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New studies examine the impact of performance measures

Do comparisons, financial incentives really impact quality?

With ever-increasing data collection burdens for performance measures and a growing emphasis on linking this quality data to reimbursement, you may wonder how they actually impact patient care at your organization.

A growing body of research is answering that question, with studies showing that performance measures do have a significant impact on quality. A recent report from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) examined data from 3,087 hospitals from 2002 to 2004 for various performance measures and found evidence of significant improvements.[1]

"There was a steady indication of progress over the two-year period, which was of course, very positive from our perspective," says **Scott Williams**, PsyD, one of the study's principal authors and project director in JCAHO's division of research.

Researchers found that hospitals ranged from 3% to 33% in improvement. "This has certainly reinforced the goal and the mission that we had set forth 10 years ago, which was to use data to drive performance improvement," says Williams. "It's very consistent with JCAHO's mission to improve care, that we can work both as an accrediting body and provide data to the general public to make informed choices."

There already was ample research evidence showing that if hospitals are provided with comparative feedback they will use it to improve their performance, but studies were small and never done on a national scale, she says.

The researchers were surprised to find that the poorest-performing hospitals improved at a faster rate than their peers. The theory was that hospitals starting on a lower performance level had significant problems with quality and therefore wouldn't be likely to take the needed steps to make improvements.

"We had every reason to expect that they wouldn't do anything to improve their performance, but that wasn't what we saw. We saw them improve at a faster rate than hospitals that started at a higher level of performance," says Williams.

Poorly performing hospitals may have been embarrassed by how they

measured up against their competitors, Williams theorizes. "They had a greater opportunity for improvement because they started out at the very lowest levels and may have been most sensitive to the comparative data," he says.

Leadership is an essential ingredient to achieve results in improvement of performance measures and quality, adds Williams. "The impetus is on hospital quality professionals and medical staff and administration to lead the way," he says.

The performance measures used by JCAHO and the Centers for Medicare & Medicaid Services are evidence-based and well supported in the literature, he says. "There is consensus on almost all of them that these are things that should be happening in hospitals. So these are things that are relatively easy to get behind when performance isn't as it should be," he says. "But it requires leadership to make it happen. Quality professionals must use the data that they have available to them now, in a positive way."

Another study looked at data for 10 quality indicators at 3,558 hospitals and found poor or spotty compliance for many performance measures, even within the same hospital. "The implication for health quality professionals is simple," says **Ashish Jha**, MD, MPH, the study's lead author and assistant professor of health policy and management at Harvard School of Public Health in Boston.[2]

"Given the tremendous variation we observed in quality of care, it is possible to reach high levels of performance. But too many hospitals are just not there," he says. "Organizations that prioritize quality assessment and quality improvement can ensure that their patients receive the right care consistently."

Performance measures represent a double-edged sword, says Jha. "If we continue to pick good measures that are clinically relevant, then focusing on them will clearly improve the care and outcomes for our patients," he says.

One challenge is for organizations to continue to pay attention to the aspects of health care that are not being measured. "Most of the things we do in health care are not measured in these performance measurement programs. For example, there are no measures for a vast majority of diseases that we manage in the hospital," says Jha.

Staying focused on all aspects of quality will become especially important as the number of performance measures continues to multiply, he says. "The role of the quality professional is to create an environment for providers to improve processes being measured, without distracting the providers from their day-to-day activities," says Jha.

Pay-for-performance impact unclear

The impact of tying performance measures to reimbursement is still unclear, says Williams. "It's happening more frequently and it seems like a good idea. Certainly when you tie money to these things you expect an impact. But we don't know for sure yet what that will be."

Research suggests a positive impact on quality,

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Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

with the first study to assess the effects of a pay-for-performance program in a large health plan finding significant quality improvement in a physician group with an incentive program.[3]

However, many unanswered questions remain, according to a new report from the National Quality Forum. The report argues that scientific evidence is weak and doesn't compare costs of effectiveness with other strategies for improving quality, and also that there is potential for adverse consequences with pay-for-performance.[4]

Still, many quality leaders report that pay-for-performance has had a positive impact on the care they provide. "We think this is a very positive movement, that started with the transparency of quality data," says **Sam Flanders**, MD, senior vice president of medical quality for Clarian Health Partners in Indianapolis. "Having that data available is a good thing. It's put more pressure on all of us to excel in those areas. It has helped us to focus on those items that are going to make the biggest impact on patient care."

Although the pay-for-performance movement hasn't been as rapid in Indiana as some other states, it is growing steadily, reports Flanders. "Right now, it doesn't affect too many of our contracts. We are seeing that already in other parts of the country, and it is just a matter of time before it hits our market," he says.

Currently, the organization has only the CMS program and one large payer with a program. "But we really have jumped in with both feet to maximize performance, particularly on the publicly reported data elements," says Flanders.

Instead of adding more quality resources to handle increased data collection burdens, the organization has redirected its resources, says Flanders. "If I look back 10 years ago compared to now, we haven't really added many people to our quality department per se. But the way we have it organized, quality is the job of everyone here."

The central department's role is the "orchestra conductor" for quality, whereas hundreds of people are involved in quality as part of their jobs, says Flanders.

For example, a recent project for improving blood sugar control in the intensive care unit has had a major impact on patient care, with front-line staff implementing the new protocol. "We have seen our infection rates after heart surgery drop to almost zero as a result of doing that," he says.

The organization already has increased its reimbursement as a result of pay-for-performance. "We have gotten our bonus from one payer as a result of meeting quality targets, and it is a significant bonus," Flanders says.

Indirect financial gains come from preventing infections and shortening length of stay, adds Flanders, since most reimbursement in hospitals is fixed. "Every case of pneumonia you prevent not only benefits the patient but also benefits the hospital's bottom line," he says.

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[For more information, contact:
Sam Flanders, MD, Senior Vice President of Medical Quality, Clarian Health Partners, I65 at 21st, P.O. Box 1367, Indianapolis, IN 46206. Telephone: (317) 962-2475. E-mail: sflanders@clarian.org.
Ashish Jha, MD, MPH, Assistant Professor of Health Policy and Management, Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115. Telephone: (617) 432-5551. E-mail: ajha@hsph.harvard.edu.] ■

JCAHO, AHA clash on performance data

Debate rages over how quality data is being used

Performance measures may be getting glowing reviews from researchers and are an integral part of the Joint Commission on Accreditation of Healthcare Organization (JCAHO)'s new survey process, but a recent advisory from the American Hospital Association (AHA) has criticized JCAHO's intentions. The advisory claimed, among other things, that JCAHO "plans to become a purveyor of performance data analysis for a variety of purposes."

The AHA charges that JCAHO plans to seek patient-level data for purposes unrelated to accreditation. In response, JCAHO insists that patient-level data are being used only to improve the accuracy and completeness of the data collection and data aggregation processes and that no protected health information would ever be released to third parties. In addition, JCAHO adds that patient-level data would be de-identified before it was ever used for research or other purposes not related to accreditation.

In a prepared statement, JCAHO responded that it is "not an information company and intends to remain focused on its mission to continuously improve the quality and safety of health care. Using and analyzing data is a critically important element of a credible and continuous accreditation process."

In addition, JCAHO recently announced that it would continue to use data analyses and reporting to measure and encourage quality improvement in accredited health care organizations but has decided not to sell performance measurement data analyses to private third party payers.

JCAHO says it is committed to the creation of a single collection system for hospital performance data, for a single reliable data source to support JCAHO's own Quality Check web site and the Centers for Medicare & Medicaid Services and Hospital Quality Alliance's Hospital Compare web site, provided JCAHO is allowed unfettered access and the data quality could be assured.

Although both web sites report hospital performance data, the Quality Check web site reports additional accreditation-related performance information.

Here are assertions made by AHA and JCAHO's responses:

• AHA accuses JCAHO of making patient privacy an "afterthought." To this, JCAHO responded that its current uses of aggregate performance data are not in violation of requirements under the Health Insurance Portability and Accountability Act (HIPAA) since these protect individual privacy, not institutional privacy.

JCAHO says it welcomes guidance from the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) on patient privacy concerns raised by the AHA and will not move forward with its quest for the patient-level data in question until the relevant HIPAA issues are resolved.

According to JCAHO, access to patient-level performance data is needed to support its ongoing accreditation-related measurement activities, and it plans to work in collaboration with AHA to resolve this issue. But JCAHO insists that it has never breached the confidentiality of any protected health information (PHI).

The AHA claims that hospitals are at risk for civil and criminal penalties if JCAHO's uses of patient information are found to be out of compliance with HIPAA requirements. JCAHO denies this. "The Joint Commission feels it is on solid legal ground under the HIPAA privacy rule with its past and current uses of PHI for accreditation-related purposes," says **Mark Forstneger**, spokesperson for JCAHO.

He adds that the previous disclosure, to which the AHA objects, involved only de-identified aggregate data that will not subject hospitals to any civil or criminal penalties. Forstneger notes that JCAHO recently met with OCR representatives, who affirmed that once PHI appropriately received for health care operations under a business associate agreement has been de-identified, it is no longer protected by the privacy rule and can be disclosed to a third party.

"I agree with JCAHO," says **Kathleen A. Catalano**, RN, JD, director of regulatory compliance services for Dallas, TX-based PHNS. "If the information is de-identified, it means that all of the 18 enumerated identifiers have been removed."

According to HIPAA, an expert opinion is needed stating that a statistically small risk exists that the released information could be used by others to identify the subject of the information. "If JCAHO does this, there should be no problem. I doubt anyone could identify a patient after all of this information is removed," says Catalano. "JCAHO is also saying that they will be in compliance with HIPAA requirements."

If information is de-identified, no authorization is needed to use the information, she adds.

Some hospital risk managers do have problems with JCAHO using data for purposes unrelated to accreditation, fearing possible liability under HIPAA. "It was really inappropriate for the JCAHO to do what they did. If hospitals hadn't raised the issue, then I think we could have faced some exposure," says **Sue Dill**, RN, MSN, JD, director of hospital risk management at OHIC Insurance Company, based in Columbus, OH, and former vice president of legal services at Memorial Hospital of Union County in Marysville, OH. "Shame on the JCAHO, and I can't believe they didn't think this would upset the hospitals."

[For more information, contact:
Kathleen A. Catalano, RN, JD, Director of Regulatory Compliance Services, PHNS Inc., One Lincoln Centre, 5400 LBJ Freeway, Suite 200, Dallas, TX 75240. Telephone: (214) 257-7112. Fax: (214) 257-7042. E-mail: Kathleen.Catalano@phns.com.
Sue Dill, RN, MSN, JD, Director, Hospital Risk Management, OHIC Insurance Company, 155 East Broad Street, Columbus, OH 43215-3614. Telephone: (614) 221-7777. E-mail: sdill1@columbus.rr.com.] ■

New CMS guidelines for managing complaints

You'll need system to investigate grievances

When the Centers for Medicare & Medicaid Services (CMS) issued its original Patients' Rights Conditions of Participation (COPs) for hospitals in 1999, the definition of a "grievance" was unclear, says **Patrice Spath**, a Forest Grove, OR-based health care quality specialist. Now newly published interpretive guidelines from CMS attempt to clear up the confusion. The guidelines address several COPs, including patient grievances. (You can access the guidelines at www.cms.hhs.gov/medicaid/survey-cert/sc0542.pdf.)

"One area that may be problematic for hospitals is an unresolved verbal complaint," says Spath.

According to the guidelines, these are to be treated like formal grievances. This means that the hospital will need to have a mechanism for identifying unresolved verbal complaints so that the proper grievance investigation and resolution process can be initiated in a timely manner.

Your policy and procedure must give specific steps for managing an unresolved verbal complaint, says **Michelle Pelling**, MBA, RN, president of the Propell Group, a Newberg, OR-based health care consulting organization specializing in Joint Commission compliance and performance measurement.

Once these requirements are in the policy and procedure, staff who could be involved with an unresolved verbal complaint should receive training about the patient's right to know that they may file a grievance, and what to do if a patient complaint cannot be resolved by the staff members, supervisors, or representatives from administration available at the time, advises Pelling.

Another issue addressed by the guidelines is the role of the hospital's governing board. "It is no longer acceptable for the board to delegate grievance review to one individual, such as a patient advocate," says Spath.

If the board chooses to delegate the grievance review and resolution process, then it must be assigned to a committee comprised of an adequate number of qualified individuals. Although the guidelines mention a grievance committee, it isn't necessary to form a new committee with this title, Spath says. "An existing committee, such as the Quality Council or other multidisciplinary group, could serve as the hospital's grievance committee. Just make sure you get this in writing," she advises.

If the board delegates the grievance process, board minutes should reflect this decision and specify which group is responsible, she says.

The CMS patient rights regulations are much more detailed and stringent than the Joint Commission's standards, Spath notes. "This is just another example of how important it is for quality managers and compliance officers to stay current in their understanding of CMS regulations as well as accreditation standards," she says.

The Joint Commission standards merely state that hospitals are to have a process for receiving, reviewing, and when possible, resolving complaints from patients and their families. "The CMS regulations contain a lot more detail about how this process should work," says Spath. "For example, according to the CMS interpretative guidelines, a timely response to patient complaints is considered to be seven days."

Quality professionals should be familiar with their organization's policy and procedure on patient grievances, says Pelling. "The first step is to make sure that CMS's definition of patient grievances is reflected in your policy," she says.

Your organization's policy and procedure should clearly outline what the term "staff present" means, Pelling recommends. According to the CMS definition, this refers to any hospital staff present at the time of the complaint, or those who can quickly be at the patient's location to resolve the complaint.

To assess whether your organization is prepared to comply with the CMS requirements, quality professionals should query staff members periodically to determine their degree of under-

standing, says Pelling.

She recommends querying nurses and other clinical staff monthly or quarterly about their role in addressing patient complaints, along with other questions about other procedures related to patient satisfaction, patient safety, and the provision of care. "This will support ongoing knowledge of CMS and Joint Commission requirements," says Pelling.

As a quality professional, you also should develop methods to review patient complaints to determine if they were resolved at the time of the complaint or, if not, whether the organization followed the procedure for patient grievances. Depending on the outcome, additional education and coaching may be necessary, says Pelling.

However, the quality professional's role is to work with the individuals responsible for developing methods to assure compliance with these requirements, not to take full ownership of the process, adds Pelling.

"The quality professional's role is that of an internal consultant and should be to guide the efforts of those who are responsible for assuring that their staff members understand and comply with the requirements," says Pelling.

[For more information, contact:

Michelle Pelling, MBA, RN, The ProPell Group, PO Box 910, Newberg, OR 97132. Phone: (503) 538-5030. Fax: (503) 538-0115. E-mail: michelle@propell-group.com.

Patrice Spath, RHIT, Brown-Spath & Associates, P.O. Box 721, Forest Grove, OR 97116. Phone: (503) 357-9185. E-mail: patrice@brownspath.com. Web: www.brownspath.com.] ■

Strategies to ease data collection burden

New core measure sets coming from JCAHO

Four years after the Joint Commission introduced standardized core performance measures with its 2002 ORYX initiative, quality professionals still are struggling to improve compliance with core measure data collection.

Compliance remains poor at many organizations, with only 55% of heart failure patients receiving necessary discharge instructions, according to a new study.[1] The study found that compliance with performance measures for heart attacks, pneumonia, and congestive heart failure is spotty, with wide variances in quality across regions and sometimes even in the same hospital.

Researchers at the Harvard School of Public Health used newly available data from the Hospital Quality Alliance to look at 10 indicators from the Centers for Medicare & Medicaid Services at 3,558 hospitals in the first half of 2004. They found that treatments were not provided for 11% of heart attack patients, 19% of patients with congestive heart failure (CHF), and 29% of pneumonia patients.

Part of the problem may be that data collection struggles are increasingly burdensome. "The time commitment and resources needed to capture the information have become quite challenging," says **Linda Gaul**, RN, senior consultant for quality at St. Vincent in Indianapolis. "It has also been rather challenging keeping up with definitions. It seems every week there needs to be clarification regarding abstraction. Just when you think you understand an indicator's definition, we learn something new."

Organizations have found it necessary to add additional staff to manage data collection and analysis. "We have added one FTE data abstractor for a total of two, and a QI director to oversee core measure data collection," says **Renee Shalosky**, director of quality improvement at Southeastern Ohio Regional Medical Center in Cambridge. "Both abstractors are responsible for core measure data for the CHF, acute myocardial infarction (AMI), and pneumonia measures."

The upcoming new core measure sets from JCAHO for pediatric asthma, intensive care unit (ICU), and pain management undoubtedly will add to the data collection burden, says Shalosky. "The ICU measures are extensive and time consuming," she adds.

Additional resources for the upcoming new measure sets will "absolutely be needed," says Gaul. The organization currently is in the process of implementing an electronic medical record. "We hope this will relieve some of the abstraction burden. But we will have to consider additional resources to review for accuracy and to keep up with the actual export. We are adding staff to our quality team now and are anticipating the need for dedicated IS staff in the near future."

Education is the way to improve core measures compliance, including one-on-one inservices as

(Continued on page 11)

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System achieves 'right patient, right level of care'

Training nurses to ask questions was key

An increasing number of one-day stays and patients who failed to meet admission criteria formed the impetus for a throughput initiative that is reducing inappropriate admissions at Sutter Health in Sacramento, CA, says **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health.

"My personal driver was getting patients into the right status of admission," she adds. "There is so much confusion, so much [area] that is gray, when an outpatient needs to remain for a longer period than normal because of unforeseen complications."

The Centers for Medicare & Medicaid Services (CMS), Leach notes, sets a target percentage for one-day hospital stays by Medicare patients. The rationale, she explains, is that if a patient is in the hospital for only one day, the question arises as to whether the person might more appropriately have been given observation status, for example, or referred to a skilled nursing facility.

That issue, combined with the push to meet InterQual criteria — a group of measurable clinical indicators and diagnostic and therapeutic services that reflect a patient's need for hospitalization — set the stage for the effort to place "the right patient in the right hospital at the right level of care, Leach says.

The first pilot project took place last June at Sutter General Hospital, she says, with a team composed of a case manager, a patient placement nurse already charged with assigning beds, and bed placement clerical staff who keep track of admission data and verify insurance eligibility.

"We live in an area where people change [insurance] carriers all the time, so one issue is determining whether a patient should even be admitted to this hospital," Leach notes. "We were often not finding out until a day or two later that someone was capitated to another hospital. The other hospital calls and says, 'Thanks for providing open-heart surgery to our patient.' It doesn't take too many of those cases to feel like you're hitting bumps in the road."

Even if there still is the opportunity to transfer after a patient in another managed care plan is inappropriately admitted, she points out, "there is the disruption to the patient who has to move, and the expense to our hospital. We [incur the cost] of the most expensive day, and then we have to move the person to another facility."

To hospital administrators, Leach adds, she emphasized the initiative's focus on controlling access so that only appropriate patients are admitted. To physicians, on the other hand, she stressed that it would facilitate the admission of their patients.

While some hospitals have a similar process in place for planned admissions, she notes, the Sutter project was designed around unscheduled admissions, which are "our Achilles heel."

"We had all these people managing information," Leach says. "They verified that [patients] had appropriate insurance and they validated with information from physicians that patients met InterQual criteria for level of care — whether telemetry, intensive care unit [ICU], observation or inpatient."

Once the level of care was established, the patient placement nurse was asked if a bed of that type was available, she says.

In the past, Leach adds, physicians would call and say they needed a bed at a certain level of care, and staff would respond that it was available or not. "We never knew [at that point] if the patient met criteria. Or, the [patient placement nurse] might say, 'I don't have an ICU bed, but can you take a telemetry one?' It might turn out that's what the patient needed anyway."

The project also has "allowed us to dialogue" with physicians in the emergency department (ED) — where there is a case manager — when patients don't meet InterQual criteria, she says.

"[The case manager] can say, 'The patient doesn't meet inpatient criteria, but may need placement in an SNF [skilled nursing facility], and I can help you with that,'" Leach continues. "Or she can say, 'I need more information to qualify this patient for emergent admission. Please document the tests and procedures you are planning for this patient.'"

That means, she adds, that when physicians admit patients and say they'll check on them later, the response now is, "That's not enough — we need a plan of care in order to move [the patient] along in the process."

Recognizing the potential for conflict that questioning physicians about their orders can cause, she notes, staff choose their words carefully.

Instead of saying, "The patient doesn't meet criteria," and having the physician respond, "I don't care — admit him anyway," Leach says, "We might call and say, 'We need to better understand the treatment plan so we can put the patient in the right place.'"

In the past, she explains, physicians would simply write the orders and the patient would be taken to the nursing unit. "We would have that dialogue [with the physician] 24 hours after admission when the case manager was doing the utilization review and would say, 'Why is this person here?'"

Inappropriate admissions avoided

As a result of the Sutter General pilot, Leach says, staff were able to identify a number of ED patients that otherwise would have been inappropriately admitted to the hospital and refer them to outpatient treatment, place them in SNFs, or have them transferred to the facility designated in their managed care plan.

For all 51 patients admitted during the pilot — which was confined to the hours between 8 a.m. and 5 p.m. — staff were able to document that they met the criteria for admission, she says. "That's not a huge number. We did this during a time when we were not getting slammed so we could work our process and have the necessary resources available."

By communicating with physicians, staff avoided admitting between seven and 12 people as inpatients, instead directing them to observation status or another type of care, Leach notes. "For example, physicians often will admit patients to the hospital for infusion, for hydration, but we have a clinic where that is done, so we can help set that up."

In the months since the pilot, the proactive communication with physicians has continued to work beautifully, she notes, adding that since the project began, with "every patient about whom [nurses] have dialogued with the physician regarding either level of care or criteria, the issue has been resolved prior to admit."

"The key has been to adequately train the patient placement nurses with questions to ask and alternatives to offer the physicians so they can be sure the patients are getting the treatment they need," Leach says.

While Sutter Health has had the patient placement nurse function for some time, she says, formerly the job "was only to figure out what bed to put the patients in."

Apart from causing a financial loss to the hospital, Leach points out, she believes that inappropriate admissions are a quality-of-care issue. "The risks of being in the hospital — falls, medication errors, bed sores, infection — are all well documented. Those are all things that we are able to prevent if a person is not admitted unnecessarily to the hospital."

A pilot project done at the health system's other hospital, Sutter Memorial, was a much bigger challenge, she says, because the majority of unscheduled admissions come through services other than the ED. That hospital, Leach explains, is located in a residential area and specializes in pediatrics, obstetrics, and cardiology. It also is a larger facility than Sutter General. Together, she notes, the two acute care facilities have well over 600 beds.

"Cardiology patients often come through emergent admits from other hospitals or scheduled admits from interventional procedures, such as heart catheterization or diagnostic imaging,"

she says. "We are dealing with specialists and with patients who are having procedures, not coming to the ED with a cold."

Because the patients being admitted may already be outpatients or may be coming from another facility, Leach adds, it is easier for them to "slip through the cracks." During the Memorial pilot, she says, only nine people were admitted through the ED.

Although data from that pilot haven't been analyzed, Leach says, "we know anecdotally that we were very effective in the ED and that — even with the lesser number of admissions — probably impacted the same number of patients who were at the wrong hospital or needed to be hooked up with other services."

Hospital administrators initially were concerned that the steps involved in ensuring proper placement would delay patient throughput, she notes. "We provide tertiary care for multiple areas, so we have a specialty services network from all over California. We don't want to lose that business by putting up barriers to admission."

Those fears proved to be unfounded, Leach says, noting that in both studies, the length of time between a patient presenting at the ED or outpatient department and being admitted to the hospital did not increase.

In fact, the time may have been shortened, she adds, "but we don't have enough data to show that yet."

While the project's patient placement nurse is currently working 10 hours a day, the goal is to have the kind of patient coordination done in the pilots in place around the clock, Leach says. "We'll probably be making decisions on [hiring] that person or people based on some volume studies." ■

CHF project aims to bridge gap between providers

Goal is better outcomes, fewer readmissions

Drawing on 20 years of quality improvement experience, MPRO, Michigan's Health Care Quality Improvement Organization, is bringing together hospitals, home health agencies, and physician practices to come up with solutions to communications barriers between providers, with the ultimate goal of improving the outcomes for the state's cardiovascular disease patients.

"In the state of Michigan, no one has brought different groups from across health care settings together at one table. This pilot project is the first time that hospitals, home health agencies, and physician offices come together to work together for better patient outcomes," says **Linda Charles**, RN, BS, project coordinator for MPRO's hospital quality improvement team.

MPRO has been awarded a contract with the Michigan Department of Community Health for the pilot project "Cardiovascular Health Project." The goal is to reduce the number of hospital readmissions for patients with cardiovascular disease, especially congestive heart failure (CHF) by reinforcing education and self-management before and after hospitalization.

The project aims to improve the consistency of documentation, patient assessment, and reporting of clinical findings and to close the gap between the hospital, home health agencies, and physician offices.

"The goal of the heart failure collaborative across settings is not just to decrease readmissions. Other goals are to reinforce heart failure patient education and self-management prior to and after hospitalization and to help the patients gain more control over the disease process," says **Teri Aldini**, RN, MS, project manager for the home health and hospital team.

Heart failure is the leading diagnosis for Medicare patients in the state of Michigan and is among the leading diagnoses for hospital readmissions.

The 325,000 patients discharged with a diagnosis of heart failure last year incurred approximately $226 million in hospital costs. About 25% are discharged from Michigan hospitals with a home health referral.

"When we worked on cardiovascular quality improvement projects in the past, our team had observed the disconnect between the hospital, the home health agency, and the physician office. We wanted to create a collaboration between the hospitals and home health offices, realizing that the physician's office is an integral part of post-acute care," Charles says.

The disconnect appears to occur when patient care is managed by a cardiologist while the patient is hospitalized and following the patient's discharge home, care is then resumed by the primary care physician.

Typically, the cardiologist will discharge the

patients to home with home health and the patient receives post-discharge instructions from the hospital but it takes a while for the discharge summary to reach the physician's office. If the patient has a question or an acute event or the home health agency calls for further orders, the physician does not have the information he or she needs to prescribe follow-up care.

Integrating care

"Even if a primary care physician assumes care in the hospital and writes a home health referral, he has the knowledge of what happened in the hospital but the office staff may not, and they are the ones who typically triage the patients," Charles says.

The project aims to integrate care across all settings to improve patient outcomes by bringing together hospitals, home health agencies, and representatives from physician offices for two intensive learning sessions during which the providers share ideas about improving communication.

"We serve as facilitators at these sessions, bringing different stakeholders together and giving them the opportunity to identify where the problems are and work on solutions to overcoming barriers. It's the responsibility of the providers to adapt the lessons they learned when we were together and change the process of care in their individual settings," Charles adds.

MPRO holds a monthly conference call in which participants report on what they have implemented.

Participants include hospital and home health quality improvement staff, home health administrators, hospital discharge planners and offices managers, and sometimes nurses from physician practices. The pilot project with the Michigan Department of Community Health involves two hospitals, three local home health agencies, and four physician practices.

The organization has led a number of other cardiovascular quality improvement initiatives, including the Michigan Heart Failure Discharge Documentation program, developed with Blue Cross and Blue Shield (BCBS) of Michigan and the Michigan chapter of the American College of Cardiology.

The aim of the project is to ensure that admission and discharge orders meet the core measures for quality established by the Centers for Medicare & Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations.

The team brought together 39 participating Michigan hospitals for intensive learning sessions and sharing ideas to make sure the quality initiatives are being met.

"The goal of the program was not just to increase the rate of discharge instructions documentation but to increase patient knowledge and to give the patients more tools to help them control their disease process and adapt their lifestyles," Aldini says.

The hospitals received a template document designed to improve the documentation for the six core measures for heart failure and were encouraged to use it or adapt it.

MPRO followed up with conference calls in which hospitals reported their use of the tools provided.

As a result of the project, hospitals in Michigan have begun sharing tools that help them address the core measures and other quality initiatives, Aldini says. ■

CMS Releases HCAHPS Survey

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, 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 Nov. 7 Federal Register. After a 30-day comment period, which closed on Dec. 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/. ■

needed, says Shalosky. "We've done so much education on the importance of these measures. We've started trending per person to identify any trends there," she reports. "We've also been educating one-on-one with those that have been identified as not complying."

Here are strategies to improve core measure data collection:

• **Put a progress note in the patient's chart.**

St. Vincent has implemented a progress note, called a "Quality Note," which specifically addresses core measures. The attending physician receives a letter reminding them of the indicator requirements for any case that continues to be out of compliance. "This has greatly improved our results, but we do recognize there is room for improvement," says Gaul. "Our goal is to build the evidence-based logic into our electronic medical record to assist physicians and staff."

The quality note is placed in patient charts for case managers, clinical data abstractors, and physicians to refer to and serves as a communication tool between caregivers regarding compliance.

"We have seen the greatest improvement for those indicators which require documentation of a contraindication for not utilizing recommended drug therapies," reports Gaul. "The note allows the physician to either check a contraindication or serves as a gentle reminder that a patient needs a particular drug therapy."

• **Have clinical staff perform data abstraction.**

All data abstractors at St. Vincent are nurses. "It is difficult for non-clinical staff to grasp the nuances of each indicator and what the intent of the indicator is," says Gaul. "Physicians also tend to have a better relationship when the nurse is speaking to them about core indicators and their results."

The nurses also are responsible for ICD-9 coding, abstraction for other national and state registries, reporting indicator results to their assigned QI committee, and assisting caregivers, managers, and physicians with understanding areas that need improvement, says Gaul.

Nurses have the best understanding of the specific deficiencies and the actual indicator definitions and are visible on the units, says Gaul. "The actual implementation of agreed-upon action plans is the responsibility of the physicians, managers, and nursing units," she explains.

• **Do concurrent collection.**

At Southeastern Ohio Medical Center, most data collection is done retrospectively, including indicators for CHF, AMI, and pneumonia, says Shalosky. "None of the core measures are done concurrently," she says. "I would definitely like to increase the amount so that action plans are done in real time — proactively — instead of retrospectively."

Abstraction is done concurrently whenever possible at St. Vincent, providing an opportunity to prompt the physician for missing documentation, such as contraindication to drug therapies. "Each nurse is responsible for their list of patients based on medical record terminal digit. Oftentimes the care the patient is receiving is appropriate but the actual documentation is lacking."

Reference

1. Jha AK, Zhonghe L, Orav J, et al. Care in U.S. hospitals—the Hospital Quality Alliance program. *N Engl J Med* 2005; 353: 265-274.

[For more information, contact:
Linda Gaul, RN, Senior Consultant Quality, St. Vincent Indianapolis Hospital 2001 West 86th Street, Indianapolis, IN 46260. Telephone: (317) 338-8199. Fax: (317) 338-2801. E-mail: LSGAUL@stvincent.org.
Renee Shalosky, Director of Quality Improvement, Southeastern Ohio Regional Medical Center, 1341 Clark Street, Cambridge, OH 43725. Telephone: (740) 435-2339. E-mail: rshal@seormc.org] ■

THE QUALITY - CO$T CONNECTION

Improvements don't end with the action plan

A monitoring system to can help ensure success

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

When a patient care problem or improvement opportunity has been identified, it must be resolved. If the problem is significant, it is important to take action as quickly as possible. Good ideas for resolving the problem are solicited from physicians and staff and the best

solutions identified. At this point the improvement project is over, right? Unfortunately, once an improvement initiative has been completed and corrective actions apparently implemented many projects stop here. The final step (follow-up) is where a lot of performance improvement initiatives fail.

The reason for this is that corrective actions don't get fully implemented and without monitoring some actions fall through the cracks. It is vital to develop a tracking system that will give senior leaders and oversight groups the capability of knowing what corrective items have not been completed. A monitoring system that tracks closure helps to ensure a successful improvement initiative. If the entire system is expected to function properly, then fixing the few problem areas is vital.

Corrective actions are generated as result of improvement projects, root cause analyses, and proactive risk assessment projects. The quality manager often has two different roles to play in the corrective action process: (1) assist in developing the plan; and (2) verify completion of the plan. Neither of the roles involves assuming the responsibility for implementing and evaluating corrective actions. Implementing and monitoring the effectiveness of actions are the responsibility of management of the area or activity being improved.

Quality managers can assist in the corrective action plan by suggesting methods of process improvement. These methods may be based on successful improvement initiatives in other parts of the organization or external best practices. Bear in mind, however, that no one is obligated to follow your recommendations. Even if you offer detailed instructions for improving a process, people may still find their own solutions. The important thing is to have effective corrective actions. Remember also, that the more input you have in developing problem solutions, the greater chance you will have of "owning" the corrective action.

Whatever corrective actions are selected, the plan to be submitted to the leadership group should be well-defined. The quality manager can help with this. Review the proposed actions, the timeline, and measures of success to determine if plans are complete. Work with the PI team leader or process owner to create a comprehensive action plan that documents the steps to be taken, when each action is expected to be done and the accountable people, and the strategies for evaluating the effectiveness of actions.

Verifying completion of corrective actions and impact on problem resolution may take several different forms. The evaluation methods should be part of the corrective action plan so that the

One-Page Improvement Project Status Report

Project Title:		**Report Date:**
Project Leader:	**Reported by:**	**Date of Last Report:**

Actions for This Reporting Period			
Action Description	**Start Date**	**Target End Date**	**Percent Complete**
1.			
2.			
3.			
4.			
5.			

Variance Details: (Actions that didn't go as planned and reason for variances)
Corrective Actions: (Your responses to variances from planned actions)
Planned Actions: (Activities to be done between now and next status report)

Source: Brown-Spath & Associates, Forest Grove, OR

quality manager and over-sight individual or group knows up front which methods of verification will be used. The timetable for measuring effectiveness of corrective actions needs to be part of the plan as well.

The organization's leaders must be kept informed of the status of all improvement activities, whether it is an intra-departmental or cross-functional project. Use a reporting and tracking system to monitor improvement action plans. This can be a paper process — one page per project — such as the form show on page 12. For ease in data entry and retrieval, the same information can be computerized using a spreadsheet or database program. The disadvantage of a paper system for reporting improvement projects is similar to the disadvantage of any paper-based information system — data overload and inflexibility. If improvement project information is computerized, the quality department and other groups can easily excerpt summary information to produce concise project status reports. The projects can be sorted by department, month follow-up is due, important processes, and a variety of other configurations to meet the information needs of different groups.

An improvement project tracking process should provide a means of determining what stage improvements projects might be in at any given time. Make it your ambition to help facilitate the improvement follow-up process, not be the law and order. Department managers and PI team leaders have lots of other work responsibilities and documenting follow-up of action plans may be the last thing on their minds. Use your tracking log to send out reminders approximately one week prior to the due date of follow-up information. When reports are submitted, don't settle for vague entries. For instance, if a supervisor notes that "procedure changes are in progress," ask for more details. If corrective actions are accomplished within the planned timeline, and the evidence indicates the corrective action works, then the improvement project can be considered closed. However, another follow-up evaluation may be warranted if the issue represented a major problem area or if corrective action was complicated. Build safeguards into your tracking process to prevent incomplete corrective actions or evaluations from dragging on.

No matter what format and process is chosen for reporting the status of improvement projects, it will never be an exact science. Report deadlines may be missed or people may be reluctant to let others know that planned actions have not taken place as expected. To combat these situations, organizations need to set the stage for timely and honest reporting. Pave the way for open communication by establishing a structured, yet simple, format for project status reporting. Status reporting should not be a tedious or time-consuming process. In fact, the simpler, the better. An electronic format of the project status report could be developed for online Intranet use or people could simply be asked to fill in the electronic format and send to the appropriate individual or group via email.

Improvement projects usually get behind schedule a day at a time, not a month at a time. Having a means of documenting and tracking these delays is important for spotting the trends that lead to major setbacks. Bi-weekly status reports from the project leaders to oversight individuals or groups are recommended.

The objective of action planning, implementation, and follow-up is to have effective and sustained performance improvement. Organizations cannot allow people to fall into the trap of believing that once the action plan is written, the job is over. Improvement projects should end only after the process owners and senior leaders are satisfied that the corrective action has met the goals and is effectively implemented. ■

'Culture of safety' yields dramatic results

System wins Eisenberg award

A pharmacist noticed that two patients with the same name were admitted to the hospital on the same day. The pharmacist notified each unit and posted signs in the pharmacy warning staff of the coincidence, and encouraging them to use extra caution to verify that they were giving the correct medicine to the correct patient.

A nurse recognized a co-worker for being a great "wingman" when he stopped her from interrupting another nurse getting medications out of the Pyxis machine. She realized that by interrupting the nurse she could have caused additional stress which could have triggered an error — all for the desire to save what turned out to be 10 seconds.

These are two examples of the impact of a

systemwide "culture of safety" which won Sentara Healthcare the 2005 John M. Eisenberg Patient Safety and Quality award from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Quality Forum for "Innovation in Patient Safety and Quality at a Local or Organizational Level."

The initiative began at Sentara Norfolk General Hospital (SNGH) in the fall of 2002 and incorporated successful safety principles from the nuclear power and aviation industries. It has since been implemented systemwide in Sentara's other five hospitals and other sites of care.

"It's about every employee learning our systems to prevent errors, patient injuries, and workplace accidents, and actively applying that knowledge in their work," says **Gary Yates**, MD, chief medical officer. This involves not only clinical staff, but also housekeepers, dietary, security, and environmental services staff, he adds.

The initiative begins with a three-part assessment that includes a safety culture survey, a common cause analysis of past events and an assessment of current improvement practices and outcomes. Specific recommendations are tailored to each site but always include development of behavior-based expectations (BBEs) and revision of the facility's event analysis approach.

BBEs are developed by task forces of staff from various departments who work with the results of the common cause analysis and lists of proven error prevention tools from other high-reliability industries. Here are several BBEs:

• Communicate clearly, using repeat backs and read backs, clarifying questions and phonetic and numeric clarifications.

• Have a questioning attitude, using "validate and verify."

• Hand off effectively by using the "5P" technique: What is the patient or project? What is the plan? What is the purpose? Are there any problems? Do you need to take any precautions?

• Never leave your "wingman." "This is all about being a good team member and coworker, checking each others work along the way, and peer coaching, which is about encouraging safe behavior and discouraging unsafe behavior," says **Carole Stockmeier**, a director of the Sentara Safety Initiative.

For each BBE, there are tools and techniques, such as use of the mnemonic STAR (Stop, Think, Act, Review) for pay attention to detail. "This allows your brain to catch up to what your hands are ready to do," she says. "The BBEs have given

CE *questions*

1. What does a recent *New England Journal of Medicine* study show regarding performance measures?
   A. Performance measures had an adverse effect on quality.
   B. Performance measures had a significant impact on quality.
   C. Poorly performing hospitals showed no improvement after performance measures were implemented.
   D. Since performance measures are not evidence-based, leadership support was difficult to obtain.
2. Which is recommended to improve data collection for core measures?
   A. Give noncompliant staff one-on-one inservices.
   B. Avoid using an electronic medical record.
   C. Have only non-clinical staff perform data abstraction.
   D. Do mostly retrospective data collection.
3. Which is true regarding new requirements from the Centers for Medicare & Medicaid Services (CMS) for patient grievances?
   A. Unresolved verbal complaints can be treated informally.
   B. Only written complaints must be formally addressed.
   C. The hospital board may define what constitutes a grievance.
   D. Unresolved verbal complaints must be treated as formal grievances.
4. Which is accurate regarding CMS' patient rights regulations for resolving complaints?
   A. Timeliness of resolution is defined as within seven days.
   B. Only complaints from patients are required to be addressed, not those of family members.
   C. There is no specific time frame required for resolution of complaints.
   D. JCAHO standards are more stringent than those required by CMS.

Answer Key: 1. B; 2. A; 3. D; 4. A

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

us a new language. When you walk through the halls, you start to hear the language of the new culture, with people saying 'Let me ask a clarifying question.'"

To address physician behavior, a parallel process was developed by a group of physician leaders and nurses. "These teams also looked at the assessment results and added behaviors that were important for the physician community," says Stockmeier. These include physician-to-physician communication for all consultations and establishment of a coordinating physician.

Since multiple doctors are caring for each patient, one member of the team must be the point person for the family and also for the nursing staff. "If a problem comes up, they must know exactly who to go to, so there is no confusion about who exactly is the captain of the ship," says **Gene Burke**, MD, vice president for medical affairs at SNGH.

Generally, when a patient came to the hospital, the doctor acting as the coordinating physician was the one who admitted the patient. "But as we become more specialty focused, sometimes that broke down," says Burke. "And if the doctor who admits the patient feels that he or she isn't the best person to do that job, he arranges with another doctor to do it. There is more formalized recognition that there is one doctor who is the 'go to' person."

The organization's event analysis program also was revised to be more efficient and effective in identifying root causes and determining common causes of past events. "We have revamped our approach to root cause analysis for serious events, so it is quicker and much more operationally based," says **Shannon Sayles**, RN, a director of the patient safety initiative.

Previously, all the responsibility for analyzing the event, developing the action plan, and tracking progress fell on the shoulders of the quality management department.

"Now it is much more embedded in operations,

COMING IN FUTURE MONTHS

- Strategies to maximize reimbursement under pay-for-performance
- Switch to a non-punitive error reporting system
- How to perform a FMEA on medication administration
- Effective ways to implement a medication reconciliation process
- Update on new core measure sets from JCAHO

with a senior leader serving as a sponsor to that particular project," says Sayles. "There is now an incredible awareness across the organization about cause analysis that we didn't necessarily have before. It's no longer stepping outside your role — it is your role."

The organization also trained a large number of staff from a wide range of departments including security, nurses, and pharmacists analysts, in a two-day workshop. They now participate in the various levels of event analysis that occur in the organization.

"The more diverse you make your problem solving team, the better. If you have people all of one mindset looking at a problem, they will have a bias for the solution," says Yates.

Instead of gathering staff together and using typical tools such as flow charts and fishbone diagrams, there is more focus on individual interviews of all involved people, even those who were only indirectly involved, says Sayles. Individual failures within the event are analyzed and coded using charts that outline the various types of human error, system interface failure modes.

"Before, we looked at root causes much more superficially," she says. "If we had a wrong-site procedure, we might have said the root cause was they didn't follow the procedure for time out, and left it at that, and reeducated staff."

During interviews with front-line staff in a recent analysis project, it was discovered that staff did the time out procedure differently depending on the physician. "Some of the staff are willing to confront the physicians and some aren't," says Sayles. "We would have never gotten that type of information before."

In addition to human error and process failure modes, the new system also looks at management system failure modes. Instead of saying that staff didn't follow the time out procedure, the focus is on leadership responsibility to build accountability to be sure the procedure is always followed.

The results of event analysis including individual failure modes are put into a database. These data become part of periodic common cause analyses that look for common themes and issues across a wide variety of cases. "As we get more cases in the database, we can break it down into the specific types of human and system failure modes," says Sayles.

In order to reinforce the behavior expectations, a group of "safety coaches" is developed in each facility. "These are front-line employees from all departments. We train them in observation techniques and how to coach and give constructive feedback," says Stockmeier. "The focus isn't to audit and catch people doing it wrong, but to observe them doing it right and tell them how well they are doing."

Results to date have been promising, such as a 50% decrease in the sentinel and serious event rate. Senior leadership is encouraged by these outcomes, but knows that they are just a "few miles in to a long marathon," says Burke. "This is all about 'making it stick,' and not allowing the work to become a 'flavor of the month,'" he says. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to:

- 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. ■