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IN THIS ISSUE

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Publicly reported data on the rise: Act now to work that to your advantage

Unprecedented access to data: Disaster in the making or golden opportunity?

A patient is about to be admitted to your hospital but first goes on-line to the Joint Commission on Accreditation of Healthcare Organizations' new Quality Check web site. Upon learning that you're ranked far lower than your competitors in compliance with the National Patient Safety Goals, the patient decides to go to another hospital instead — and lets your CEO know exactly why.

Sound far-fetched? This actually occurred at one hospital recently, and you can believe it had a strong impact. "Just based on reading that data, a patient said they didn't want to go there. That was the thing that finally got the CEO of this organization on board in terms of having more of a commitment to quality," says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting, based in Metamora, MI.

The public initially was slow to access publicly reported data but is catching on quickly, she explains. "When the public data first started hitting, I don't think the public responded as quickly as many organizations feared," Homa-Lowry says. "But people are becoming more astute in terms of obtaining that information."

There is no question that the amount of data being publicly reported will continue to increase, with current requirements from the Joint Commission, the National Committee for Quality Assurance, and the Centers for Medicare & Medicaid Services (CMS), which announced recently that nearly all the nation's eligible hospitals have begun reporting quality data.

Prepare your hospital for a very unusual flu season

Vaccine shortages may wreak havoc with hospital EDs, absenteeism

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments (EDs) and for staff shortages due to record absenteeism. After almost half of the United States' planned vaccine supply was contaminated, high-risk candidates

(Continued on page 162)

A pivotal development is the Joint Commission's Quality Check web site (www.qualitycheck.org), launched in August 2004, which allows consumers to compare patient care at 3,357 hospitals statewide and nationally. Consumers can find out quickly how your hospital ranks in the care of patients with heart attack, heart failure, pneumonia, and pregnancy and related conditions.

Although CMS's National Voluntary Hospital Reporting Initiative (Go to www.cms.hhs.gov and click on "Quality Initiatives.") provides similar data to consumers, the new JCAHO site is more user-friendly, making comparisons easier.

The JCAHO site also allows patients to see how your hospital compares with others in complying with the National Patient Safety Goals. "Now that there is information about the safety goals in addition to the public information about surgeries that has been available for some time, the public is paying more attention," says Homa-Lowry. "The public *is* reading those. So obviously, compliance with the safety goals is huge."

As consumers assume more responsibility for their health care choices, they want information they can understand to guide these decisions, says **Karen Pietrodangelo**, executive director of quality management for Tallahassee (FL) Memorial HealthCare. "Payers — both private and governmental — want quality to guide their purchasing decisions, and providers of care want information to improve their clinical practices," she says. "The quality manager is now challenged to meet all these needs, whereas in the past, the primary focus was on institutional quality alone."

Third-party payers are jumping on the bandwagon, says **Patti Higginbotham**, RN, CPHQ, FNAHQ, vice president of quality management and medical staff services at Arkansas Children's

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Editorial Questions

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Hospital in Little Rock. "In our state, Blue Cross/Blue Shield is very active in working with hospitals to identify measures of performance that can be reported and made available to their clients and customers," she says. "I think it's coming down the line — certainly other states have already seen it."

As a proactive approach, the organization is considering completing the Washington, DC-based Leapfrog Group's Hospital Quality and Safety Survey. "We believe we probably do meet a lot of those standards already," Higginbotham says. (For more information, go to www.leapfroggroup.org.)

Comparing apples to oranges?

While it's clear that publicly reported data is a top priority, health care administrators are hampered by a lack of agreement on which measures are true indicators of quality care and how the data can be used to accurately compare one hospital to another, Pietrodangelo says.

The main concern is that publicly reported data, though prevalent, may be misleading and even dangerous. "It's concerning, because it's not an apples-to-apples comparison," Higginbotham notes. She gives the example of her own organization, a pediatric hospital that cares for infants requiring quaternary care. "The care and management of those babies and their outcomes are shakier from the day they are born," she says. "Comparing outcomes for neonates in neonatal intensive care with outcomes of infants in the newborn nursery of a general hospital may be confusing to the public."

Likewise, if your organization has a mortality rate within your cardiovascular service that is higher than your competitor's, that may be due to the fact that the competitor operates only on patients with a better chance of recovery, notes Homa-Lowry. "So, if you are one of those organizations that turns away patients, your mortality rate is going to be lower," she says.

The standards are too generic to take into account the different populations served by different organizations, Higginbotham adds. "It's hard to look at two numbers and compare them, unless you can do some acuity adjustment."

The other problem is the definitions used at individual organizations, which she argues are not well-defined. For instance, one hospital may count near-misses as medication errors, and another hospital may count them only if the error reaches the patient. "That hasn't all been worked out, either."

Higginbotham's facility currently is working with pediatric organizations to develop consistent pediatric measures of care, and she has given presentations to the quality improvement committee about public reporting requirements.

If the comparisons were truly accurate and consistent definitions were used, she says that publicly reported data would be very beneficial. "If it's an apples-to-apples comparison, I think we compare well for pediatric care — and if we don't, I want to know it."

Your biggest concern should be that publicly reported data accurately reflect the services and care provided at your organization, advises **Pamela R. Voss**, FACHE, FASHRM, director of risk management at Round Rock (TX) Medical Center.

"You need to be certain that your data are as good and clean as possible," she says. "You should do that at any point in time, whether it's published or not — but if you're going to be in the spotlight, you want to look your best."

Leverage for changes?

Publicly reported data potentially can give you a lot of leverage when asking administrators to invest resources in specific quality projects, says Voss. "For instance, if there is a target area in nursing or the laboratory that needs improvement, the data might display this in clearer terms than previously and get greater attention than before," she explains.

Many quality professionals feel that the pay-for-performance trend is a positive development, arguing that the transparency that comes from requiring hospitals to publicly report data inevitably will lead to safer care. That's because in addition to the financial incentive, the reputation of the organization is at stake, emphasizes **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of JB Quality Solutions, a Pasadena, CA-based consulting firm.

"If leaders tell the medical staff, 'We're in the 10th percentile for getting antibiotics to pneumonia patients on time. That's hurting our patients and our reputation in the community; that's a great incentive. Patients are going to improve; the data are going to improve; and the hospital will be better off."

If the numbers are not good and the public now knows it, you have a strong incentive for caregivers to make necessary practice changes,

Brown adds. "I think that getting performance measures linked to accreditation and Medicare reimbursement, with mandatory public reporting, is one fix," she says.

The JCAHO/CMS set of National Hospital Quality Measures, with its specifications manual of common data definitions and collection specifications does provide a legitimate comparative data set for public reporting, as long as like facilities and, as much as possible, similar patient populations, are compared, Brown says. "Of course, acuity and clinical risk-adjustment are always issues that may be the basis for a rebuttal of less-positive data results," she adds.

Quality professionals can't make practitioners provide better care, Brown acknowledges, but data are a strong incentive. "Physicians and nurses want to do what's right, but they need to see the data," she says. "It's a matter of helping them understand the value of performance measurement and the organization's goals for improvement of patient care and outcomes. That understanding is now being quickened by the need to be responsive to what the public knows."

PR and quality team up

The link between public relations staff and quality professionals has become more important due to publicly reported data, says Voss. "When JCAHO came out with publicly reported data on hospitals, we made sure that our marketing staff were knowledgeable and knew how to respond," she adds. "It's critical to have their involvement, to help us all look the best that we possibly can."

Too often, there has not been a drill-down analysis done for data that are publicly reported, Homa-Lowry warns. "So when you start presenting the numbers, sometimes that public data can be somewhat misleading," she says.

Before bragging about your results, be sure to do the analysis so you can let the data speak for themselves, says Homa-Lowry. "If you have done the drill-down and feel they are credible and reliable, then you may want to use them as a marketing tool," she says.

You also need to make sure the data are the most recent available, says Homa-Lowry. "In some of the reports, they are using MEDPAR data that could be old, and recent results may be much better," she explains, adding that organizations might not want to wait for the next run of the Medicare data if the results suggest problems.

For example, the results of the MEDPAR data can be the result of coding issues, which may result because the coders are dependent upon the documentation contained in the medical record to code. "Therefore, the data do not always indicate a quality-of-care issue, and the organization might want to show the improvements they have made or explain the data," Homa-Lowry says.

The organization may participate in other databases with different information and results concerning the issues reported in the MEDPAR data. This information can be used in response to the MEDPAR data reported, and in addition, the organization may have an opportunity to use data from previous years to show incremental improvement, Homa-Lowry says.

Regardless, there is a definite need for a strong relationship between marketing and quality staff, Homa-Lowry says. "I would certainly start having regular meetings with them and also get them more involved in the process," she says.

Tallahassee Memorial's web site (www.tmh.org) features a press release stating that the organization is rated by JCAHO as "above the performance of most accredited organizations" for heart attack care and ranked in the top 10% for inpatient mortalities for heart attack victims both statewide and nationally. Quality leaders were instrumental in putting together this campaign, says **Warren Jones**, the organization's chief communications officer.

"We worked very closely with the organizational improvement department," he says. "We look at this as an extension of our internal communications and how we celebrate successes, and transfer that outside the hospital."

As more information becomes public, you clearly want to have your marketing people involved so they are aware of the requirements and also keep current regarding potential risks, Homa-Lowry says. "For example, if the quality department becomes aware of a patient complaint from the Joint Commission or Medicare, eventually the marketing people will hear about it, but it would be better if there were an ongoing relationship so they can get together and discuss it beforehand," she says, because in many organizations, these are the individuals who prepare statements for the public in response to inquiries from the media. **(See related story on liability risks of publicly reported data, p. 165.)**

Often, marketing people have access to data sources that aren't necessarily consistently used in quality, such as the demographics of your community, changes in market share based on competitors,

and planning information, Homa-Lowry says.

"Usually, the quality people will get the DRGs in rank order and so forth, but it would be interesting to see how the community is changing — are you getting an influx of young people? What about physician practices in terms of competitors or new markets?" she says. "It's always helpful for the quality people to know that, because it can have an impact on how to prioritize quality issues."

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Consider risks of sharing quality data with public

Address your liability implications first

If your organization is ranked as having lower mortality rates for heart attack patients than any other hospital in your community, your public relations staff probably would want to jump all over this for their next promotional campaign.

Indeed, many hospital web sites now include press releases using publicly reported data to trumpet how they compare to competitors.

But what if the data presented are potentially misleading, due, for example, to differences in patient populations that affect outcomes?

There could be increased liability risks if the organization boasted that its care was safer and this is shown to be unfounded during a malpractice lawsuit, warns **James W. Saxton**, JD, chairman of the health care litigation group at Stevens & Lee, based in Lancaster, PA, and chairman of the American Health Lawyers Association's practice group on health care litigation.

Before using quality data in advertising and marketing campaigns, consider the potential impact on patient lawsuits, Saxton advises.

"We are in a crisis right now throughout the country, with medical liability rates literally driving physicians out of practice," he says.

Therefore, you must balance impressive-sounding quality data with maintaining realistic expectations, notes Saxton, adding that patient expectations right now are at an all-time high.

"Patients assume their providers will be able to cure their problems 100% of the time, that it's done with a smile and conveniently, and when that doesn't happen, that is often what drives patients to lawyers in the first place," he says. "When expectations are out of line with the reality of what is being delivered, we have a potential problem."

Attorneys are poised and ready to use any leverage they can, and that includes your organization's promotion of its comparative quality data, Saxton stresses.

"You need to understand that plaintiff's lawyers are downloading advertisements found on the web and in journals, are taking pictures of billboards that boast of this type of information, and are literally attaching this to the legal complaint they file and using it in the courtroom," he says.

"They literally blow them up the size of a movie screen and say, 'This is what this hospital told the patients in this community. Don't let them tell you that delivering anything less than that is OK,'" Saxton adds.

That type of evidence can be admissible despite the objections of defense attorneys, so juries can consider it along with everything else brought in as evidence.

"And it can be pretty powerful in the courtroom," Saxton explains. "Remember that you always get 12 patients on the jury, you don't get 12 doctors or 12 hospital administrators."

Take these steps to reduce legal risk:

- **Make sure the data are accurate.**

As a quality professional, you play a key role in ensuring that data are not easily subject to misinterpretation from the lay public.

"I think you have to be very careful that the spirit of what you are saying is not misleading," Saxton says. For example, saying that you give safer cardiac care may be a good sound bite, but an attorney can challenge that on a factual basis in court.

"A plaintiff's attorney may say, 'What was it about your organization that you felt was safer?' And if you mention the statistics, they will ask, 'Does that really mean that your hospital is safer for this patient than the health system down the street?' If the answer is no, could the jury get upset about that? Maybe it can affect your all-important credibility," says Saxton.

- **Balance boasting with realistic expectations.**

If you are proud of how you stack up against your competitor and have the data to prove it, it's not a bad idea to brag about it, says Saxton.

"I'm not suggesting that an organization shouldn't use this information for a marketing initiative, but you need to balance it with what I call 'expectation management,'" he explains.

Examples of this include patient education materials such as videos and brochures that explain the risks of medical procedures and a thorough informed consent about surgical procedures, says Saxton.

- **Collaborate with risk managers and public relations staff.**

As a quality professional, your input is essential before publicly reported data are used for a marketing campaign, since you know what will hold up under a microscope — and which statistics may fall apart upon closer inspection, advises Saxton.

"In the past, that collaboration is something that has not occurred, but clearly now that publicly reported data are becoming an important issue, quality professionals need to collaborate with public relations and marketing people," he says. "You will get a healthy tension between the two and will probably end up with about the right balance."

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Anesthesia awareness alert is call to action

Patients must be identified, counseled, referred

If an obviously upset patient told a nurse that he thought he remembered his surgery taking place, would appropriate steps be taken, or would the patient's complaint be dismissed or ignored?

Your organization needs effective strategies to prevent and manage anesthesia awareness, according to a new *Sentinel Event Alert* from the Joint Commission on Accreditation of Healthcare Organizations.

The alert gives recommendations for this underrecognized and undertreated condition, which affects an estimated 20,000 to 40,000 patients annually.

As a quality manager, you must help nurse anesthetists and anesthesiologists determine their roles in complying with the recommendations, notes **Jeffery Beutler**, CRNA, MS, executive director of the Park Ridge, IL-based American Association of Nurse Anesthetists.

"You need to lay out the process of how to prepare the patients for surgery ahead of time, so they know the risks associated with anesthesia, including awareness, what are people going to do during the procedure to prevent that from happening, and what to do postoperatively to identify any incidents of awareness," he says.

It is up to individual hospitals to determine how they will incorporate the sentinel event recommendations into existing procedures, but you should draw upon the expertise of anesthesiologists, recommends **Eugene P. Sinclair**, MD, president of the American Society of Anesthesiologists, also based in Park Ridge.

"Because there is wide variation in how awareness is defined, efforts that are adopted may be difficult to measure with any consistency," he adds.

Here are recommendations for management of anesthesia awareness from the *Sentinel Event Alert:*

- **Educate clinical staff on anesthesia awareness.**

"From a quality perspective, anyone providing anesthesia should have clear guidelines on what they should be doing to prevent awareness under anesthesia," says Beutler.

(Continued on page 171)

PATIENT SATISFACTION PLANNER™

Poor communication: Root of most patient safety ills

Change culture, improve patient satisfaction

A 54-year-old man presented to the emergency department (ED) with chest pain, and the emergency physician performed an initial evaluation, including an electrocardiogram and cardiac markers, but they didn't reveal a diagnosis.

As the doctor continued to work on his differential diagnosis, the patient was having problems maintaining his blood pressure, so the physician considered the possibility of a thoracic aortic dissection.

As a result, he took the chart and, according to him, notated in the order section that he wanted a computed tomography (CT) scan of the chest with infusion, and gave it to the clerk.

The order was not put in. The clerk said she never saw the order and didn't believe it was communicated to her. Two hours later, the patient was still in the ED and had not gone for a CT scan. The physician, upon realizing this, ran to the nurse and clerk to get the scan performed. The patient went down for a CT scan, and he died in the room.

In court, the emergency physician pointed a finger at the clerk and vice versa. The jury believed the clerk.

The verdict was more than $2 million, according to **Daniel J. Sullivan**, MD, JD, FACEP, president of the Sullivan Group, a consulting company in Oak Brook, IL.

As this example illustrates, poor communication in the ED can have dire consequences. In fact, poor communication between health care professionals is the root cause of nearly seven of 10 sentinel events, according to the Joint Commission on Accreditation of Healthcare Organizations, and nowhere is communication more critical than in the ED.

According to the Joint Commission, there were a total of nearly 500 sentinel events in 2003 and more than 400 in 2002.

"The ED is a high-stress, high-risk environment where there is not a lot of room for mistakes," says **Marc Taub**, MD, FACEP, chairman and medical director of the ED at South Coast Medical Center in Laguna Beach, CA, and director of team training for California Emergency Physicians, an emergency physician partnership that includes more than 600 emergency physician partners in California.

Taub points to the pilot, co-pilot, crew model. "No one can possibly know everything that's going on, so if there's not good communication between staff and nurse and physician, there will be things [the physician] will not know about," he says. The physician's decision-making ability and patient safety will be diminished, he adds.

Attitude important part of communicating

Attitude is an important component of communication, adds **Diana S. Contino**, RN, MBA, CEN, CCRN, a consultant with MedAmerica, an Oakland, CA-based medical practice support company for emergency services, and owner of Emergency Management Systems, a Laguna Niguel, CA-based consulting firm that specializes in staffing issues.

"A nurse will be reluctant to approach a physician who is unapproachable, and vice versa," she explains. "It makes them less likely to solicit information from one another."

Whether you communicate openly should not be an option in the ED, Taub says.

"You must open lines of communication and constantly work to improve," he advises. "Even when people have information they may not think is that important, it should be brought to the decision makers."

For example, a registration clerk might hear a patient mentioning a suicidal plan. "That information should be brought immediately to the physician or nurse caring for the patient," Taub says. "Don't assume they already know."

On the flip side, he says, decision makers should share what they're thinking and planning and ask for input from others.

"By communicating to others, it allows them be more proactive and helps you achieve your goals," he says.

Taub recommends that after seeing a patient,

physicians share their impression and treatment plan directly with the patient's nurse.

For example, a physician could say, "I saw Mr. Jones in bed 8, and I don't think he's having cardiac chest pain, but given his age and risk factors, I'm going to order a cardiac work-up. Any other thoughts or concerns?"

In addition, he says, it must be recognized that although physicians and charge nurses are the designated leaders, at any time, anyone may become a situational leader.

"For example, if multiple critical patients are in the ED simultaneously, a nurse or technician may need to step up to the plate and assume temporary leadership for a patient while waiting for the physician," Taub notes.

Better communication is built upon what Contino calls key tenets:

- Create systems that foster double-checks for verbal orders and clarification of written orders.
- Track and trend errors.
- Promote optimal communication through a multitude of channels.
- Hold people responsible for their interpersonal actions.
- To promote patient safety, remove blame and look for solutions.
- Give staff the tools to improve.

Principles such as insisting on open communication sound fine in theory, but how do you translate that theory into reality?

Taub's hospital and five others affiliated with California Emergency Physicians implemented a program called MedTeams, a teamwork training course from Dynamics Research Corp. in Andover, MA.

The course teaches teamwork principles, including communication, based on a model used in high-risk industries. The program is based on error reduction, teamwork, specific behaviors, and cultural change.

The course begins by recognizing human fallibility, Taub says. In this new paradigm, everyone is encouraged to feel confident and empowered to bring information forward. In this culture, "It is no longer good to have a hierarchy if patient safety is involved," he explains.

Two behaviors are key

Taub points to two specific behaviors he says have been instrumental in improving performance:

1. Interdisciplinary rounds or briefings.

Scheduled after each shift, these include physicians, nurses, registration, and anyone else who worked on the shift.

"The physician leads a quick briefing on all available information on each patient, as well as logistics, such as are we on diversion, bed issues, and so on," Taub explains.

"It's like a preflight briefing." And, he notes, no pilot would ever take off without a preflight briefing.

2. Conflict management.

"You want to get away from notes like 'Doctor so and so was aware . . .'" Taub explains. "If you have a concern, go to the physician and voice the concern.

"We give staff a specific script to voice concerns, and as in aviation, if the concern is not answered, we have a double-challenge rule; you can go back a second time." he adds. ■

Shift bidding: Hospitals see boost in staff morale

Lower vacancies result; substantial savings seen

A number of hospitals across the country have found they can drastically reduce the cost of staff salaries, while at the same time ensuring full nursing shifts, through shift bidding. This on-line vehicle also has been shown to boost staff morale while improving patient care and satisfaction.

While it varies from facility to facility, shift bidding basically works like an "eBay in reverse." Available shifts are posted on-line, and interested staff can bid for them.

A starting hourly salary is listed, and staff can bid a lower wage if they want, to win the shift.

"It has allowed us to communicate staffing needs much more clearly to staff, allowed staff to put in more time if they elect to do so, and to have more control over when they decide to do it," says **Christine McCarthy**, MSRN, nurse recruiter at St. Peter's Hospital in Albany, NY, one of the recognized pioneers of shift bidding. "It also decreases frustration and anger levels, as there is no forced overtime."

"We see it as an enhancement of our ability to staff our units," adds **Anne Davis**, vice president of workforce at Sharp Healthcare in San Diego, which uses an outside vendor called BidShift to

conduct its on-line auctions.

"We know our nurses pick up extra shifts outside of Sharp, so we've tried to find ways to keep staff within our company. If we have our own staff pick up an extra shift with us, they know our policies and procedures and how to take care of our patients better than anyone; there's a whole lot less room for error," she notes.

Kathy Whelchel, RN, vice president of nursing at Spartanburg (SC) Regional Medical Center, sees another benefit. "We found a productivity issue with agency nurses," she asserts.

"They are not your employees, and they do just what they need to do to make it work. For the most part, they are not team players."

The whys and hows

St. Peter's started its program in 2002, recalls McCarthy. "Like everyone else, we were looking at high vacancy, loss of staff to agencies, and travel because of perceived convenience and a higher pay rate; and the nursing shortage did not help replace people when they left. So we decided to look at how to keep our own staff here."

One of the hospital executives noted that he bought all kinds of things on-line by looking for the best price.

"So we decided to kick that idea around," she continues. "We have a very talented IT [information technology] department, so we had a webmaster and another individual work with nursing administration and human resources." After about a year, the program went live.

They began with their own staff, with managers providing information as to who was qualified for specific units, and then held informational sessions for staff.

"We fiddled around until we got a product that was easy to use on the manager's part, easy to use on the nurse's part, and finally developed a methodology to bring people in from the outside and put them through an orientation that met the same quality indicators as our staff; and they eventually came on staff themselves," McCarthy explains.

This helped to gradually enlarge staff, through newspaper ads and e-mail exchanges.

The St. Peter's system works like this: The manager reviews the schedule, then decides to put shifts on the site to let people know there are openings.

People responding must meet the qualifications necessary to work on that unit (i.e., educational requirements, certifications).

If respondents are qualified, they are allowed to access the calendar. "We give them a salary range, and they put in what they want to make," McCarthy adds.

The negotiation starts between the manager and the nurse. For example, the manager can call and say, "I got your bid, but I also got three lower bids; do you want to stay in the game?"

Spartanburg Regional was another early adapter, after reading about the experience at St. Peter's.

"Our COO and I were in a regular management interview; and he said, 'I wish we could do this to help get the agencies out,'" Whelchel recalls.

"We found out that what St. Peter's was doing was proprietary, so we met with IS [information systems] and personnel, and the guy from IS got real excited," she says.

The programmer stayed up all that night and wrote the entire program for Spartanburg Regional.

The program is similar to St. Peter's — nurses have to meet basic competencies to bid for a shift. It went live in August 2002 and proceeded very slowly at first. "We sent a letter to every RN's home but only sold 12 shifts in the first three weeks; then, all of a sudden, it was up to 35 a week," Whelchel adds. "Now, we've sold as many as 250 a week."

Agency nurses are a thing of the past

There is no agency nursing left in the system today, although at one point, the facility was using up to 54 full-time equivalents through agencies.

A newly added module has self-scheduling for the flow pool. Managers post the schedule, and the person goes on-line and fills in when he or she wants to work.

"This has totally changed how we do the flow pool," Whelchel notes. "If a shift is not selected, it goes into auction. We put out six weeks of schedules at a time; so if a shift is not picked, the managers can know four weeks ahead if they need to bid it out."

Additionally, Spartanburg Regional now has a quick-pick module, through which nurses can guarantee they get the shift they want by immediately accepting the stated wage.

At Sharp, not only do nurses bid for shifts, but

also nurse assistants, respiratory staff, and physical therapists.

Soon radiology staff will participate as well. Otherwise, the BidShift program, which was initiated in September 2002, is similar.

"The nursing units fill schedules as normal, and any open shifts not filled typically go to our large resource pool; those not filled are posted to BidShift," explains **Angela Athis**, director for the staffing resource network.

"Nurses have the ability to log on and view what is available. They see the wage we have posted, and they can take it, but then someone else can come on and take it for less," she says.

More money, more flexibility

The health care professionals using shift bidding cite a wide range of benefits, but perhaps the most significant is the boost in staff morale and the ability to make more money while saving the hospital money at the same time.

"There's no mandatory overtime; people make choices," McCarthy points out.

And while the nurses can make more than they would on overtime, "the costs to the hospital are absolutely less than when they used temp nurses," she says.

"There's probably a minimum 20% difference between agency fees and those bid on-line. We do expect the people bidding to make more than they would otherwise," McCarthy notes.

While agency use is way down at St. Peter's, she stresses, "We want to keep good relationships with the agencies."

Nonetheless, it is an advantage to have the open shifts filled by your own staff, she says.

"They are on board with the mission and philosophy and how that is carried out in patient care. Someone from the outside may not know all the resources available to them; and if they feel frustrated, they may show that to patients and family.

"We have found that patient satisfaction has improved [since the system was implemented]." The vacancy rate also has vastly improved, McCarthy notes.

Athis has had similar experiences. "Before we went live, we conducted focus groups with our RNs," she recalls.

"To a person, they all said they preferred not to work with outside agency nurses, because it took time to orient them and then to follow up. We think this has been such a savings of time and has increased the quality of people who come to our unit," McCarthy explains.

As at St. Peter's, the posted rate on bid shifts is higher than what all the nurses make on an hourly basis (about $10 an hour more), but less than Sharp would pay to outside registries. "

I know we have filled close to 3,000 shifts, and they would have gone to outside registries," Athis says.

Whelchel sees similar financial results. "Our average wage for an RN is around $23 an hour, and an agency nurse costs around $50. On shifts bid for, we average around $35 to $37."

She adds, however, that bids have gone as low as $27 for the more popular units and shifts.

Again, however, this is not the greatest benefit. "It completely changes how staff feel valued by the system," Whelchel notes.

"You give $50 to that agency, and they think you give that to the nurse, who they perceive as not working as hard, and that builds resentment. This takes them out of the equation, and lets our nurses choose when, where, and what to work. They came through for us and covered shifts, and we got the agency out," she says.

As for the hospital, "We are able to cover shifts with people who want to be at work," Whelchel explains. "And in terms of patient satisfaction, that is *huge*. You see it in demeanor at the bedside; if you want to be somewhere, you are happy, and it shows."

Vacancies go down and morale increases

In the past, she notes, even though the hospital never had mandatory overtime, "We had to beg, and people were tired."

Vacancies today are way down, she reports. "In 2002, our high might have been 104, and now we are probably at 30 today," Whelchel says. Other departments, she adds, have begged to be included in the program.

Davis sees another major benefit. "I sit on a lot of patient safety committees, and as we have our own staff working here, they will clearly know what those efforts are about, what our resources, policies, and procedures are; and that puts our patients at far less risk.

"It also unburdens the nurses on the unit, because when you have outside registry nurses, a lot of that burden falls on those nurses. So we now have a safer, less stressful environment, and that improves quality all the way around," she adds. ■

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You need to ensure that the individual doing preoperative counseling is explaining to patients the difference between a general, regional anesthetic, and local anesthetic with sedation; and as part of the informed consent, they need to be told there is a possibility they will have recall, Beutler says.

"Fortunately, it's very rare; and most of the time when it does happen, it's things that are normal, such as when waking up at the end of a case and somebody is doing an extubation," he adds. "But if you don't explain that to the patient, they don't know it's normal."

- **Ensure appropriate postoperative follow-up of all patients who have undergone general anesthesia, including children.**

"You need to be sure whoever is doing the post-anesthetic assessment of the patient is asking the right questions in the right way," Beutler says. "In the past, a lot of people have ignored this issue because they were afraid of planting an idea in a patient's head."

Beutler recommends standardizing the questions for this assessment, and asking patients: "What is the last thing you remember before you went to sleep?" "What was the first thing you remembered when you woke up?" and "Do you remember anything in between?"

"By asking these questions, you are able to elicit any immediate recall they might have," he says.

- **Identify patients who have experienced awareness.**

In addition to postoperative assessment, your organization should do a sample assessment after discharge, Beutler recommends.

"If a patient does have recall, they may not remember it right away. It may not show up for several months," he explains.

Therefore, a sample of patients should be surveyed three or six months after surgery on at least an annual basis to determine if any have had recall that they did not have previously, Beutler says.

"You don't have to do that with every patient, but this sample would at least give you a sense of whether you have a problem at your organization," he adds.

- **Provide necessary counseling for patients who are experiencing post-traumatic stress syndrome or other mental distress.**

Any patient who reports an episode of anesthesia awareness should be treated with respect and compassion, Sinclair emphasizes.

"Patients who have stress or anxiety over recalling parts of their surgery can often be substantially relieved by discussing their experience with their anesthesiologist and other health care professionals," he adds.

"For those patients who need more help, we recommend that counseling be offered," Sinclair notes.

Post-op follow-up is important

In addition to anesthesia providers, you should work with other providers who will be seeing the patients postoperatively, including the post-anesthesia care staff, surgeon's offices, and diagnostic physicians and their office staff, so when patients return for postoperative visits, signs and symptoms of an awareness event can be identified, Beutler says.

"The problem is: Many times, we are not finding out about this until the patient is several weeks or months out of the hospital," he adds.

"Their memory starts coming back about what happened; but by this time, they are out of the system. They are probably not under the care of the surgeon anymore, and they may not even know where to get the help that they need," he explains.

Give providers specific directions for how to get help for these patients, and how to prevent and treat the ensuing post-traumatic syndrome that sometimes is associated with awareness, Beutler advises.

"That is a major focus for the Joint Commission," he points out.

"Certainly, prevention is important to them, but if it does occur, does the organization have the right people and processes in place to get appropriate help for the individual? That is equally important," Beutler adds.

[For more information on anesthesia awareness, contact:

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- ***Eugene P. Sinclair**, MD, President, American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Phone: (847) 825-5586. Fax: (847) 825-1692. E-mail: mail@asahq.org.]* ■

Coming patient safety law will have dramatic impact

Legislation a powerful tool to change culture

If a devastating medical error occurred at your organization, would all the involved parties feel free to discuss the circumstances candidly and openly? Too often, the answer is no, and with good reason, says **Jeffrey Driver**, chief risk officer and director of the risk management department at Stanford (CA) Hospital & Clinics and president of the American Society for Healthcare Risk Management.

"The bottom line is — practitioners are not comfortable disclosing anything. They live in this world of fear," he adds.

After one prominent surgeon disclosed a medical error to the state, the matter quickly turned into a "shame-and-blame game" during the ensuing investigation, Driver recalls. "The physician said to me, and I will never forget it, 'I will never report another error to you.'"

Even with heightened awareness about the importance of nonpunitive reporting of medical errors, retribution still is common, he says. "In many cases, nurses are attacked by the state when they report errors; and even now, we still have hospitals with very punitive approaches to medical errors," he says. "This discourages disclosure and makes people just want to hide things."

If enacted into law, the Patient Safety and Quality Improvement Act, recently passed by the Senate, would allow health care errors and serious events to be reported in a voluntary and confidential manner, without the threat of legal repercussions. "This legislation is huge — it creates a national safe space for us to explore medical error and do something about it," Driver says. The House of Representatives passed a similar bill in 2003.

The legislation would establish a system for reporting and analyzing health care errors and adverse events in an environment that is free from blame, allowing individuals to explore why errors occurred and how to prevent them from occurring again, he notes.

Most states have peer review laws that protect communications of physicians but often do not provide for the same protection for other individuals such as nurses or quality professionals.

"The problem is that we are relying on state confidentiality and peer review laws to help each hospital and group of physicians to look at how quality can be improved, but it's done in an environment of fear," Driver says. "You've got all this variability between the states, and some have very little protection."

The law would allow for medical errors to be reported to a single national database with complete confidentiality instead of the patchwork of databases that currently exists, such as Joint Commission on Accreditation of Healthcare Organizations' Sentinel Event reports, state health departments, the Institute for Safe Medical Practices, and other private initiatives, he adds.

"This will reduces barriers to reporting, so we will have a very rich database. Then experts can make sense of the data and turn them into information that we can all use," Driver points out.

[For more information on the patient safety legislation, contact:

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You'll soon need to update your PPR every year

Start using the tool for ongoing PI

As of Jan. 1, 2006, the Joint Commission on Accreditation of Healthcare Organizations will require your organization to complete or update its periodic performance review (PPR) once a year, as opposed to every three years. Does this sound like an additional burden for your already overworked staff? If so, you may not be using the PPR as you should.

The goal is to encourage organizations to use the PPR on an ongoing basis as a quality improvement tool, says **Darlene Christiansen**, RN, LNHA, MBA, director of the JCAHO's standards interpretation group in the office of quality monitoring. "We need to move away from the idea that this is a seen as an episodic evaluation, because that's what the issue is right now," she says. "The PPR should be used as a continuous

management tool in organizations integrating accreditation standards into business operations."

Instead of looking at the PPR as a "once every three years" requirement, the tool should be updated continually to determine which areas are in compliance and which still require improvements, says Christiansen. "If we live and breathe this and use it as a tool embedded in our performance improvement and risk management systems and update it on a regular basis, then the point of submission on an annual basis becomes a nonissue," she says. "It's just a matter of pushing a button because the tool is already updated."

Organizations are moving rapidly in that direction, Christiansen reports. "It has been difficult for them because the PPR hasn't been available on a continuous basis," she acknowledges. "They will now be able to update their plans and measures of success, and give other staff access to that tool, too."

Continuous access to the PPR tool becomes available to organizations as of Jan. 1, 2005.

If your organization uses Option 1, in which the organization performs the midcycle self-assessment but does not submit information to JCAHO, you still will have the ability to work on the PPR on an ongoing basis on JCAHO's extranet site, but nothing from your working tool will be transferred back to JCAHO, Christiansen notes.

"This provides an educational tool to continually assess compliance with the standards and elements of performance [EPs]," she explains. "Through using that tool, it encourages ongoing compliance with the standards, supports continuous operational improvement, and facilitates a continuous accreditation process."

If your organization chooses Option 1, you also can submit hypothetical situations due to concerns about discoverability. "We have built into our system a way to dialogue about what-if situations, to see if your plans would meet the intent of the standards," she says.

However, organizations will receive the full benefit if they choose to submit the full PPR, which is sent back with comment and approvals from the standards interpretation staff on established plans of action and measures of success, Christiansen explains.

"The positive side of choosing to complete a full PPR is that the organization can openly discuss any standards or EPs that are not fully compliant, and then get an approval of their plan of action and measures of success that is actually documented on the tool," she says.

As of Jan. 1, 2006, when you submit the PPR tool, you also will be required to submit a short summary statement listing the top issues you have addressed, if they were corrected, and what other areas you are working on.

Trend toward full PPR

Organizations are going to become more comfortable submitting the entire PPR, predicts Christiansen. As of June 2004, 61% of organizations that accessed the PPR tool chose to submit their findings via the Joint Commission's on-line tool, while 32% chose Option 1; 6% selected Option 2, in which the organization undergoes a midcycle on-site survey; and less than 1% selected Option 3, in which the midcycle survey is performed, but no written documentation of the survey is left with the organization.

Christiansen points to JCAHO's rollout of its Sentinel Event policy several years ago, when organizations were given several options and alternatives for evaluating their root-cause analysis (RCA), including sending a surveyor to the organization or having designated individuals from the organization come to Chicago to review their follow-up. "At that time, we had received a flurry of information that organizations would not feel comfortable because of the concern over discoverability," she says.

The Joint Commission now is seeing a significant increase in the percentage of organizations that are sending in the complete RCA, Christiansen reports.

Organizations have become more comfortable with the sentinel event follow-up process over time, and the same thing is expected with the PPR, she says. On an annual basis, organizations will have the chance to change their selection for the following year, she notes, but you must do so within 30 days of submission of your selection choice for that year.

"So if in January 2006, I select Option 1, but my attorneys have said, 'After this year, you can go ahead and do the full PPR.' Within 30 days of that submission, I need to let JCAHO know that in 2007, I'm going to do the full PPR," Christiansen adds.

"What I've been encouraging organizations to do, once the tool becomes continuously available to them, is go back in and address the tool in smaller areas, such as provision of care one month and the medical staff chapter the next, until you can build that tool back up again and assess all the standards," she says.

Many organizations already have processes built internally to go back in and complete the updated tool, Christiansen notes.

"When new standards come out, at this point, we are anticipating that it will be an organizational responsibility," she says. "The reason for that is that we don't want to surprise the organization by adding something to a document they are currently working on." ■

THE QUALITY - CO$T CONNECTION

Move from measurement to data intelligence

Addressing the value of measurement

By **Patrice Spath**, RHIT
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The subject of health care performance measurement has to date focused on two main topics: What should be measured and how to design efficient measurement systems. The first issue is concerned with making choices about what to measure and how to measure it. The second issue deals with the measurement framework and data collection process. While these two issues are clearly important, it is now time to address the value of measurement. The problem is that performance data are worth nothing unless they are acted upon. People must use the data intelligently to manage and improve performance.

Health care quality professionals must take a leadership role in developing robust measurement systems that add to the knowledge of the organization's leaders and staff members. New tools and techniques are needed to help people be better managers through measurement.

Insights must be extracted from the data and these insights communicated to those in a position to make changes.

How can quality professionals help ensure measurement influences action and positive results? There are some simple yet powerful techniques for making measurement more valuable.

CE *questions*

This concludes the CE semester. Fill out the enclosed evaluation form and return in the envelope provided. When your form has been received, a certificate will be mailed to you.

21. Which is recommended to reduce liability risks of using publicly reported data as part of a marketing campaign?
    A. Delete all reference to quality data in advertisements.
    B. Balance expectations with patient education materials and informed consent.
    C. Use the most impressive data available, even if they are potentially misleading.
    D. Allow public relations staff to select data to feature without involvement from quality professionals.

22. Which is recommended to prevent and manage anesthesia awareness?
    A. Give preoperative counseling only to high-risk patients.
    B. Never ask patients if they recall anything during surgery.
    C. Standardize the postoperative assessment questions.
    D. Avoid following up unless patients have immediate recall of events during surgery.

23. Which is accurate regarding the Patient Safety and Quality Improvement Act?
    A. Health care errors would be reported without the threat of legal repercussions.
    B. The law would protect physicians, but not nurses.
    C. States would determine who is covered by peer review protection.
    D. Medical error reports could no longer be anonymous.

24. Which is recommended for completing the periodic performance review?
    A. working on the tool only once a year
    B. using the tool to ensure continuous compliance
    C. updating the tool only before submission and not before
    D. avoiding submitting the complete tool to the Joint Commission

Answer Key: 21. B; 22. C; 23. A; 24. B

- **Reward improvements, not measurement.**

In too many health care organizations, people spend their time justifying why performance is as it is rather than explaining how things are going to improve. Data put people on the defensive. Rather than acknowledge improvement opportunities, managers will use performance reports to explain why everything is just fine. Why is it that in performance reports, people spend most of their time justifying why performance is as it is? They come to the table armed with excuses.

"We are only at 70% of our target because too many of our staff have taken vacations this month." Such discussions, which focus on why performance is as it is, are irrelevant, or at least relatively unimportant in comparison to those discussions that focus on how the department is going to get to where it wants to be. In organizations that reward improvements, not merely measurement, excuses become irrelevant. What matters most is how people are going to achieve ever better performance. The organization's performance improvement plan should place more emphasis on reporting strategies for improving performance than on reporting actual measurement results.

- **Seek answers, not data.**

Why do people get drawn into justifying past performance rather than planning for performance improvements? A significant reason is that far too often committee meetings are structured as performance reviews, not planning sessions. It is very common for committee members to simply present raw performance data with an expectation that people will analyze the data on the spot. Nobody in advance of the meeting has been through the data and extracted the messages they contain. People are given mortality rates by service, staff turnover data, and other performance measurement results, and they are expected to make sense of this numerical jigsaw puzzle.

Committee members spend their time trying to draw correlations between differing sets of data to identify unacceptable performance or offer explanations for unusual occurrences.

To change this situation, committee members should define the specific performance questions that they want answered prior to the meetings. Department managers and quality professionals should come to committee meetings armed not with raw data or excuses, but instead with data presentations that address questions of fundamental concern to the committee, e.g., are we going to hit our patient satisfaction targets for this year, how closely are we complying with congestive heart failure guidelines, have our patient falls decreased from the previous year's rate, etc. The committee's role then is to probe the quality of the analysis and once the members are comfortable with it, decide what they are going to do to move performance in the desired direction. By changing the focus of performance reports, committees involved in performance evaluations can begin to eliminate the defensive behaviors associated with performance reviews and encourage creative dialogue aimed at performance improvements.

- **Build performance analysis capabilities.**

Moving to a focus on improvements rather than measurements requires that managers, including quality directors, upgrade their performance analysis skills. As performance analysts, people need to not only to be able to manipulate performance data but also interpret them and present them in a way that engages and provides insight to others.

Think of a performance analyst as a journalist. A journalist not only presents a story, but he or she also very carefully identifies the hook or

COMING IN FUTURE MONTHS

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headline that will capture the reader's attention and then flush out the detail in the small print. This is how performance reports should be presented. Rarely do people really analyze data before presenting them. Instead, all of their time is spent collecting and collating data.

This issue becomes even more important in a complex organization such as a health care facility. The reality is that performance is the result of multifaceted interdependencies between departments and functions.

Nursing performance relies on materials management as well as other services. Laboratory performance relies on nursing functions as well as transport and other services. Yet when it comes to measurement, these interdependencies are often ignored. Nursing looks at the nursing functions. Laboratory looks at the laboratory functions, etc. It is as if health care organizations have functionalized measurement, just as everything else is functionalized.

- **Identify the big picture.**

Yet the reality of a health care organization is that the activities being undertaken in different parts interact, and this interaction must be recognized if we are to get the most from performance measurement data.

This is where analysis comes in. Quality professionals, the keepers of performance data from the many different functional areas, are in the best position to identify the bigger picture — the story of what actually is happening within the organization. Prior to committee meetings, quality professionals should sit down with the committee chair and go over the performance data.

Like a journalist, the quality professional should bring up improvement opportunities and interrelationships with the committee chair. Armed with this information, the chair now can use the performance report at the committee meeting as a starting point for discussing plans for improvements. The agenda item is no longer merely a presentation of a numerical jigsaw puzzle that people rarely have the time to piece together.

To enhance business intelligence, quality professionals must help the organization set up systems to acquire, share, and analyze performance information of all kinds, from the data derived from record reviews to customer satisfaction results.

The ability of an organization to gather and effectively analyze performance information is a major step in the journey toward performance excellence.

CE objectives

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

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

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A fundamental concept is that of "intelligence," which is different from "information." Intelligence is actionable information — data turned into knowledge that is actually used for something. ■

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