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Are handoffs too 'automatic'? QI experts fear errors could rise

Completing checklists without thinking can present safety challenge

When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) speaks, people listen. That was certainly the case when it began to issue its National Patient Safety Goals; health care professionals sat up and took notice and immediately began designing processes for complying with the new standards.

Things change quickly in today's world of patient safety, however, and some quality improvement experts are beginning to note a disturbing new trend; medical staff are still going through the same steps to comply with standards such as hand-offs, but a number of them are doing so without really thinking about what it is they are doing — or, as one quality expert put it, "something that is done so automatically that people aren't really paying attention to the issues they are supposed to be evaluating." This had led in some cases, they say, to errors being made even though staff indicated the processes were followed.

"We're beginning to hear the same current of conversations amongst ourselves," notes **Cheryl Como**, RN, senior vice president of patient services at UPMC (University of Pittsburgh Medical Center) McKeesport (PA). "This is a trend; we've heightened everybody's awareness, and things were good for awhile,

Key Points

- Since errors have not been eliminated, additional controls must be considered.
- Have a clinician from another department serve as your "second set of eyes."
- Reformat your checklists to draw staff attention to key sub-processes.

but now problems seem to be surfacing again. We have done the strategies, but we have not eliminated error. When you study errors that occur, you see the staff went through the motions but were not really aware."

"There's an argument made out there that when you standardize processes — like here, where we use standardized order sets — there's value to it, because often you begin with common elements," adds **Doris Gaudy**, RN, senior director of patient services at UPMC McKeesport. "But as people engage in that kind activity day in and day out, that's what leads them to go through the motions and take their 'brain' out of the process."

"I think that's the case with anything that becomes routine," offers **Judy Homa-Lowry**, president of Homa-Lowry Consulting in Metamora, MI. "For example, someone who goes to church regularly may read the same thing they've read many times before and yet 'be somewhere else.'"

A 'second pair of eyes'

The good news is that quality experts are aware of this potential problem, and are already thinking of ways to heighten quality assurance in hand-offs and other patient safety processes.

"We know some very smart people who have their eye on quality all the time, and their knee-jerk reaction is that we may need someone else to come in and do last-minute checks — somebody not involved in the case," suggests Como. "For example, in the OR, people who are not involved in that room can come in and look at the processes afresh."

Homa-Lowry agrees. "It might help to bring other clinicians in," she says. "Or, you can bring consultants in, who may be more likely to see the forest for the trees. Their knowledge base may be the same, but if they are not part of the process, perhaps they can see things better."

Another option, suggests Homa-Lowry, is to engage someone from another department who isn't even a clinician. "Why not use an environmental care worker? They're just doing a separate check sheet to see if you went through the process correctly; you just need someone who is competency-trained. And if you rotate them, that person will not get complacent."

It's important, she continues, for that person to make sure everyone is participating actively in the process. "That would be part of the role of someone — to assume that leadership and make sure they clearly ask [questions of] everyone in the room," Homa-Lowry observes. "You really are supposed to have input from everybody in the room."

Carleen Penoza, RN, MHSA, clinical informatics specialist at William Beaumont Hospital in Royal Oak, MI, agrees. "One of the key things we felt was important was that we wanted to bring in all the clinical people — including transporters — who touched the case; we did not want to skip over somebody in the handoff process," she asserts. "If the patient was sent to radiology, you didn't just deal with radiology. A key piece is to include everybody in that transport process."

Whatever approach you take, the key is "to

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ensure communication is there," says **Peter Angood**, MD, vice president and chief patient safety officer at JCAHO. "The Joint Commission set the national patient safety goals as just that — we don't get too prospective of how institutions should do it. When the surveyors come through the hospitals they look for indicators of how the hospital is managing the process — not necessarily the specifics."

Ensure communication

So, how can quality experts best manage those processes? Angood offers several suggestions. "The use of the airline industry model, which is crew resource management, is seen to be very helpful in controlling system-oriented checks and balances," he offers. "Other types of systems that put in place the same sort of things are Six Sigma and Toyota lean processes; those have been implemented and shown some success."

The main components of such systems, he explains, are a routine, standardized process and open communication between each of the team members. "If there is a deficiency, then any one of the team members is able to flag it and stop the process," Angood notes.

SBAR, or Situation-Background-Assessment-Recommendation, is another "reasonable tool" for managing processes, he adds. "There is a variety of process and flow industry tools trying to be applied to health care; they are all meant to routinize things," he says. **(For more on SBAR, see "SBAR initiative to improve staff communication," HBQI April 2005, p. 40.)**

Como says her facility has been taking a close look at SBAR. "It's the kind of communication that keeps the brain engaged — where you follow the process and think about it every step of the way," she notes.

Gaudy agrees. "If you use SBAR as a methodology for communication, if done correctly it forces you to think about what you want as an outcome of your communication," she asserts.

Ensure communication

Health care experts agree such approaches can be helpful, although not always directly translatable to health care.

"In the airline industry, the pilot and co-pilot go through a checklist," Gaudy notes. "Somehow in that industry they are able to keep their brains engaged and not go through the motions. That's one of the missing pieces in health care."

Homa-Lowry thinks she knows why. "What they do [in the pre-flight checklist] is different, in that they literally have to press the button and say the word – like 'flaps on'" — she observes. "You can't just look at a light and say 'Okay.'"

You can also sharpen the concentration of your staff by making specific adjustments to the actual forms you use, says Penoza. "One of the things we are doing is trying to use human factors in making the checklist usable, where you can quickly get the data you need up front," she says. "The first version we used was not as nice looking, and your eyes did not necessarily go to the answers of the questions."

Her team actually conducted some studies, says Penoza, and then looked at compliance. "If something was not directly in a line they were skipping it," she reports, noting that part of the formula for success is how you physically lay out your checklist.

"Another thing we try to minimize is leaving things too open-ended," Penoza continues. "We seem to do better if staff can check a box."

For example, she recalls, in the original forms, if a patient diet was NPO (nothing by mouth), the "diet" area on the checklist was blank. "What are we really trying to get at?" Penoza queries. "Are they NPO or not? If so, since when?"

Keep it interesting

"Even though you have a check sheet, you may want to look at varying the order so it's just not so routine," adds Homa-Lowry. "Otherwise, your staff can become rote and complacent. You want to still cover all the same things, but vary the process in which it was done to keep it more interesting."

Gaudy offers this final thought: "As we move forward in health care, things are moving at the speed of light," she observes. "Oftentimes, we try to implement things for the sake of doing them — for example, because JCAHO says we should. But I am a firm believer that you have to take the time to implement things correctly, and your staff has to be well educated."

It's critical, she continues, that your staff clearly understand why the things you are asking them to do are important. "Not everyone always understands these processes that way," she asserts. "Take the time to implement processes in the right way, because you know you can fully engage your staff that way."

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Stroke program wins first Codman award for DM

Minimizing variance through staff training

The Joint Commission on Accreditation of Healthcare Organizations has named Swedish Medical Center in Seattle, WA, the winner of the inaugural Ernest Amory Codman Award in the disease-specific care category, for establishing a comprehensive program that deploys a coordinated team to assure comprehensive, timely, and efficient acute stroke care.

The program, initiated in 2001, has:

- reduced the mortality rate by 12%-16% from 'already low' levels;
- reduced the cost of care significantly;
- cut average length of stay by 1.4 days;
- improved patient satisfaction;
- performed in the top 10% nationally in compliance with American Heart Association guidelines for stroke care.

"The program was started to bring into Swedish Medical Center advances in diagnostic testing and therapy that had been going on in some leading institutions in the country, but which for the most part had not percolated down to most medical centers," explains **William Likosky**, MD, medical director for the Stroke Program at Swedish Medical Center. "The idea was to offer guideline-driven care to all patients — not just to some patients whose doctors might be familiar with the guidelines."

The reality, says Likosky, is that most patients with stroke are admitted by someone who admits perhaps one or two stroke patients per year. "Therefore, there is a lot of variability in the doctor component; the same could be said for the nursing component, and the nursing unit component," he asserts.

Key Points

- Most staff who admit stroke patients have limited experience treating such cases.
- National guidelines are readily available from heart, stroke organizations.
- Measuring outcomes, focusing on processes are keys to program's success.

Tools readily available

The good news, says Likosky, is that the tools necessary to achieve his goal were readily available. "The American Heart Association (AHA) and the American Stroke Association have been producing recommendations for care over the past five or six years," he notes. "These are very good guidelines, available for the taking, with regard to treating ischemic stroke, intra-cerebral hemorrhage, who might benefit from thombolytic therapy, and so forth."

Along with these guidelines, he continues, you must have certain structures in place to ensure the desired outcomes. "You have to train people; you also have to have a CT scan available '24-7' with trained personnel, and units organized to take care of stroke patients," he asserts.

So, each nurse received eight hours of training in key areas such as the swallow screening (developed by Swedish Medical), deep-vein thrombosis prevention and urinary tract infection prevention.

"They were trained to the point where you could not be admitted by a nurse here who was not trained in this," says Likosky.

The actual providing of care was restricted to three or four units, he continues. "We instituted the guidelines and assured they were followed."

As for the physicians, a stroke team was developed from among those physicians who specifically wanted to take care of stroke patients. "We provided literally hundreds of hours of available training," says Likosky. "For example, everyone is trained and certified in the NIH stroke scale."

He notes three key areas that have contributed

to the program's success. "We have measured our outcomes using the AHA's 'Get with the Guidelines' database," he says.

"This is marvelous — it defines the processes of care and allows you to compare your performance with others. This way, you are actually benchmarking against some of the top institutions in the country."

The second component is the use of the Dartmouth Compass of Outcomes. "This is a way of looking at the relationship between quality of care, cost of care, and staff enablement in patient satisfaction," Likosky says. "Quality is very much related to training of staff; the better trained they are, the better your quality becomes. At the same time, if you watch expenditures — i.e., if people are not in the hospital as long, if they are treated more quickly – you will also improve quality."

Third, the facility employs the "bundles of care" concept developed by the Boston, MA-based Institute for Healthcare Improvement. "This is based on the concept that if you want to minimize error, you must know how many processes need to be done, because your most likely errors are errors of omission," Likosky asserts. "So, if you have 100 processes of care, you need to know who's responsible for each of them."

Of course, he points out, these processes can be interdependent; for example, you cannot plan a discharge properly if the respiratory therapist has not let you know when the patient can leave. "We developed contracts, so that each of the processes is assigned to a group, and that group does the process each time," says Likosky. "However, they have the right to ask other groups for what they need in order to do their jobs correctly."

Finally, he adds, compliance is tracked regularly. For example, the program ensures that stroke patients receive expedited evaluations in less than 45 minutes when warranted.

"We have a nurse practitioner at the bedside virtually instantaneously, who works with the physician to immediately then create a plan of evaluation and therapy — all of which is fully in place within two hours," Likosky notes, adding that "If we get all the guidelines right, we are less likely to have errors."

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Michigan P4P program given high grades

Seven RWJF grantees honored

Since it's one of the oldest incentive programs in the country, it might not come as a big surprise that Blue Cross Blue Shield of Michigan was among seven Robert Wood Johnson Foundation "Rewarding Results" grantees selected to highlight its successes in pay-for-performance programs during a National Press Club briefing on November 15 in Washington, DC. **(See related story, page 7.)**, but the results it has have achieved to date are nonetheless impressive.

Consider the following:

- rates of patients receiving aspirin upon arrival were 95% at incentive hospitals, compared with 91% nationally and 90% for non-incentive hospitals;
- patients at discharge counseled to take aspirin were 96%, compared with 86% nationally and 85% non-incentive;
- patients receiving BETA blockers upon arrival were 93%, compared with 83% nationally and 80% non-incentive;
- patients prescribed BETA blockers at discharge were 96%, compared with 84% nationally and 80% for non-incentive;
- patients receiving a left ventricular function assessment (a determiner of blood flow through the heart) were 93% compared with 78% nationally and 75% at non-incentive hospitals;
- patients prescribed ACE inhibitors at discharge were 82%, compared with 74% nationally and 67% at non-incentive hospitals.

The program, which builds upon nationally recognized quality measures used by the Joint Commission on Accreditation of Health Care Organizations, currently focuses on three areas:

Key Points

- Program focuses on quality of care indicators, patient safety, and community health.
- Facilities can potentially receive incentive of up to 4% of hospital inpatient DRG payment each year.
- Program is not static; as performance data is accumulated, the "bar" can be continually raised.

quality of care indicators, patient safety, and a third component that rewards hospitals for programs that target the health of their local communities, particularly in reducing tobacco use and encouraging physical activity and nutrition.

"It was becoming increasingly apparent to everyone in the health care community that there was a gap between actual and optimal quality," explains **David A. Share**, MD, MPH, clinical director of the Center for Health Care Quality and Evaluative Studies at Blue Cross Blue Shield of Michigan. "Practices pertaining to medication known to achieve better outcomes were not being uniformly adopted, along with other practices known to improve patient experience and outcomes, so we decided to focus on these areas by selecting performance indicators generally accepted to be relevent, in hope of increasing the hospitals' focus on those issues and developing resources for system changes for improve performance." Currently, he notes, 60% of a hospital's score is based on quality, 30% on patient safety, and 10% on community programs.

The incentive program actually was initiated in 1989 — "Well ahead of the pack," notes Share. Its focus for the first 10 years, he says, was on rewarding hospitals for low-risk, non-acute cases and days. "But that eventually became a non-issue," he notes, and in 1999 the organization partnered with the Michigan Health & Hospital Association (MHHA) to develop a revised hospital incentive program, which was implemented in 2000.

How the program works

The program as currently structured includes a master contract called the "Participating Hospital Agreement," or PHA. The MHHA and Blue Cross Blue Shield partner on administering that contract, which includes explicit mention of the PHA incentive program. "One of its parameters is the potential to receive [an incentive of] up to 4% of hospital inpatient DRG payment in a given calendar year," says Share. "That's based on performing at 100% on all of the indicators."

For example, the contract used JCAHO/CMS core indicators for heart attacks — i.e., the use of BETA blockers after an MI. "In 2000 when we began the program, the statewide average was 81%; in 2004, it had risen to 96%, and at that time the national average was 84%," Share notes. "Clearly, there was a pretty intense focus."

The program is not a static one, he adds. "For example, in patient safety, if a hospital had an ICU, we provided an incentive to be in the Keystone project," he relates. (The Keystone Intensive Care Unit Project is a joint effort of the MHHA and Johns Hopkins University.) "So at first, you were rewarded for just being in it. Once there was a baseline, however, we raised the bar by basically tying it to actual performance on measures like ventilator-associated pneumonia [VAP]."

Significant value for quality managers

Both VAP and catheter-related bloodstream infections dropped dramaticaly in the Keystone project, he adds, "And I'd like to think the incentive made them participate — because it was not cheap," he emphasizes.

Qualitative evaluations of the engagement of the hospital community also have been conducted, Share observes, which indicated a significant value in such programs for quality managers. "These involved everyone from CEOs to physician leaders to QA directors; we had independent folks interview them," he reports. "What we repeatedly heard was that QA directors and some of their staff told interviewers the PHA incentive program was responsible for the CFO getting to know their names and phone numbers, and to actually call them up and ask questions about performance. Many made sure they had the necessary resources to improve performance, because there were dollars on the line."

The boards of many participating hospitals now get regular reports on performance on quality indicators, says Share. "Some are even tying CEO incentive pay to performance on these measures — so, as you can see, they get quite engaged," he emphasizes.

Many challenges remain

Despite the success of his program, says Share, there are still a number of remaining challenges for P4P. "One challenge is defining the ROI (return on investment)," he says. "There is a whole science in evaluating these programs, like which influences are causal and which just happen at the same time in the marketplace. Generating valid, generally comprehensive evaluations is a newly emerging challenge."

Quality indicators, surprisingly, also offer a challenge. "Everyone agrees on indicators pertaining to areas of care where there is scientific

certainty of optimal care, but that's only 15%-20% of all care given," he claims. "Many other areas are highly technological, rapidly evolving, and the evidence base is not so clear. There are many areas of surgery, for example, with new technology, so how do you measure quality when you can't define it properly?"

Issues such as these are being addressed in Michigan by creating collaborative quality initiatives. "We are getting hospitals together in consortia to pool comprehensive clinical information so we can do risk-adjusted studies for links between process and outcome, see what is a best practice, then implement them statewide," Share explains.

In other words he says, these erstwhile competitors must "Leave their guns at the door, stop competing on quality and start collaborating," Share asserts. "This pretty dramatically increases the rate of QI," he continues. "We've done it in angioplasty and shown a 27% decrease in mortality. This demonstrates that the process works, and now we are expanding into cardiac surgery, weight loss surgery, breast cancer care, general and vascular surgery."

The goal, he says, is to transform systems of care across a wider area. "Then, hopefully, we can incorporate what we learn into a more modernized incentive program," he concludes.

P4P can improve quality, proponents say

Programs achieve results through incentives

Pay-for-Performance programs can improve both medical care and quality of life by giving health care providers a financial incentive to seek measurable improvements in the health of their patients, it was reported in a November 15, 2005 National Press Club briefing in Washington, DC. The findings were the combined result of seven experimental projects designed to test a variety of pay-for-performance models (P4P). Known as the Rewarding Results program, the three-year effort is both the largest and most diverse of its kind.

According to the findings, through use of incentives, the Rewarding Results projects have:

- significantly increased patient visits to the doctor for everything from adolescent check-ups to diabetic screening among privately insured and Medicaid patients;
- prompted physicians and physician groups to embrace information technology and electronic medical records at a faster pace;
- increased the numbers of patients who receive annual mammograms, well-check ups, and other preventive screenings;
- motivated physicians to monitor patient care more aggressively, particularly for chronically ill patients.

The projects "provide some of the first tangible evidence that P4P incentives can raise the quality of patient care," said **Suzanne Delbanco**, CEO of the Leapfrog Group, the organization providing technical assistance to the projects, which are supported by grants from the Robert Wood Johnson Foundation, the California HealthCare Foundation, and the Commonwealth Fund.

Despite their achievements, however, the report noted these projects are still grappling with:

- working out what size financial rewards are needed to effect change;
- how to engage physicians continuously in quality improvement activities linked to P4P;
- whether the return on investment and the quality gains outweigh the financial and human effort;
- how to sustain improvement with adequate information technology and other infrastructure;
- whether P4P can work in all settings, particularly an environment in which there is a looser network of physicians such as a PPO — or even traditional Medicare.

The P4P programs highlighted at the conference were:

- Blue Cross Blue Shield of Michigan, a pioneer in developing hospital-based incentive programs.
- Blue Cross of California. The California-based health insurer stands out for implementing P4P in the most complex and most popular health insurance model — a preferred provider (PPO) network in the San Francisco market in which a loose network of physicians is not directed by any one health plan.
- Bridges to Excellence (BTE). The largest employer-sponsored effort that rewards and recognizes physicians for meeting specific quality benchmarks, BTE doubled the number of diabetics seeing physicians.
- Excellus/Rochester Individual Practice

Association (RIPA). Excellus/RIPA has improved the management of patients with sinusitis, otitis, diabetes, asthma and heart disease by giving doctors measures of quality, affordability, and satisfaction.

• Integrated Healthcare Association (IHA). A California-based coalition of health plans, physicians, health care systems, purchasers, and consumers, IHA has issued a public scorecard, comparing actual physician group performance. Through its efforts, it has seen an increase in improvement across the board in every quality measure they are using.

• Local Initiative Rewarding Results (LIRR). The largest collaborative P4P effort to improve the health of babies and teens in Medicaid, LIRR found that simple targeted incentives can improve children's health. The California-based project involved seven health plans, paid out $5 million, engaged 3,300 physicians, and touched the lives of 350,000 babies, teens, and parents. Five of seven plans improved the rate of well-baby visits, with increases from 4% to 35%.

• Massachusetts Health Quality Partners (MHQP). Working with five health plans and physician organizations in the state, MHQP designed and implemented a performance report that for the first time enables comparison of physician organization performance on a common set of quality measures. ■

Study: Chances missed to avoid many heart attacks

Some patients don't receive aggressive treatment

Despite the fact that clogged arteries in the legs usually mean clogged arteries near the heart, a new study led by a University of Michigan cardiologist finds that doctors often fail to give heart-protecting care to people who have clogged blood vessels in their legs. Lack of aggressive treatment for body-wide problems means missed heart attack prevention opportunities, the study shows.

In a presentation at the American Heart Association's annual Scientific Sessions, November 13-16, 2005, the University of Michigan Cardiovascular Center, Ann Arbor, researchers showed data on 553 patients who came to five Michigan hospitals for procedures to re-open clogged blood vessels in their legs and abdomens. Such blockages are called peripheral artery disease, or PAD. The study shows that among such patients, those who also had a history of heart problems were more likely to receive drugs to lower their cholesterol and blood pressure, compared with those who hadn't had heart problems.

Key Points

- Clogged arteries in the legs usually mean clogged arteries near the heart.
- Problem must be addressed as an important QI initiative and seen as a systems issue.
- Standard order sets can help ensure patients receive appropriate care.

"Patients who have severe PAD but haven't experienced heart-related problems are undertreated when it comes to medical therapy, especially statin drugs to lower cholesterol," says senior author **P. Michael Grossman**, MD, an assistant professor of cardiovascular medicine.

The patients in the study were all having procedures called peripheral vascular interventions, or PVIs, which are nearly identical to angioplasty and stenting procedures performed in blocked or narrowed heart arteries.

Once diagnosed, the first treatment for PAD patients is to exercise, lose weight, and stop smoking. The same actions that are known to help their hearts. But medicines such as blood thinners, cholesterol drugs, ACE inhibitors and BETA blockers, and procedures such as PVI, are used when lifestyle changes don't do enough.

Before their PVI procedure, 91% of the heart patients were taking blood-thinning drugs such as aspirin or clopidogrel to prevent the formation of dangerous clots, compared with 83% of patients with no heart history. An even larger gap in statin use was seen: 65%, compared with 51% of non-heart patients. And BETA blockers, which lower blood pressure and heart rate, were used in 62% of heart patients, compared with only 42% of non-heart patients.

A 'systems' solution

While there may be any number of reasons why individual physicians fail to follow national guidelines for treating PAD, Grossman proposes a "systems solution" for addressing the problem.

"You have to decide this is an important QI

initiative and build a system where health care extenders who are really tuned to this kind of thing can help screen patients' meds and make sure they are on the right ones," Grossman recommends. "We've seen this kind of phenomenon with cardiovascular problems, where QI initiatives have made a difference in improving outcomes with guideline recommended therapies. Armed with this data, the next step is to look at ways to improve."

There is a window of opportunity to make an impact on the disease process at the time of diagnosis, says Grossman, when the patient and family are focused on the disease. "That's when you can hit them and get success with smoking cessation, taking meds, exercise, and so forth," he suggests. "It's a real opportunity for those of us who do these procedures to make an impact not only on the disease, but on patients' long-term outcomes, by putting them on the right meds."

In addition, he says, the hospital must do a better job of focusing on the problem and communicating with primary care providers about screening for PAD and, when it's found, to treat the patient aggressively with medications known to improve their long-term health. (For more on the treatment of PAD, go to www.med.umich.edu/cvc/; in the "search" box, type in "PAD.")

Getting docs on board

There are additional strategies that can be employed to ensure greater physician compliance with national guidelines, says Grossman.

"There are a couple of things that seemed to work well in GAP [The Acute Myocardial Infarction GAP Project in Michigan; www.acc.org/gao/mi/ami_gap.htm]," he says. "First, have standard order sets computerized or on paper, so, for example, when the patient is admitted, in the written orders there is perhaps the name of a BETA blocker, and the physician just fills in the dose. In the discharge summary, you include a list of meds the patient is on, and a field on the screen says something like, 'These medications have been shown to improve long-term outcomes in patients like you.'" This way, he notes, if the patient is not on one or more of these medications, they may be prompted to ask their physician why they aren't on them.

Such strategies also help focus attention on who is filling out the discharge papers, Grossman adds. "For example, there are opportunities here to have an impact on the patient's diet. So you might want to set up a system where the dietitian can see the discharge papers," he suggests. "Or, you can have smoking cessation team meetings with the patient."

This critical time is what Grossman refers to as a 'therapeutic window.' "You can catch a few patients and really make a difference, because family members can really influence behavior," he asserts.

As for follow-up, this is generally handled by the primary care provider, but, says Grossman, "In my practice, I like to see patients back in a month to see if they are doing okay, and then do some long-term follow-up to see if there is evidence of re-narrowing of the arteries. If there is a non-internal medicine trained physician taking care of them, it may be important to work closely with them."

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AMA unveils health care ethics program, toolkit

Eight hospitals will be field-testing program

The Ethical Force Program, a collaborative effort of the American Medical Association (AMA) to develop health care systemwide performance measures for ethics, will be field-testing a tool kit on patient-centered communication with diverse populations from March to December 2006 with eight volunteer hospitals and eight physician groups. The program aims to overcome communication barriers that are prevalent in vulnerable minority populations, with the expectation of reducing racial and ethnic disparities in health care.

Eight hospitals and eight large physician practices are being selected from across the country to field-test the patient-centered communication tool kit. In addition to being able to use the toolkit at no cost, they will:

- receive a comprehensive report on their assessment results from Ethical Force Program staff;

• collaborate with a research team and hospitals and physician practices across the country, share insights, and learn from what others are doing;

• evaluate their organization's commitment to communicating effectively with all patient groups.

What the program does

The Ethical Force program is a means for developing mutual and multilateral accountability in ethics among all participants in the health care delivery system. It is charged with creating, testing, and disseminating performance measures for domains of ethics in health care. The program is directed by a 23-member oversight body, which includes representatives from numerous relevant groups, including patients, practitioners, health plans, purchasers, government, and accrediting organizations. The oversight body members are elected to serve up to two three-year terms, says **Ron Davis**, MD, AMA Trustee.

Increasingly, physicians and managed care organizations are being held accountable for quality of care based on the processes and outcomes of medical care and patient satisfaction. "But high-quality health care delivery involves more than good technical quality and acceptable customer service," says Davis. "It also means upholding high ethical standards. Health care is ultimately a moral enterprise, built on protecting the potential extraordinary vulnerability of patients. It is grounded in a covenant of trust, which relies on every part of the health care system living up to shared ethical norms."

Measuring the full-spectrum of health care quality, therefore, requires developing explicit shared sets of expectations for ethical behavior across the full range of parties involved in health care delivery and then learning how to measure performance in meeting these expectations.

Like so-called "condition-specific" performance measures, Ethical Force performance measures for ethics quality will include questions that can be placed into practitioner and patient surveys, as well as easy-to-use site review criteria and policy review criteria. The measures will be distributed — with grading instruction and examples of good performance — in Ethics Performance Measurement "Toolkits," which can be easily and inexpensively used to measure organizational performance in specific domains of ethics.

"The first stage of the Ethical Force Program's process is to develop a consensus report on each topic it addresses," Davis says. "These consensus reports include a set of performance expectations that all organizations in health care should be able to meet."

The second stage of the Ethical Force Program's process is to translate the expectations into performance measurement tools. This means translating the expectations into survey questions that organizations can use for self-assessment. "The toolkits developed by the Ethical Force Program include patient surveys, staff surveys, policy checklists, and workbooks to determine how well the organization believes it is implementing its policies," says Davis.

"The results of the assessment compare how the organization views its performance with how its patients and staff view the organization's performance."

The first two "domains" that have been selected for ethics performance measure development are (1) privacy and confidentiality protections in health care; and (2) processes for designing health benefits and adjudicating coverage decisions.

"The oversight body recognizes that the integrity and fairness of processes for making health coverage decisions are important factors in fostering trust in health care organizations," notes Davis, "But, coverage decisions can be ethically complex. Within the context of designing and administering a benefits package, each stakeholder has unique, and sometimes conflicting, responsibilities that must be weighed against one another. The Ethical Force framework provides a means to help balance these competing demands and ethical obligations."

The Ethical Force Program expects that organizational processes for designing and administering health benefits should be: transparent, participatory, equitable and consistent, sensitive to value, and compassionate. Within each of

Key Points

- High-quality health care delivery means upholding high ethical standards.
- Ethical Force develops performance measures for ethics quality.
- Toolkit includes questionnaires, surveys, and other forms to assess ethics performance.

these areas, the Ethical Force Program outlines expectations for organizational performance (www.ama-assn.org/ama/pub/category/12089.html).

No gold standard

While there are no gold standards for many aspects of ethics in health care, this does not make ethical performance unmeasurable, Davis says. Many aspects of clinical care also do not have gold standards for performance, he notes, yet performance measures still are used to assess performance in these areas. For areas with no clear gold standard for performance, measures focus on assessing (1) whether baseline expectations have been met, (2) whether progress is being made towards aspirational goals, and (3) whether acceptable processes are being used to ensure that difficult issues are appropriately addressed.

Once field-testing is complete, Ethical Force Performance Measures Toolkits will be available at cost on the Ethical Force web site and through the Ethical Force National Program Office at the Institute for Ethics at the AMA. At that point, says Davis, quality managers should play an important role in seeing that their facilities participate. "The quality manager is well placed to advocate for or coordinate this type of self-assessment effort," he says. "While some quality managers may not have the knowledge to complete the organizational pieces of the assessment on their own, they can bring together a team to inform this process. The quality manager should also be familiar with the organization's strategies for surveying patients and staff."

Finally, he notes, the quality manager will have the skills needed to compare the organization's performance on ethical topics with its performance in other areas.

For more information about the Ethical Force program, contact the program staff at the Institute for Ethics at (312) 464-4698 or (312) 464-4075. ■

CMS releases HCAHPS survey instrument

The Centers for Medicare & Medicaid Services (CMS) recently released the final Hospital CAHPS (HCAHPS) survey instrument. The HCAHPS survey is the first national attempt to standardize patients' satisfaction with care in order to make "apples to apples" comparisons.

Hospitals will begin using HCAHPS through the Hospital Quality Alliance, a private/public partnership that includes the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges, Joint Commission on Accreditation of Healthcare Organizations, National Quality Forum, AARP, and CMS/AHRQ, and other stakeholders. Participation by hospitals will be voluntary and results will be publicly reported on the HHS Hospital Compare web site.

The final survey instrument was published in the November 7 Federal Register. After a 30-day comment period, which closed on December 7, the Office of Management and Budget was to have 30 days to approve it. CMS expects to begin national implementation in 2006.

For more information on HCAHPS and CMS, go to: www.cms.hhs.gov/regulations/pra/. ■

AMA develops toolkit for 100K Lives

As a strategic partner in the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign, the American Medical Association (AMA) recently launched two online toolkits to encourage physicians to join the initiative. More than 2,800 hospitals already are participating.

The "Making Strides in Safety" program

COMING IN FUTURE MONTHS

- CMS's P4P program shows 6.6% increase in quality performance by participants
- Overworked staff: Is there a direct connection to quality and safety?
- Hospitals being sought to field-test communication program
- Study: Mortality, readmission rates drop when clinicians, patients team up
- Hospital implementation of CPOE still lagging, says Leapfrog Group

(www.ama-assn.org/go/makingstrides) stresses that working as a team with support from hospital administration, medical staff, executives, and other personnel is key to success.

The 100,000 Lives Campaign offers physicians the opportunity to take the lead in improving hospital care for patients on a community and national level. ■

C diff: New, more virulent strain emerges

Clostridium difficile continues to emerge in a more pathogenic form with a new epidemiological profile.

Particularly disturbing are new reports in four states of infections in patients previously thought to be at low risk for C. diff.

Considered in the context of recent high-morbidity, hospital-associated outbreaks in North America, Great Britain, and the Netherlands, the cases of severe *C diff* appear to reflect a "changing epidemiology," the Centers for Disease Control and Prevention reports.[1]

Clinical features that have been less common in the past include close-contact transmission, high recurrence rate, young patient age, bloody diarrhea, and lack of antimicrobial exposure.

C. difficile exotoxins A and B cause colonic dysfunction and cell death. A new emerging epidemic strain of the pathogen produces 16 times more toxin A and 23 times more toxin B compared with other common strains.

Virulent strains can cause more severe disease in populations at high risk, but also cause more frequent, severe disease in populations previously at low risk (e.g., otherwise healthy persons with little or no exposure to health-care settings or antimicrobial use).

In Pennsylvania and three other states, severe *C diff* infections have occurred in two groups traditionally considered at low risk: healthy people living in the community and peripartum women (those in the last month of gestation or the first few months after delivery).

The findings underscore the importance of judicious antimicrobial use, the need for community clinicians to maintain a higher index of suspicion for *C diff*, and the need for surveillance to better understand the changing epidemiology of the pathogen, the CDC concluded.

Reference

1. Centers for Disease Control and Prevention. Severe Clostridium difficile — Associated Disease in Populations Previously at Low Risk — Four States, 2005. MMWR 2005 54(47);1201-1205 ■