paper was designed to address the interim draft until HCFA issues its final rules. (The entire text of the paper is available on HCFA's Web site: www.hcfa.gov/.) In the case of the bed side rail, HCFA notes that "if the side rail restricts the patient's movement and the patient cannot remove it, the side rail is a restraint and must meet the requirements of the CoP."

In the case of the handcuffed prisoner, however, the situation would be covered by the criminal law and not subject to the HCFA standards.

"The key is assessing each patient and each situation," HCFA says in its Q&A paper on the subject of restraints. For instance, a gerichair with a tray across the front is not a restraint if the patient can lift the tray and get up at will. The same reasoning applies to a wheelchair strap.

However, if the patient can't reach and release the strap, it becomes a restraint under the conditions of the CoP.

"Individual assessment is necessary," HCFA adds in the Q&A paper, "because what functions as a restraint for one patient may not do so for another."

HCFA's position on chemical restraints takes careful reading. In general, HCFA defines a restraining drug as a medication that is used to control behavior or to restrict that patient's freedom of movement. But in examples of the use of drugs for restraint, HCFA cites a patient on an acute medical/surgical unit who during recovery suddenly becomes agitated and aggressive. Since her condition until now has not indicated the need for sedatives, the use of drugs to calm her will require the assessment of a physician within an hour.

On a detox unit, however, if a patient becomes violent and aggressive, the staff can administer a PRN medication ordered by his physician to address this outburst. Since it is a conventional treatment for his medical condition, it is not affected by the HCFA standard and is not considered a restraint.

"The variation in the range of restraints is huge," says Allen. "Many facilities should be reducing the rate at which they use restraints. Patients are traumatized by this. Some end up with post-traumatic stress disorder. We need to be thinking about how this affects them afterward." ■

THE QUALITY - CO$T CONNECTION

Continuity of care means better instruction on meds

Are patients going home with enough information?

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

Improvements in the continuity of patient care have traditionally focused on care coordination among practitioners and organizations. Hospitals have made significant strides toward assuring adequate clinical information is communicated to other settings where patients will receive care after discharge.

One aspect of continuity that frequently is overlooked is the transfer of information to patients. An area of high risk is medication instruction. Patients who are discharged from the hospital with take-home medications must have clear instructions on how those medications should be taken. While the nursing and pharmacy staff may verbally discuss the medication regimen with the patient, it is important that the prescription itself contain written full dosage instructions that the patient can refer to after leaving the hospital. Incomplete or missing dosage instructions can be the cause of much

Take-Home Medications Dosage Instruction Study

Rx No.	Prescribing M.D.	Order Contained Complete Dosing Instructions?	Pharmacist Dispensed as Ordered?	Pharmacist Requested Order Clarification?	Time Pharmacist Spent Clarifying Dosage Instructions (minutes)	Pt. Received Rx Instruction Prior to Discharge?	Post-Discharge: Pt. Needed Clarification of Instructions?	Post-Discharge: Time Spent Clarifying Instructions (minutes)	Post-Discharge: Pt. Health Problem Due to Unclear Instructions?
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no
		yes no	yes no	yes no		yes no	yes no		yes no

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

irritation and time-consuming discussions between pharmacists, patients, and doctors. The ability of some of patients to take their medicines as the doctor has intended may be compromised with resulting medication errors or patient noncompliance.

How often are clear and complete dosage instructions missing from take-home prescriptions? Start your investigation of this issue by determining the importance of the problem. Remember, something may be important because it occurs frequently or, although it occurs infrequently, it takes a large amount of time and energy to resolve. You may find that only a small percentage of take-home prescriptions contain unclear dosage instructions, but if the resources are not available to resolve the problems caused by incomplete instructions, then the consequences can be significant. By conducting a baseline study of this issue, you can determine if problem-solving actions need to be taken.

To determine the extent of the problem, conduct a study to identify the number of take-home prescriptions that do not have full dosage instructions and what impact, if any, the lack of instructions had on resource use and patient outcomes. Information you can collect might include:

• number of occasions the pharmacist had to seek clarification of the dosage instructions from the ordering physician;

• number of times prescriptions are dispensed without full dosage instructions and how this related to the total number of take-home prescriptions that are dispensed;

• number of times patients contact the pharmacist or another hospital caregiver to clarify dosage instructions after they've been discharged;

• number of times patients request clarification of dosage instructions during telephone follow-up by a case manager or other caregiver;

• number of health problems that arise due to incomplete or inadequate dosage instructions (e.g., lack of symptom control, treatment failure, adverse effects, etc.);

• number of rehospitalizations that appear to be related to medication errors caused by inadequate instructions.

The form shown above can be used to collect data. This is a baseline study, so you only need to collect information for a sample of take-home prescriptions (30 is suggested as a minimum number). In selecting your sample, be sure to take into consideration the variations in daily workload and staffing. Because this can be a labor-intensive study, you may wish to avoid starting the collection at the busiest part of the week / month / year. Data can be gathered on a random group of prescriptions, those dispensed to a specific patient category or those drugs in a certain therapeutic group.

What can the baseline study tell you about the importance of the problem? If you find that a significant number of patients are receiving take-home medicines with incomplete dosage instructions or the number is small but troublesome, several steps should be taken to investigate the problem in greater depth. Start by listing the types of situations that cause the greatest difficulty in relation to dosage instructions, e.g., on weekends, a particular physician, a particular class of drugs, patients receiving repeat prescriptions. Do different physicians use a different approach in writing out instructions?

Do different pharmacists have varying tolerance for incomplete dosage instructions? List the steps the pharmacist normally takes to clarify the appropriate dosage instructions to be included on the prescription label. This may include checking with the patient and the physician.

Patients' lack of compliance with therapeutic treatment regimens is often overlooked as a continuity-of-care problem. There is mounting evidence to suggest that it may be a contributory or even causal factor in treatment failure, representing significant avoidable morbidity and mortality. Taking medicines depends on a variety of factors, including motivation to comply, anxieties relating to risk and side effects, physical ability, and knowledge of the medicines. Hospitals can do much to reduce these risks by assuring the patient has sufficient information about how medications must be taken to obtain optimal benefits.

Confirming missing dosage instructions with the ordering physician is a time-consuming activity for the pharmacist, often causing discharge delays while questions are sorted out. Time pressures can decrease the likelihood that patients and families will ask questions about dosage instructions. Studies such as the one described in this article can help hospitals quantify the problem and identify patient or drug groups where instructions might be conveyed better through different means (e.g., instruction booklets for steroids / warfarin, inhaled drugs, etc.). Inpatient education practices might need to be reviewed and amended. Practitioners may need to change established prescribing habits. As our patients begin to assume more responsibility for self-care at home, we must ensure that continuity of care is not compromised by inadequate transfer of information. ■

NEWS BRIEF

Study finds 33% of ICU patients malnourished

A multi-center study presented at the recent 24th Annual Clinical Congress of the American Society of Parenteral and Enteral Nutrition in Nashville, TN, found that caregivers underestimated the nutritional needs of one out of every three intensive care unit patients.

In this study, researchers used sensor technology instruments to measure the daily metabolic rate of critically ill patients. They found that current practices of estimating nutritional requirements resulted in caloric deficits of more than 10,000 calories in one third of patients during their ICU care. In addition, patients who suffered these large caloric deficits required substantially more days on a respirator and more days in the ICU than patients who received adequate nutritional support.

"Unfortunately, tables and formulas intended for everybody cannot reliably predict the needs of an individual patient," notes **James Mault**, MD, a surgeon at the University of Colorado Health Sciences Center in Denver and a researcher on the project. "As a result, without us realizing it, many of our

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critically ill patients are subjected to circumstances equal to you and me not eating for five straight days. It's not hard to understand why it may take longer for these patients to recover from their illnesses. Ideally, patients' nutritional needs should be routinely monitored just like heart rate and blood pressure. However, the current technology available to make these measurements is far too complicated and expensive."

Advances in sensor technology are likely to result in a simpler and much less expensive monitor of individual nutritional requirements by the end of this year, researchers note. For more information on the study and others presented at the clinical congress, visit the organization Web site at www.nutritioncare.org. ■

SourceKit

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