Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JULY 2005
VOL. 12, NO. 7 • (pages 73-84)

Medicare P4P demonstration project shows significant QI

Participants improve in all five clinical areas over three-year period

Quality of care has improved significantly in hospitals participating in a groundbreaking Medicare pay-for-performance demonstration project, according to preliminary reports from more than 270 participating hospitals on their experience during the project's first year.

Called the CMS/Premier Hospital Quality Incentive (HQI) Demonstration Project, after its partners, the Centers for Medicare & Medicaid Services and Premier Inc., a health care alliance entirely owned by more than 200 of the nation's leading not-for-profit hospital and health care systems (a total of about 1,500 hospitals), the initiative tracks hospital performance on a set of 34 nationally standardized and widely accepted quality indicators and pays annual incentives to top performers among participating hospitals.

To date, four quarters of preliminary data have been gathered, which show median quality scores for hospitals improved:

- from 90% to 93% for patients with acute myocardial infarction (AMI);
- from 86% to 90% for patients with coronary artery bypass graft (CABG);
- from 64% to 76% for patients with heart failure;

Key Points

- In demonstration project, Medicare offers bonuses based on how well hospitals meet quality measures.
- Median performance composite score for all hospitals was up 7.5% in project's first year.
- Incentives may not have been the only reason for improvement, observers say.

- from 85% to 91% for patients with hip and knee replacement;
- from 70% to 80% for patients with pneumonia.

The median performance composite score for all hospitals — just one measure of improvement — went up 7.5% in the project's first year. A number of individual hospitals scored impressive results. For example:

- Nineteen hospitals improved their quality score for care of heart failure patients more than 30%.
- Eighteen hospitals improved their score for care of pneumonia patients by more than 20%.
- Seventeen hospitals improved their score for care of hip and knee replacement patients by more than 15%.
- Twenty-one hospitals improved their AMI score more than 12%.
- Sixteen hospitals improved their CABG score more than 10%.

In addition to overall improvement in quality scores, the variation in quality of care among participating hospitals is narrowing as all hospitals are demonstrating improvements. This means the gap between top performers and lower performers is shrinking.

Hospitals participating in the project cared for more than 400,000 patients in the five conditions during the first year. During the course of the three-year demonstration project, which began in October 2003, Medicare will reward high performers with bonuses totaling $7 million per year for a total of $21 million. Poorly performing hospitals may face financial penalties in the third year.

Under the Premier demonstration, a hospital can receive bonuses in its Medicare payments based on how well it meets the quality measures. Hospitals are scored on measures for each condition, and those in the top 10% for a given condition will be given a 2% bonus on their Medicare payments for that condition. Hospitals in the second 10% will be given a 1% bonus. Hospitals in the remainder of the top 50% get recognition for their quality, but no bonus.

At the end of the first year, baselines will be set for the bottom 20% and the bottom 10%. These levels remain static, and CMS and Premier expect that all hospitals will be above the baselines by the final year of the demonstration. If any hospitals are below the 10% baseline in the third year of the demonstration, they will get a 2% reduction in Medicare payments for the clinical area involved, and those between 20% and 10% will get a 1% reduction.

Sponsors pleased

Not surprisingly, both CMS and Premier are pleased with the results to date. "We were hoping and expecting that the provision of incentives would serve to enhance quality," says **Mark Wynn**, PhD, CMS' director of the division of payment policy demonstrations. "I think we are all delighted we've seen such immediate and good improvement in the quality of care provided as measured under the demonstration project. Our focus is on improving quality for Medicare beneficiaries, and we can see, at least in this initial test, that paying for performance can move quality in the right direction," he notes.

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $539. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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Closer look at project scoring

The CMS (Centers for Medicare & Medicaid Services)/Premier Hospital Quality Incentive Demonstration Project's overall composite score is calculated by combining the process of care and outcome measures, including mortality and complications, from five clinical focus areas.

The clinical focus areas are acute myocardial infarction, coronary artery bypass graft, heart failure, pneumonia, and hip and knee replacement surgery.

Premier collects, processes, and reports data for the project through its Perspective clinical comparative database. The data remain preliminary until CMS completes a rigorous auditing and validation process.

While the preliminary data reveal significant improvements in all focus areas, the most dramatic improvements were seen in indicators reflective of care provided to heart failure and pneumonia patients.

For all hospitals participating in the project, the overall quality score for heart failure, which includes assessment of heart function, provision of detailed discharge instructions, and appropriate use of selected medications, improved 12%.

Similarly, the overall quality score for pneumonia care, incorporating indicators such as assessment of patients' oxygen status and selection and implementation of appropriate antibiotics in a timely manner, improved 10%. ■

"The results have been absolutely outstanding," adds **Stephanie Alexander**, MBA, senior vice president with Premier. "The participating hospitals were already using data to improve and were performing at higher quality levels than other hospitals, but when I looked at the first quarter of data and began tracking them, it's just amazing that the whole group in aggregate really moved forward."

Of course, cautions Wynn, "We're not going to prove the whole concept until we finish our evaluation, but the initial numbers are so dramatic so far, it appears true that the incentives and the focus surrounding these incentives are the reasons for the improvement."

He adds, however, that the incentives may not have been the *only* reason for the improvement, but that they are a means of focusing on important quality improvement issues. "I think both the Medicare program and the participating hospitals are all focusing on QI to the extent possible and that this project is giving a meaningful focus for these efforts," Wynn says. "We find from our initial discussions with the hospitals that they use this as a motivating focus to really drive their QI work."

Assessing impact of P4P

Alexander says she's convinced that the P4P arrangement contributed to the quality improvement at participating hospitals. "We have quite a few health systems, and some came in with all of their hospitals, while others did not.

"One of them showed us that those who were in the project were performing better than those who [were] not. The project creates a sense of urgency and focus, and bringing this group together to focus on improvement brought results that much faster," she explains. **(For more on Premier's interpretation of the results, see box, at left.)**

Clearly, numerous structures are being used within the broad category of "pay for performance." What does Alexander think of this particular model? "I think there are absolutely some very good parts to this structure from which to move from a national pay-for-quality model to a pay-for-performance model," she notes, making an important distinction.

"This only measures effectiveness of care — in the future, we will focus both on effectiveness *and* efficiency. The other challenge we have is that we must find a way not just to incentivize physicians or hospitals but to incentivize them as a team together. That's a fundamental flaw in our Medicare system today — there are two different payment structures," Alexander points out. **(For one participant's view of this model, see related article, p. 76.)**

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- Comprehensive information about the CMS/Premier Hospital Quality Incentive Demonstration Project is available at www.qualitydemo.com and on the CMS web site at www.cms.hhs.gov/quality/hospital.

"The point is, these are not huge increases," Wynn notes. "But even with these limited amounts of money, it's helping to focus the attention of these hospitals and CMS on these improvements. We will have a web site on which the winning hospitals are prominently displayed, and hospitals are really interested in that."

He adds that the Bush administration "is very interested in evaluating and pushing on pay for performance," and that to that end, the results of the project will be forwarded to the appropriate administrator. ■

Pay-for-performance programs continue to proliferate

According to a new national study, the number of pay-for-performance (P4P) programs nationwide has increased sharply since 2003.

In its 2003 study, Med-Vantage, a health care informatics company in San Francisco, identified 35 P4P programs and predicted that number would double by 2006. Med-Vantage's new study, released last month, indicates that by November 2004, the number of P4P programs had risen to 84, covering 39 million beneficiaries, and by March 2005, the number had increased to 104. According to the report, "Based on continuing health plan and employer interest, as well as emerging new sponsors, Med-Vantage predicts that the number of P4P program sponsors will almost double again from 84 [2004] to 160 by 2006."

According to the study, current trends in P4P include "the emergence of the Centers for Medicare & Medicaid Services as a P4P market driver" and "growing interest in using P4P performance results for public reporting to consumers."

The executive summary of the report is available at www.medvantageinc.com. ■

For this hospital, money is secondary

Memorial Health System in Springfield, IL, one of the participants in the CMS (Centers for Medicare & Medicaid Services)/ Premier Hospital Quality Incentive (HQI) Demonstration Project, certainly will not be disappointed when it receives the financial incentives it stands to earn through improved quality.

However, says **James R. Bente**, RN, MBD, vice president of quality and organizational development, that was not the prime consideration for participating in the project.

"When I became aware this was under way, I took it to our entities and said, 'I think we want be part of it' — not so much for reimbursement, though that was well received, but for transparency and to be in a cohort of other organizations that are also striving to be better than they are today," he says. "When CMS launched the program, we probably sent our confirmation the same day they announced it, making us the first in the nation to get involved."

For Bente, this was the next logical step in a long journey for the system, a multifacility organization with three hospitals — a flagship 550-plus bed tertiary receiving facility (Memorial Medical Center) and two critical access hospitals — and four other health care service entities.

"As a health system, we've made a commitment toward performance excellence and safety and translated that into very meaningful perspectives, such as a performance excellence model," he explains. "Quality means reduced variation, safety, preventing harm, and clinical effectiveness — providing evidence-based care. When we looked at the demonstration project, we also set as a goal for ourselves to be a Baldrige-level performer by the end of the decade."

But for his five years at Memorial, Bente says he is most proud of the system's transparency to itself and to its patients. "As things have evolved with looking at different indicators, there has been a tremendous convergence — CMS, JCAHO [the Joint Commission on Accreditation of Healthcare Organizations], and so on — around some very similar diseases as they collaborated and agreed they were interested in many of the same things," he notes. "This really got me excited. Out of that came Voluntary Hospital Reporting by AHA [the American Hospital Association], and now the Hospital Quality Alliance."

As a result, Memorial became one of the first systems to agree to public reporting of such measures as acute myocardial infarction (AMI), heart failure, and pneumonia. "Otherwise, we would not have been transparent," Bente notes.

Pride a big motivator

Bente says that Memorial did not really adjust its approach to quality as a result of the project.

"We were already working very diligently on a

lot of these things," he explains. "But our doctors are data-driven and outcomes-focused; we showed them that we had data from other hospitals that were among the better performers. By showing them we were part of this elite group . . . we could compare ourselves to the best. That stirs a sense of pride."

And Memorial did, in fact, see significant improvement. "There were a couple of areas that really stood out more than any others," Bente says. "Our performance in door to antibiotics for pneumonia, for example, rose from 70% to in excess of 85%; that was huge. Another big area was the starting of preoperative prophylactic antibiotics. We saw improvements in all surgery areas from the 60s and 70s to virtually 100%."

Does Bente think the P4P factor had an impact on hospital performance? "To me, it could be an outgrowth [of the incentives], which is a nice thing to have at the end of the day, but if you focus on that as a driving factor, it will be a mistake," he asserts. "To make these changes, it really does take two major things: Have the goal you want to achieve — and you must be focused around the patient. Plus, you have to have the right culture in place."

Model is attractive

Bente is, however, a supporter of the model used by CMS. "I do like this model, and here's why: It's very simple and very straightforward," he says. "Anyone can understand it — there are no hidden 'black boxes.' I know that The Leapfrog Group has done one, and it is weighted differently for different indicators — which I can see intellectually. *Should* they be weighted differently? That's a great question."

The answer for now, he says, is probably not. "You start to introduce some degree of cynicism in the process, and people ask who decided these weights — and once somebody has any question about methodology, you diminish the ability to use a tool effectively with a broad range of audiences," Bente explains.

"This way, it is a simple denominator/numerator thing. When you look at all the indicators, you just add all the numerators and denominators and divide for the score. It is this straightforwardness and comparativeness that gives the demonstration project its strength," he adds. ■

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Premier cites key lessons of project

Premier has conducted site visits with top performing hospitals to document best practices and share them with other participants and the rest of the health care industry. These site visits have revealed that the improvements necessary to achieve top performance need not be onerous, expensive, or dependent on technology.

Key lessons learned to date include the following:

- **Leadership and culture are critical:** The top-performing hospitals make quality of care the core value of their institution and compete in the marketplace on quality. Quality is the priority of the executive team, which actively engages physicians in the process of quality improvement. These hospitals prioritize the implementation of best practice methodologies and dedicate resources to ensure their success.
- **Clinicians need to be engaged in actively harvesting and disseminating best practices:** Clinicians need to be engaged in quality improvement activities guided by improvement methodologies and change theory, based on valid data. Established, evidence-based best practices are quantified and documented, and collaboration forums are used to exchange real results. Top performers actively implement these practices and track progress over time.
- **A focus on process improvement is key:** Effective improvement strategies begin with evaluation and improvement of care delivery processes; the state of technology infrastructure is not necessarily a barrier to process improvement. Simple solutions such as posting signs on operating suite doors stating "Stop. Has pre-op antibiotic been given?" can lead to significant improvements in outcomes. Improving ineffective processes, regardless of technological sophistication, has led to significant quality improvement among the diverse hospitals participating in the project. ■

Culture change is critical part in improved outcomes

Underscores opportunities for improvement

Children's National Medical Center in Washington, DC, has made significant improvement in its clinical outcomes through benchmark utilization. For example, it has been able to reduce infections by 55% in post-op ventricular peritoneal (VP) shunt infections and has achieved an 82% reduction in 180-day readmission rates.

But none of that would have been possible without first successfully engendering a hospital-wide culture change, says **Kathy Chavanu**, RN, MSN, executive director of quality and clinical support services.

"We'd been doing benchmarking since the late 1990s; I think we needed to start looking at our data from more of an external perspective, to see where we were in the market area," she recalls. "But [it wasn't optimized] until we really took hold of our culture and integrated benchmarking fully, to where the clinicians were fully engaged, which was about 2001-2002. This culture shift was emphasized by our CEO and by our VP of patient services."

Education critical

Education was a critical component of the culture change, Chavanu says.

"A lot of education had to happen around the benchmarking tools we were using," she recalls. "We needed to establish trust of the data with clinicians. They are used to seeing 'P' values, so when they don't see them you need to demonstrate the integrity of the data before it is believed."

That was made easier through leadership buy-in, Chavanu adds. "We integrated benchmarking into our quality program, and we had some clinician champions. Once we were able to do that, with the help of a dedicated data manager, we were able to demonstrate to the clinicians how benchmarking could be used in their clinical practice."

Another important step was to establish a set of guiding principles, she explains. "One of those said we would use benchmarking from a patient safety and quality perspective, and *then* look at things like cost and increased revenues. That was a very important message for our clinicians to hear, as they had been hearing so much about cutting costs in recent years."

Key Points

- Fully integrating benchmarking helps make clinicians fully engaged.
- Guiding principles put safety and quality ahead of cost savings and revenue increases.
- Benchmarking data help earn trust and business support of high-volume payer.

To address the need to improve clinical quality and efficiency, Children's used the Pediatric Health Information System (PHIS), from the Child Health Corp. of America in Shawnee Mission, KS.

That system gives them access to information from approximately 40 other children's hospitals. "It contains a wealth of information — about 10 million patient visits," Chavanu notes.

Using PHIS, Children's is able to benchmark anything from utilization measures to outcomes, she explains. "You can examine data such as what percentage of the hospital's surgical procedure patients had infections," she observes. You can also call up comorbidities and mortalities, Chavanu adds.

"For starters, we mined our database; and through that mining, we were able to prioritize initiatives," she notes. "We focused on diagnoses and processes of care, and within diagnoses, how we could use benchmarking to leverage ourselves with payers. More recently, we have even used it for R&D."

Infection rates tackled

When the staff initially examined their PHIS data, "as related to infection rates, we were below the average," Chavanu recalls. "We also recognized our 180-day readmission rate was higher than average." The infection rate team, led by a neurosurgeon and operating room nurse director and supported by a multidisciplinary group and the data manager, decided to reduce the infection rate by 50%.

"The team looked at all of the opportunities for improvement," she reports. "With close coordination between the OR and the nursing staff, we adjusted the timing and change of antibiotics and improved surgical prep changes, such as double-gloving in the OR."

As a result, Children's achieved the previously

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mentioned 55% reduction in post-op VP shunt infections, as well as an 82% reduction in the 180-day readmission rates.

In another initiative made possible through benchmarking, Children's is repositioning itself with payers in terms of diabetic care. "Five years ago, we had one particular high-volume payer who felt we did not provide efficient care, so when their patients came to our ED, they would send them to another hospital," Chavanu adds. "We used the PHIS data, created a new clinical pathway, and now have one of the lowest lengths of stay for diabetic care in the country." (Their LOS dropped from 2.75 days to 1.5 days, while seeing an increase in volume of more than 136%).

As a result of this improvement, she says, "That same payer came back to us and told us that we provided such efficient care that they'd like to contract with us for regional diabetic care." ■

Sudden jump in VAP spurs QI to cut rate to near zero

New mouth care processes at heart of solution

Sometimes, as a quality manager, you can be proceeding with the confident assurance that you "are doing everything right" when it comes to a cohort of patients, when suddenly your data give you an uncomfortable wake-up call.

That's precisely what happened at Coral Springs (FL) medical center several years ago.

"I noticed in 2002 that we had had a severe increase in VAP [ventilator-assisted pneumonia] compared to 2001; it went up by 70%," recalls **Ava Dobin**, RN, BSN, CIC, the facility's epidemiology coordinator. Dobin, who has been at the facility for 19 years, "follows every single patient infection."

"We were most astounded by the increase in infection," adds **Robin McElligott**, CHCQM, LHRM, the quality manager at Coral Springs.

The good news is that a quality department-based team swung into action, and in the past three years, there have only been three cases of VAP — and those were in long-term patients who ultimately survived.

How did Coral Springs make such a dramatic turnaround? With one major process change: the introduction of a device that allowed them to brush ventilated patients' teeth three times a day.

Identifying the source

The answer to the problem may seem simple at first blush, but many steps had to be taken to first identify the source of the problem and then subsequently determine the best solution.

"We formed a team through our quality department," Dobin explains. "It included physicians, infection control, respiratory therapists, the critical care manager, a quality specialist, and even our customer relations coordinator. Our goal was to find out why the infection rates were going up."

"Once the problem was identified, they brought the PI team proposal to the quality council," McElligott adds. "At that time, it was approved for the team to actually form. Then I joined the team, and we went through process improvement."

That included just-in-time training to get the team reoriented to any tools it might be needing, including cause/effect diagrams, control charts, and so forth.

"We also checked out all the best practices," Dobin notes. "We usually comply with CDC [the Centers for Disease Control and Prevention] guidelines, but it seemed like we were doing what we were supposed to do."

So she determined to sit in patients' rooms and watch everything the caregivers did. "We wanted to see if it was hand washing, or not using antibiotics quite enough," she says. "What I found, in

Key Points

- New device allows staff to brush ventilated patients' teeth three times a day.
- Just-in-time training for teams includes reorientation to cause/effect diagrams, control charts.
- Benchmarking data helps earn trust, business support of high-volume payer.

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working with the manager of critical care, is that there was a missing piece."

And just what was that missing piece? "Not everybody was doing mouth care, and when they *were* doing it, they were all doing it differently," Dobin points out. "Some people were swabbing the patients' lips a bit with glycerin to keep them from cracking, but that was about it."

Finding the solution

As part of the PI effort, "We pulled all the research we could find on mouth care when patients are on ventilator," she continues. "We found mouth care could play a role; when the bacteria in a patient's mouth gets swallowed, it can lodge in the lungs and cause pneumonia."

Further research identified two vendors who had products for cleaning the mouth. "We even tried to make our own, but the home-grown product did not work very well," Dobin points out.

So the staff tried the two products, and the nurses ultimately preferred the device from Sage Products Inc. of Crystal Lake, IL. "It includes three different packages for the morning, afternoon, and evening nurse," Dobin explains. Each package includes a Yankauer connection to the ventilator, so the patient can remain on the ventilator without breaking open the system and contaminating it. "This way, we are able to brush the patients' teeth three times a day without ever taking them off the ventilator," Dobin explains.

"The most interesting lesson we learned," says McElligott, "Is that the people closest to the work are the ones you should ask how to improve a process. The staff who initially were brought in reviewed a lot of the literature themselves, and one nurse tried developing the prototype herself." This was facilitated, she says, by that fact that the critical care manager "empowers her staff to be very proactive in problem solving."

Since the inception of the program, she continues, the facility has not had a single mortality.

The new regimen has now been instituted in all of the hospitals in the North Broward Hospital District. "Districtwide, we project savings of $4 million a year in patient infections," McElligott notes. "And, patient stays will be much shorter; VAP usually causes an additional 16 to 17 days of hospitalization." ■

Education earns high comparative AMI rankings

Improvement spurred by desire to 'be the best'

For some quality teams, being good is just not good enough. That was certainly the case at Providence Hospital, part of the St. John Health System in Southfield, MI.

"We were always good, but we wanted to be the best," recalls **Shukri David**, MD, chief of cardiology, who was a key member of the team that has earned the hospital high rankings in quality improvement for acute myocardial infarction (AMI) as compared to the state and country by the Centers for Medicare & Medicaid Services (CMS).

Today, the facility ranks well above the state and the nation in the following measures:

- percent of heart attack patients given beta-blockers at discharge;
- percent of heart attack patients given beta-blockers at arrival;
- percent of heart attack patients given aspirin at discharge;
- percent of heart attack victims given aspirin at arrival;

Key Points

- Initiatives enable facility to gain high rankings in five clinical measures.
- Even though physicians know what they should do, reminders still are necessary.
- Physicians who are not compliant with new pathways are talked to by department chairs.

- percent of heart attack patients given adult smoking cessation advice/counseling.

Years of work

David says the efforts began about four years ago, when the hospital adopted new clinical pathways.

"We conducted a 100% view of cases coded AMI," adds **Cheryl Pistolesi**, RN, CCRN, performance improvement coordinator.

"Since then, the Joint Commission [on Accreditation of Healthcare Organizations] has required core measures to be submitted, and we also submit them to the national system, Ascension Health, to our local system, St. John Health, and the Blue Cross-Blue Shield Center of Excellence [program]," she notes.

To successfully conduct these benchmarks, David explains, "we needed to identify key leaders to help us get the message out. In a hospital as large as ours [460 beds], we really needed to involve a lot of people and touch many different departments."

This was necessary, he explains, because AMI patients often are exposed to multiple areas of the hospital. "We started out with physician champions — designated doctors for each area," David says. These areas included the emergency department, the cardiology and cardiac care units, as well as general cardiologists on the floors.

The next step, he says, was to sit down with physicians and educate them about why they needed to fill out all the hospital forms.

"While they all knew these patients needed beta-blockers, they still needed to be reminded," notes David, adding that these patients can come in at all times of the night and early morning and may be admitted, for example, by interns. Accordingly, the team gave lectures on the appropriate subjects and demonstrated that the data showed the efficacy of the drugs indicated on the forms.

"These physicians also incorporated our residents," Pistolesi adds. "We used family practice and the department of medicine to disseminate all education to our residents."

This was done annually as part of their ongoing education, she explains. "It helped heighten awareness of what we measure, why, and so on," she says.

The forms themselves represented significant modifications over pre-existing forms, David notes. "Eventually, we standardized them across the system, but it was an evolutionary process that took several years," he says. "Now, patients in all areas get the same service."

David points out that for physicians who assert they already know what they need to do, he responds: "So do pilots, but they still need a checklist, and there is a certain minimum we need to do; we understand we are only human, so we need a way of checking what we do."

The forms, Pistolesi adds, are constantly being re-examined "to bring the bar up." If the hospital is performing in the 95th percentile, she notes, "We want to know how we can get to 100%."

Making real changes

St. John is carrying its philosophy into other areas of care to create significant improvement in heart attack management.

"For example, our cardiac cath team has to live within 30 minutes of the facility and be here within 30 minutes [of being called]," David says.

"One big problem nationally is that 92% of hospitals can't activate their cath team in 90 minutes. But we now have a '24/7' team, and we have them hooked up, for the first time, to our EMS services with cellular phones that are able to transmit EKGs to the ER. Once the data come across and it looks like a heart attack, the team is activated," he says. The first six cases using this new system saw the patient treated in less than 60 minutes, David reports.

St. John also has local targets for the aforementioned indicators. "For example, when [AMI] patients hit the emergency room door, they get aspirin," he notes. "Our target is 99%, and we are at 99%. If the patient doesn't receive aspirin, you really need to document why. For beta-blockers, our target is 95%, and we are at 98% to 100% most of the time."

"We look at the data on a weekly basis," says Pistolesi. "As it is being imported into our system, we are getting a running summary, so we have opportunities to concurrently look at cases and see where we can improve." To do that, the appropriate team is brought together and it works through its PI process, she explains. "For example, I handle the ER and cardiology."

The key to ensuring that improvement is ongoing, according to Pistolesi, is "keeping the staff motivated and constantly providing feedback showing their rate of compliance. It has to be on their 'dashboard' at all times and in front of them. When the gauges start to read a little bit of concern,

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we need to examine why through PI."

"We have used the 'stick' approach as well," David adds. "As we've been able to refine the process, if physicians are not compliant with these pathways, they get talked to. We have not yet limited their admitting privileges, but when they receive a call from the department chair, it makes a big difference." ■

NQF endorses HCAHPS patient perception survey

Results will be 'public and comparable'

The National Quality Forum (NQF), a private, not-for-profit, public benefit corporation in Washington, DC, established in 1999 to standardize health care quality measurement and reporting, has endorsed HCAHPS (Hospital Consumer Assessment of Health Plans), a 27-item survey designed and developed over the past three years by the federal Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ).

The new voluntary consensus standard — representing the consensus of more than 240 health care providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality improvement organizations — is a means to collect and publish meaningful data on how patients view the care they receive in hospitals.

"We considered the HCAHPS survey under expedited review; we did not consider any other survey," says **Philip Dunn**, NQF's vice president for communications and public affairs.

"The federal government asked us to do so because it had spent years developing this, and as a final step to get stakeholder input, the government asked us to put this through expedited review," he explains.

The survey includes 22 questions addressing seven domains of hospital care:

- communication with physicians;
- communication with nurses;
- responsiveness of hospital staff;
- pain control;
- communication about medicines;
- cleanliness and quiet of the environment;
- discharge information.

It also includes five demographic questions (used for patient-mix adjustment and other analytic purposes).

Other specifications include sampling, survey administration, survey and patient-mix adjustment, and reporting.

"As originally submitted to NQF, the survey contained only 25 questions," Dunn notes. "Our steering committee, composed of 20 members across all stakeholder groups, put two back in." The two questions were: "Were you treated with courtesy and respect by your physician?" and "Were you treated with courtesy and respect by your nurse?"

"There was concern among steering committee members that this was a particular area of concern among patients," he explains.

Patients and providers affected

As survey results will be reported publicly, it is anticipated they will be used by consumers in making decisions when choosing a hospital. Such reporting clearly will affect hospital performance as well, according to NQF officials.

"The most commonly cited expected use of HCAHPS by patients would be to help them choose hospitals, because they will have comparable information on what other people think of these hospitals," says **Elaine Powers**, vice president of programs for NQF.

Key Points

- Communication one of the key considerations in majority of care domains.
- National Quality Forum steering committee reinstates two questions dealing with courtesy and respect.
- Quality managers should use poor scores to identify opportunities for improvement.

Need More Information?

For more information, contact:

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"I expect, though, that many patients may also use HCAHPS results to actually try to affect their own hospital experiences. For instance, you may go to your local hospital regardless of its HCAHPS results, but if you know that other patients rated the hospital poorly in addressing pain, it might prompt you to have a really detailed conversation with your doctor about how to make sure you get adequate pain control," she continues.

Public and comparable

As for hospitals, Powers continues, "The issue is less about having new information — most hospitals already do some kind of patient surveys in order to inform their internal operations.

"What's new here is that the results of those surveys are not generally public. The fact that HCAHPS results are both public and comparable across hospitals may cause hospitals to refocus their internal quality improvement efforts, to make sure they're getting at the aspects of care that HCAHPS evaluates [and consumers will be able to see]," she adds.

Dunn agrees. "The purpose of a standardized survey of this nature is to standardize information across institutions and over time, so consumers and purchasers can accurately gauge how other consumers feel about the health care that they received.

"If 'Anytown General' scores well on these surveys, and 'Anytown Memorial' across the street does poorly, then residents of Anytown will likely conclude there's got to be a good reason for that," he explains.

This has implications for quality managers as well, Dunn continues. "Hospitals themselves can use these results for their QI efforts.

"If they notice they are getting poor scores in a certain area, the quality manager can seek to understand why and target their improvement efforts accordingly," he adds.

Dunn says he is not sure about the timeframe for implementation. "What I do know is that a cost-benefit analysis is being done by Abt Associates [of Cambridge, MA], to determine what the financial burden and benefits of collecting HCAHPS survey information will be," he says.

Dunn says he anticipates that ultimately the survey results will be posted at www.hospitalcompare.hhs.gov, a web site developed by CMS to help consumers compare the quality of care hospitals provide. ■

JCAHO releases its 2006 safety goals

The Joint Commission on Accreditation of Healthcare Organizations has published the 2006 National Patient Safety Goals and related requirements for each of its accreditation programs and Disease-Specific Care certification program.

The goals and requirements, approved by its board of commissioners, apply to the more than 15,000 Joint Commission-accredited and certified health care organizations and programs.

Major additions to this fourth annual issuance

COMING IN FUTURE MONTHS

- ■ JCAHO's 2006 National Patient Safety Goals: Implications for quality managers
- ■ How to develop a more holistic approach to critical care delivery
- ■ Study: HIPAA actually may hinder efforts to improve quality of care
- ■ Computerized medication systems alone do not eliminate medication errors
- ■ Identifying key stakeholders and team members for process improvement

of National Patient Safety Goals include a new requirement in all of the programs that hand-offs of patients between caregivers be standardized, with particular attention to assuring the opportunity for asking and responding to questions. This requirement is part of the goal: "Improve the effectiveness of communication among caregivers."

In addition, a new requirement for all types of accredited organizations that provide surgical or other invasive services specifies that all medications, medication containers, and other solutions used in perioperative settings are to be labeled. This requirement is part of the goal: "Improve the safety of using medications."

To access the new goals, go to the Joint Commission's web site: www.jcaho.org. ▼

JCAHO revisits emergency management standard

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is asking health care organizations for feedback to its proposed revisions to its emergency management planning standard.

The revisions would require organizations to undergo more thorough planned emergency management drills to better gauge their ability to function during a disaster, such as a bioterrorism attack.

The revisions apply to ambulatory care, office-based surgery, behavioral health care, critical access hospitals, hospitals, home care, and long-term care accreditation programs.

Some of the proposed revisions require:

- realistic planned test scenarios related to the priority emergencies identified in the organization's hazard vulnerability analysis;
- measurable performance expectations established by the organization to be used during planned tests to evaluate the timeliness and quality of core performance areas, such as event notification, communication, resource mobilization and allocation, and patient management;
- a person not participating in the test to monitor performance and documents variation from established measurable performance expectations;
- organizations to critique completed tests through a multidisciplinary process that includes administration and clinical staff, including physicians and support staff;
- organizations to modify their emergency management plan in response to critiques of tests;
- planned tests to evaluate the effectiveness of improvements that were made in response to previous test critiques;
- the strengths and weaknesses of performance during tests to be communicated to the multidisciplinary improvement team responsible for monitoring environment-of-care issues. ■