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ICU collaborative achieves major reductions in hospital infections

Statewide program links QIO, hospital association, and hospitals

Hospitals participating in the Maryland Patient Safety Center's (MPSC) Intensive Care Unit (ICU) Safety Culture Collaborative, a statewide effort to improve safety in intensive care units, are showing major improvements in the reduction of ventilator-associated pneumonias (VAPs) and catheter-related bloodstream infections (CR-BSIs). In fact, five hospitals achieved zero VAP episodes, and 10 hospitals achieved zero episodes of CR-BSIs.

"Since we started participating about 18 months ago, we haven't had any line sepsis at all, and very few VAPs," reports **Rosella Ganoudis**, RN, CCRN, supervisor of critical care at Union Hospital of Cecil County, Elkton, MD. "At the very beginning of the program we had two, and maybe a total of four in 18 months, whereas before we had maybe four a month."

The MPSC brings together health care providers to study the causes of unsafe practices and put practical improvements in place to prevent errors. Designated in 2004 by the Maryland Healthcare Commission, the center's vision is to make Maryland hospitals and nursing homes "the safest in the nation." MPSC is run jointly by the Maryland Hospital Association (MHA) and the Delmarva

Key Points

- Multidisciplinary teams conduct daily rounds to assess, revise patient care goals and processes.
- Cultural change empowers staff to ask for necessary things they once were reluctant to request.
- Secure web portal enables hospital teams to chat with each other and share experiences.

Foundation, the QIO (quality improvement organization) for Maryland and the District of Columbia. The MPSC's ICU Safety Collaborative includes ICU teams from 37 hospitals that have implemented best practices to improve care in their intensive care units.

The purpose of the ICU Safety Collaborative, launched in September 2004 and concluded in October 2005, is to bring together multidisciplinary hospital teams and national improvement experts to achieve rapid and dramatic improvements in patients' lives.

Hospital multidisciplinary teams attend three one-day workshops throughout the course of the collaborative.

Between workshops, teams test changes in their local environment and share results with other participants through e-methods and conference calls.

"The center is 20 months old now, and the reason we won the Eisenberg Award is because of the comprehensive nature of what we are doing," asserts **William Minogue**, MD, FACP, director of the center. "We're very fortunate that the MHA and our QIO got together because they have great but different strengths. The MHA has had an education subsidiary for 30 years or more — the Maryland Education Institute, which runs conferences and courses — and Delmarva brings the know-how in collaboratives."

The MPSC actually has three key areas of focus, plus a research area, explains **Margaret Toth**, MD, chief quality officer for the Delmarva Foundation, which is based in Easton, MD. "One is near-miss reporting; the second is education and training; and the third is the ICU or collaborative arm," she explains. "But the collaborative is where the rubber meets the road — that's the implementation arm."

Inside the collaborative model

Why is the collaborative approach so effective? "Traditionally, we have often known what the right things to do are, but they are much more difficult to put into practice," says Toth. "That's not because people do not want to do them, but because the systems or the environment make them hard for one hospital or one quality manager at a time to achieve."

"The QIO has a staff of people who are expert in this," Minogue adds. "Their CEO ran IMPACT for Don Berwick at the IHI [Institute for Healthcare Improvement]. As wonderful as education is, we all go to conventions and hear bright ideas, go back to the same environment and the same culture, and not a hell of a lot happens. Education builds knowledge and a tools base, but a collaborative is a year-long journey."

For example, says Minogue, hospital CEOs must sign an agreement saying that certain of their team members (hospitalists, nurses, and so forth) will participate in the program for a specified number of hours a week, and that their facility will bear a specific data burden. They must cite deliverables such as reducing central line infections, reducing or eliminating VAPs, developing rapid response teams and reducing the incidence of deep-vein thrombosis and peptic ulcers.

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Editor: **Steve Lewis**, (770) 442-9805, (steve@wordmaninc.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russell Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

"It's the IHI model entirely," Minogue says. "There are three work sessions scattered over the year, and interaction between participants over a listserv and chats on a secure web portal. The first meeting involves national and local experts, which in our case included Peter Pronovost [a quality expert from Johns Hopkins]. The second meeting was a mixture of more information, but mostly questions about how participants were doing and reports from each hospital. The third meeting, at the end of the year-long journey, involves all hospitals reporting their results and impediments."

The three main workshop meetings "brought everyone together," says Toth. Each team brought physicians, nurses, respiratory therapists, and pharmacists, and they all talked about their practices.

"The times in between were called 'time action periods,' during which we would have conference calls where we would talk about what was going on," she adds.

A number of tools were used, including the Agency for Healthcare Research and Quality's safety culture questionnaire, which all ICUs had to fill out in the beginning and end of the year. "It has great questions," says Minogue. "One is really a zinger: 'If you or a loved one went into the ICU where you work, would you feel safe?'" He notes that even at prestigious institutions, only 45% initially said they would feel safe. "That's now up to 75%-80% in units of all kinds," he observes.

Another program deliverable, he continues, is 50%+ improvement. "This takes doing rounds with true multidiscipline teams that include daily goals, for which everyone is in agreement. Around those agreed-upon goals are interventions and process measures that must be done '24/7' — like elevating patients' heads at 30 degrees to minimize the likelihood of VAP, or having no more 'amateurs' putting in central lines. In the old days, interns did all that kind of stuff in on-the-job training. We also require a completely sterile situation and tight glucose control."

For each condition there is a "bundle" of these procedures to be followed, explains Toth. "The best way to make sure these happen is to pull together multidiscipline groups, round on patients every day, have a checklist and a roadmap, discuss what you want to do that day, and keep checking," she notes. "It turns out that having those bundles and having everyone on the same page really works."

Most of the protocols came either from IHI or Pronovost, she says. "We really didn't make up anything new; we used procedures that had already been used and proved successful. We pulled that together into a change package, and basically said, 'If you want to improve, here are five things you need to work on.'"

It's called a "culture collaborative," she emphasizes, because it not only focuses on what needs to be done and how but on who delivers the care. "The 'who' is not administration, but doctors, nurses, dietitians, housekeepers," she emphasizes. "Our methodology brings all these people and their collective wisdom together."

Targeting the ICU

Why was the ICU selected as the collaborative's first target? "We chose the ICU for a couple of reasons," says Toth. "First, we kept hearing from the hospitals that this was an area where they wanted to begin; we are very committed to being certain that the service and opportunities we provide meet their needs. Second, we had very strong evidence there were some fairly straightforward types of things that could be done in the ICU in terms of keeping patients from getting infected and dying from those infections, and we felt that those interventions, if pulled together in something like a collaborative, could be achieved fairly quickly."

The impact on a single ICU can be dramatic, as Ganoudis notes. "We've gotten to the point of knowing what a good data collection system is; before, we were not collecting the right stuff, but the collaborative gave us a way to collect the right data," she explains. "Our first month that we collected data, it said we gave appropriate care in 3% of our cases. We started initiating the program elements one at a time. The next month, we were up to 45%, then we moved into the 80s, and now it's been in the 90s — our latest was between 97% and 99%."

When things do go wrong, she says, "We take that case to see if there are any common grounds on what happened, what might have happened, what could have been done differently," she says. "It is not done punitively but to learn what we have to do to correct things."

Multidisciplinary rounding has become part of the unit's culture, says Ganoudis. "We look at

things in a whole different light; our daily rounding, which includes pharmacy, nutrition, infection control, and nurses, involves getting a goal or plan for the day. We've started assessing the need and the ability to wean on *every* patient, because we won't know if they can be weaned unless we do it. We have a pretty extensive oral care policy now, and it's still being beefed up because the oral cavity is so full of germs."

The ICU nurses, she adds, have really taken the program seriously. "When they saw the first numbers they were flabbergasted," she notes. "Now, for example, every patient gets bathed twice a day." For isolation, they go into a room wearing a gown and gloves, she says. "I think that has made a really big difference."

The most important benefit of the collaborative, says Ganoudis, was being able to see the data. "We felt more of an ownership for the way we took care of patients," she explains. "It empowered staff to ask certain things, because nobody argued with them. In the past, they knew they needed to get this stuff but orders were hard to get. Now, it's more of a routine; it's a bundle, and more of a standing order."

Model is replicable

Toth says that the interplay between hospitals and interplay at the hospitals themselves during the multidiscipline rounding were key to the program's success, along with the introduction of structured tools. "And the hospitals checked twice a day every day to see how they were doing and to make corrections," she adds. In addition, she says, the access to the web portal enabled all hospitals to share their experiences.

"In Maryland, every ICU was working on improving aspects of its care," she notes. "The majority worked with us, but some had been involved in ongoing collaboratives and continued to do so. The idea is that everyone is working on the same thing at the same time, so you have a great opportunity to learn from each other. The teams not only had a better multidiscipline approach in their own hospitals, but a great connection with peers on the outside as well; that's what makes it work."

Minogue is convinced the Maryland statewide collaborative model is replicable. In fact, he says, "Michigan and New Jersey are getting similar results with Peter's [Pronovost] help." Michigan, he notes, is concentrating almost exclusively on the ICU.

"Our program is comprehensive — education, data systems, special projects; that's the key," he says. In fact, he notes, about a dozen states recently brought delegations from their hospital associations and QIOs to Maryland for a site visit. "We're running a program on how this thing works; all of this is in the public domain," says Minogue.

He goes on to re-emphasize the fact that education alone will never engender permanent change. "Education is for cognitive improvement, but without culture change it's not going to happen — or if it does, it's not going to be permanent," he asserts. "In human systems, you tend to get a mediocre state; if you change that state, unless you are constantly applying energy, it will return to that mediocre state. This approach takes that return away — it's permanent. Hospitals who once wanted a 2% infection rate now say they won't settle for less than zero. If anything at all happens, they ask, 'What *happened*?' That's a sea change unlike anything I've seen in health care."

For more information, contact:

William F. Minogue MD, FACP, Director, Maryland Patient Safety Center, 6820 Deerpath Road, Elkridge, MD 21075-6234. Phone: (410) 540-9210. Fax: (410) 540-9139. E-mail: wminogue@maryland-patientsafety.org.

Margaret Toth, MD, Chief Quality Officer, Delmarva Foundation, 9240 Centreville Road, Easton, MD 21601. Phone: (410) 712-7456. E-mail: tothm@dfmc.org.

Rosella Ganoudis, RN, CCRN, Supervisor of Critical Care, Union Hospital of Cecil County, 106 Bow Street, Elkton, MD 21921. Phone: (410) 398-4000. E-mail: rganoudis@uhcc.com. ■

NQF seeks measures for reporting of infections

Officials cite volume of infections

The Washington, DC-based National Quality Forum (NQF) has undertaken a project to seek consensus on a set of national performance measures for public reporting of health care-associated infections. The NQF has solicited measures for review, evaluation, and potential

inclusion in the final set of voluntary national measures and, as of this writing, just completed the collection of all proposed measures.

Measures are being considered at a number of levels of analysis, including individual physicians, physician offices, physician groups, health care institutions including but not limited to hospitals and nursing homes, health plans, and community- or population-level measures. To be included as part of the initial evaluation, proposed measures had to be fully developed for use (e.g., research and testing have been completed) and be applicable to health care-associated infections.

"HAIs [healthcare-associated infections] represent an important public health issue," says **Merilyn D. Francis,** RN, MTP, vice president of NQF. "Approximately 90,000 patients in the U.S. die from an HAI every year out of the estimated 2 million who contract one, and it is estimated that at least 20%-30% are preventable."

In addition, she notes, the NQF has made patient safety a primary issue for a number of years, including the publication of "Safe Practices for Hospital Use to Reduce Infections."

Seeking standardization

"One of the missions of the NQF is to help standardize the way quality of performance is measured and reported," Francis continues. "If you have several people measuring the same thing but in different ways you can't make valid comparison across entities. That's where we come in; we don't develop measures, but we do *call* for measures. We will evaluate [the proposals] at the staff level for rigor and for how they fit and will also use technical advisory panels and a steering committee."

The main objective, Francis explains, is to discover the "best in class" in terms of performance measures, so that like entities can compare themselves in a way that is fair and balanced. "We try to cut through some of the noise," she notes, "which is very important when it comes to benchmarking. What we're looking for is a national standard for reporting health care HAI rates and outcomes of interventions."

The proposed measures were solicited in several different categories:

- intravascular catheters and bloodstream infections and surgically implanted devices;
- in-dwelling catheters and urinary tract infections;
- respiratory infections, including those associated with ventilators;
- surgical-site infections;
- pediatric infections;
- reporting and implementation.

"The first four areas are the ones that are most common in terms of HAIs," Francis observes, adding that they are not listed in any specific order of frequency. "The reason we added pediatrics is that some of these patients are a little different than adults; they have a tendency to have more gastrointestinal infections, and they are susceptible to certain types of viruses from the nursery that don't go to adults."

Key Points

- Proposed measures had to be fully developed for use (e.g., research and testing have been completed) and be applicable to health care-associated infections.
- Initiative guided by NQF mission to help standardize the way quality of performance is measured and reported.
- Main objective is to establish "best in class" standards that hospitals can use in benchmarking.

Year-long review

As for reporting and implementation, she adds the following: "One of the issues with reporting is that several states are making the reporting of these infections mandatory and several others are thinking about it," Francis shares. "This advisory panel [each category has its own advisory panel] will think about what is the best way of reporting to make the information most useful to consumers and lessons learned from states that have implemented them."

There is approximately a year-long review process ahead of the NQF, says Francis. "We will run the proposed measures through for consensus, and then send them out for review and comment," she declares. "Once the board endorses them, we will have a set of voluntary standards." The project is due to be fully completed by mid-2007, she says.

Such a standard will benefit quality managers because "instead of having to create their own standards there will be a place to get them [the

NQF web site, www.qualityforum.org]. They will be posted on the site and made more broadly available through a formal report. Also, because of the consensus process we use, Medicare and Medicaid programs can use them as well," she says.

She adds that the new standards also will be beneficial for organizations with several product lines, because they will be able to use the same measures across all of them.

NQF recently joined forces with the National Committee for Quality Health Care (NCQHC), an organization of health industry leaders focused on improving quality, to establish a reconstituted organization, the National Quality Forum.

Under the direction of the board and new CEO and president Janet M. Corrigan, PhD, MBA, key programs of the NQF and the NCQHC will be enhanced, and strategic alliances with other organizations will be pursued to bring more alignment and coordination to the quality movement.

For more information, contact:
Merilyn D. Francis, RN, MTP, Vice President, National Quality Forum, 601 Thirteenth Street, NW, Suite 500 North, Washington, DC 20005. Phone: (202) 783-1300. ■

CPOE study shows drop in hospital errors

Errors included lack of adequate decision support

In a study published in the February 15 issue of the *American Journal of Health-System Pharmacy*,[1] Agency for Healthcare Research and Quality (AHRQ) researchers, using a national voluntary medication error-reporting database, found that facilities with Computerized Prescriber Order Entry (CPOE) systems in place had fewer hospital-based errors than facilities without a CPOE system.

The researchers found that the most common CPOE errors were dosing errors, and that using CPOE *itself* could lead to errors because of faulty computer interfaces, lack of interoperability, lack of adequate decision support, and human factors such as typing errors, distractions, inexperience or lack of knowledge.

Key Points

- Facilities with CPOE in place had fewer hospital-based errors and more outpatient errors than those without a CPOE system.
- Databases can be useful in identifying specific types of errors related to CPOE.
- Most effective strategy for evaluating a CPOE system would involve a pre/post study.

The primary objective of the study, say the authors, "was to assess the potential benefits and problems associated with CPOE using a voluntary medication error-reporting system, Medmarx, sponsored by the United States Pharmacopeia [USP]."[1]

"At the time we undertook the study CPOE was a hot issue — and personally, I have put a lot of effort into voluntary error-reporting systems, which is a huge issue here and in patient safety in general," says **Chunliu Zhan**, MD, PhD, Senior Fellow at AHRQ and lead author of the study. "One of the key questions was, what can we do with voluntary medical error-reporting data; what useful information can we get out of that?"

The study used Medmarx data from 2003. Medmarx (www.medmarx.com), which was established in 1998, is an anonymous system in which about 600 hospitals nationwide currently participate.

In their conclusion, the authors wrote that a national voluntary medication error-reporting database "cannot be used to determine the effectiveness of a CPOE system in reducing medication errors because of the variability in the number of reports from different institutions."[1] They added, however, that "It may provide valuable and useful information on the specific types of error related to CPOE systems."[1]

Pointing out characteristics

That is exactly what this research was able to show. For example, in describing the characteristics of medication errors related to CPOE, they found that 51.4% were dosing errors, while the next highest category, "unauthorized drug," was only 3.6%. In terms of cause of error, 57.9% were attributed to knowledge deficit, 43.4% to computer entry, 21.6% to abbreviations, and 20.9% to

calculations (the report identified one or more causes.) Factors contributing to medication errors included distractions (78.3%); inexperienced staff (10%); workload increase (7.2%); and "computer system down" (2.8%).

Limitations seen

The fact that the system was voluntary made it difficult to explain some of the findings, however. For example, why there were fewer hospital-based errors in the systems that used CPOE but more outpatient errors? "It's voluntary, so we have no idea what percentage of the errors that happened got reported," notes Zhan. "It could be that outpatient errors happen more, but that's probably not reality; it's more likely that's what got picked up and reported."

This led Zhan to what he calls one of the study's major findings. "By showing you the data, we kind of validate our conception that you just cannot use voluntary data to compare one type of provider with another type," he says.

Another significant finding, he adds, was how the data varied from provider to provider. "However," he notes, "voluntary data *can* provide you with rich information on what went wrong. In this case, can you say the error you reported was caused by CPOE and look at the patterns of what went wrong and why that kind of error happened."

In terms of simply evaluating or determining the effectiveness of CPOE, however, Zhan says there are better methods. "For example, you can do a pre/post study," he suggests. "Before you install the system, look at your error patterns, then after you install it, look again. That's probably the most valid method for determining effectiveness."

CPOE, he insists, definitely reduces errors. "The extent to which it is effective depends on the system," he adds. "A lot of doctors are turned off because a system is too 'error-proof' — it holds too much information for them to absorb. So, there has to be an optimal balance between efficiency, effectiveness, and sophistication. We don't have to prove any longer that CPOE is effective; what we need to look at now is how we can improve CPOE systems."

For more information, contact:
Chunliu Zhan, MD, PhD, Center for Outcomes and Evidence, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850. Phone: (301) 427-1225. Fax: (301) 427-1640. E-mail: Chunliu.Zhan@.ahrq.hhs.gov.

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Facility works to ensure safety in bariatric program

Most complications are preventable, experts say

Robert Wood Johnson University Hospital Hamilton (RWJ Hamilton), a recipient of the 2004 Malcolm Baldrige National Quality Award, has just begun offering a new bariatric (weight loss) program; but long before it took its first case, it has been making preparations to ensure the highest possible quality of care.

This is particularly important at a time when the complications of bariatric surgery are grabbing headlines, but **Earl L. Noyen**, MD, medical director for the program, insists those concerns may be a bit overblown.

"We have probably had over 150,000 of these cases done last year — of all types — and even more worldwide," says Noyen. "The death rate reported from gastric bypass at the American Society of Bariatric Surgery consensus conference in 2004 was less than 1%. And, from the gastric banded procedure [laparoscopic adjustable gastric banding — a minimally invasive procedure that places an adjustable band around the top portion of the stomach] it is minimal — like 0.1%."

Key Points

- Patients over 50 present greater risks because many have several pre-existing comorbidities.
- Patients are assigned clinical professionals, exercise specialists, nutritionists, and support staff to help minimize risks.
- Minimally invasive banding procedure can actually be reversed, if necessary.

The latter procedure, like gastric bypass, also restricts food intake, but without bypassing any of the small intestines. This surgical option can be reversed if needed.

As for complications, says Noyen, the overall complication rate is about 10%; these complications can range from infection to blood clots, or pulmonary embolism. "Still, it's significantly less than other surgeries we do on a routine basis," he notes.

However, many candidates for the surgery present with a significant amount of risk to begin with, he says. "It's not like taking a 17-year-old with a good history, on no meds, and operating," he says. "These patients are usually in their 40s, mainly female, with one or two problems. And when they get over 50, you see significant problems related to obesity like heart disease or sleep apnea. In addition, most if not all are diabetic, they may have had previous surgeries, and they are on meds for chronic diseases. In any setting, the risk is significant — and on top of that you have morbid obesity."

Lowering the risks

What RWJ Hamilton has done, says Noyen, is to minimize those risks. To begin with, the bariatric surgery program is comprehensive and embraces a team approach; candidates are evaluated and pre-existing conditions are evaluated. Patients receive education on procedure options, risks, outcomes, potential side effects, and lifestyle modifications. Progress is monitored and strict dietary and exercise regimens are instituted. Patients are paired with clinical professionals, exercise specialists, nutritionists, and support staff to provide a full continuum of services and counseling.

"These should be integral parts of any weight loss program; you need such a comprehensive program — outpatient care as well," Noyen observes. In fact, he says, the facility has established a separate Center for Health and Wellness where the patients can be seen for nutrition and diet classes, as well as other educational programs, and fitness trainers also are available.

The bottom line, he asserts, is that "Most complications are preventable." For example, in terms of the bypass surgery itself, the biggest worry is a leak, but the team at RWJ is working proactively to minimize the risk of a leak occurring, "When we reconfigure, there is always that risk," he observes. "To make it less likely, we do several things in the operating room."

For example, apart from sutures and staples, the team applies Tissel — a binding polymer that allows in-growth of tissue to help with the healing process. "On the day following surgery, we all go to radiology, where the patient swallows some dye and we proactively check for leaks," adds Noyen. "If there is one, we have the option to go back to the OR in 24 hours and repair it. If there is no leak, we start feeding the patient."

With that protocol, he says, the team may still miss a small percentage of leaks, but the staff are trained to be vigilant, and nurses regularly check vitals. "If the heart rate is over a certain level, the team is alerted and we may still go back laproscopically," he notes.

In addition, with minimally invasive surgery there is no big wound, so patients are able to ambulate even on the day of surgery. "One of the biggest steps you can take to cut back on blood clots is to get up and move, and the nursing staff helps patients do this," he says. "With the smaller incision, patients can breathe better, and there are fewer cases of pneumonia."

In the past, with more invasive surgery, up to 30% of patients developed incisional hernias; now, that is less than 1%. "We have put all the things in place needed to reduce our risk, and hopefully we have a benchmark program," he says.

Special equipment, training implemented

Other aspects of the program geared to enhance safety include the ordering of special equipment and specialized staff education. "We met with different ancillary folks at the hospital looking at equipment that would enhance safety," says Noyen. "That includes larger tables to accommodate obese patients in the OR, the purchase of added padding for beds, and having larger commodes. Even something like larger gowns are important. We did all of that even before our first case."

Education has been facilitated by Summerville, NJ-based Ethicon, a company from which the facility purchased a disposable surgical product. "They provide inservices for physicians, scrub staff, and the RN staff," says **Barbara Lee**, RN, CNOR, director of surgical services. "In fact, 80% of our staff went to an all-day session with them."

The program included techniques of surgery, complications, and sensitivity training for staff so they would be better able to deal with obese

patients. "We wanted to make sure the staff was aware of what the patients were feeling, learned how to help them maintain their privacy and prevent embarrassing situations, such as not having the appropriate chair because they couldn't fit into what was available," Lee explains. "We have discreetly taken care of much of that by providing appropriate chairs, larger gowns, and so forth." The nurses will have everything prepared and waiting for each particular patient, she adds.

Some of the education was also geared to the particular type of staff involved, she continues. "For example, Ethicon brought four of our scrub staff and nurses to their lab and covered hands-on aspects of the procedure with the physicians," she explains.

Lee adds that a steering team continues to meet regularly to talk about the program. Input is solicited from "any department or unit where patients go in their entire spectrum of care," she explains. "They each know what works best in their own area."

As a result of these ongoing discussions, a good deal of the equipment considered was standardized, rather than purchasing a variety of products. "Everyone is required to learn the entire process the patient will go through," Lee adds. "This way, if issues come up anywhere along the continuum of care, they know who to contact."

For more information, contact:
Earl L. Noyen, MD, Program Director, Barbara Lee, RN, CNOR, Director of Surgical Services, Robert Wood Johnson University Hospital Hamilton, One Hamilton Health Place, Hamilton, NJ 08690. Phone: (609)586-7900. ■

AHA establishes quality center for hospitals

Better outcomes among its goals

The American Hospital Association (AHA) has created a performance improvement organization to serve as a resource specifically targeting process improvement in the hospital setting.

The AHA Quality Center was slated for an April 29 launch at the AHA's annual meeting,

Key Points

- Web site will include links to all major quality organizations, as well as hospital case studies.
- Center seeks to make choices easier for quality managers seeking improvement resources.
- The AHA also is establishing a call center to answer hospitals' quality questions.

according to **Stephen Mayfield**, MBA, MBB, a health care expert from Georgia who has been named senior vice president for quality of performance improvement and director of the AHA Quality Center.

"Our main constituents and customers are hospitals and health systems, and through them the patients who receive their care," says Mayfield. "Part of the impetus for forming this center is that there are about 6,000 hospitals in the United States, all trying to serve communities and constituents. They are bombarded on many fronts by external pressures like pay for performance, public reporting, the demand for more transparency, and articles in the media. Internally, hospitals — and, in particular, physicians, nurses, and ancillary caregivers — find themselves in a system not of their own design, nor of their own choosing. That system, because of myriad forces that push and pull, often creates obstacles to them delivering the care they want to deliver. It results in waste, delays, bottlenecks, incomplete information transfer, and information not being available at the point at which it is needed."

Making the choice easier

All hospitals want to give the best care they can, says Mayfield, but "there are so many choices [for performance improvement] that many hospitals are caught in the middle and don't know where to start." This new center, he asserts, will provide one central location to get hospitals on a path to improve quality.

"A hospital may say, 'We are working as hard as we can; how can we get started? What should we work on first? How do we find the resources to do this with a limited budget?'" Mayfield says. "Our goal is that the quality center will be the first place they go to."

Mayfield acknowledges the worth of organizations such as the Agency for Healthcare

Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Joint Commission on the Accreditation of Healthcare Organizations, and the Institute for Healthcare Improvement (IHI). However, he also notes their limitations.

"Each of those entities has an agenda — CMS is payment, the Joint Commission is accreditation, IHI is safety," he asserts. "I applaud them all, but each has a narrowly designed expertise and wants a particular thing. We will not compete with them, but instead will give each their presence on our site. Anyone can come to our site and find all of these organizations."

In other words, he explains, the center will not be the creator of in-depth research or contents, "but a collector and convener of all the great work going on. We will not be in competition with these organizations, or trying to replace them, but we will try to highlight what they are doing," says Mayfield. "What we *might* do is provide a little translation for the hospital consumer that then leads them to an IHI or an AHRQ — a summary that guides them in a particular direction. Our goal is to make it facile, transparent, effective, and efficient."

So, for busy hospital professionals who have safety and affordability at the top of their minds, but only so much time to dedicate, "we can leverage their resource of time, maximize their return, and get the answer they are looking for as quickly as possible," Mayfield explains.

Several services provided

The most visible presence of the new center will be its web content, says Mayfield. "There will be three main sections," he shares. "One will be the major linkages; an opportunity assessment for hospitals on where they might start their search, a quality leadership connection, and a clinical quality exchange. The middle section will focus on the eight dimensions of the hospital that are critical to quality (leadership, improvement strategies and methodologies, the business case for quality, information technology, patient focus, physician and workforce engagement, culture and communication, and performance measurement and reporting). The third section will include timely events and case studies — stories from the field."

One of the goals of the site, he adds, is to feature stories submitted by hospitals. "So, for example, if you are from a hospital in middle Georgia and have a pay-for-performance situation coming, but your AMI [acute myocardial infarction] scores are not where you want them to be, you can go to the web site, click on AMI and find case studies from hospitals similar to you," he explains. "Our goal is to include contact names and phone numbers; that's one of the connections we're hoping to make."

The AHA will also be opening a call center, which will seek to provide responses to all questions within two days.

"One of the things I am most proud of is that the web site will be available to everyone — irrespective of your membership," says Mayfield. "You will have to create a login ID, but even non-AHA hospitals can access it free of charge – because this is the right thing to do."

For more information, contact Stephen Mayfield at (312) 422-2926. ■

Patients deserve info on quality-of-care cases

Regulations prohibit sharing of details

Medicare recipients who have a complaint about their quality of care have a means of reporting their complaints — but it's unlikely they will find out the details of investigations of their complaints, according to the American Health Quality Association (AHQA), which has launched an effort to enact major reforms in the complaints system.

The Centers for Medicare & Medicaid Services (CMS) investigates complaints by Medicare beneficiaries about quality of care by contracting with quality improvement organizations (QIOs) in each state to actually conduct the investigations. However, CMS prohibits QIOs from telling the complainants details of investigations involving physicians without permission from those physicians. Without permission, QIOs can only tell complainants whether their complaint was confirmed; they cannot reveal what went wrong or why.

AHQA, which represents the national network of QIOs, is proposing that QIOs inform beneficiaries of findings, launch a national campaign to promote more timely and direct patient feedback to providers, and help providers correct confirmed

problems reported by consumers.

According to CMS, QIOs have two methods of resolving clinical quality-of-care beneficiary complaints: medical record review and mediation.

When a case is reviewed for quality issues, one of two determinations is made — either "no substantial improvement opportunities are identified," or "care could have been better."

The Medicare patient is not given details uncovered by the QIO. In cases in which it is deemed that care could have been better, the QIO reviewer determines if care was "grossly and flagrantly unacceptable," failed to follow accepted guidelines or usual practice, or could reasonably have been expected to be better. Again, while CMS permits complainants to be kept informed as to the progress of the sometimes months-long investigation, no specifics involving physicians are disclosed.

Cases for which no improvement opportunities are identified or where better care could have been expected can be considered for mediation if the person filing the complaint wants to pursue mediation. Due to the serious implications of cases in which care was grossly or flagrantly unacceptable, or where care failed to follow accepted guidelines or usual practice, those cases are not eligible for handling through mediation.

Medical record review is the traditional option to resolve a quality-of-care complaint under Medicare. When the QIO receives a written complaint about the quality of services received by a Medicare beneficiary, a doctor of matching specialty will review the medical record. When the review is complete, the QIO notifies the complainant of the final disposition of the complaint.

AHQA is proposing that the findings of QIO investigations of complaints be given to Medicare beneficiaries who file complaints, along with information about actions taken to prevent the problem from recurring. The proposal would make QIO findings in complaint investigations inadmissible as evidence in malpractice suits.

"This approach strikes a proper balance," says **David Schulke**, AHQA executive vice president. "It isn't just Medicare that must appreciate that consumer concerns are important indicators of quality breakdowns. Providers, too, must learn to actively welcome consumer concerns, and take timely action to improve care so there is no need to bring in the QIO."

"The role of the Medicare QIO program should be to protect the entire population of Medicare beneficiaries, and to support improvement of America's health care system," says **Jonathan Sugarman**, MD, AHQA past president and the CEO of Qualis Health, a QIO in Seattle.

"Unfortunately, the current Medicare beneficiary complaint system as regulated by CMS has not been implemented in a manner that focuses on rapid resolution of disputes and systematic improvements in care, and has not kept up with our evolving understanding of quality improvement," he says.

For example, Sugarman points out, CMS does not regularly analyze and report the specific types of quality-of-care concerns that are identified by QIOs, depriving QIOs the opportunity to share data on the quality complaints confirmed nationwide.

"AHQA's proposal encourages increased transparency to complainants, remediation of systems problems, and prompt referral to appropriate authorities when willful and reckless actions are identified, and it also supports prompt and candid communication between patients and practitioners when complaints arise," Sugarman adds.

Policy part of modernizing QIOs

AHQA's call to reform the beneficiary complaint program follows the association's adoption in 2005 of a new policy to assure that all QIOs conform to the highest standards for business

COMING IN FUTURE MONTHS

- Hospital program seeks to hone documentation practices, reduce frequency of errors.
- Study: Aging population may place less burden than expected on nation's hospitals.
- 'Impostor' Joint Commission surveyors strike again; Is your facility at risk?
- What are the optimal strategies for managing adverse events?

practices, governance, and public accountability. The new code of conduct — formally adopted by more than two-thirds of QIOs — sets standards for board and executive compensation, diversity, travel expenses, and conflicts of interest.

To implement AHQA's proposals for reform of the beneficiary complaint process, Congress will need to revise the law governing operation of the QIO program. Responding to beneficiary complaints is a small part of current QIO initiatives, which focus mainly on proactive efforts to improve care by providing technical assistance to hospitals, physicians, nursing homes, and home health agencies. Congress will examine how to modernize the QIO program after receiving a report on the program from the Institute of Medicine. ■

NEWS BRIEFS

Does consolidation impact quality?

While a new report from the Robert Wood Johnson Foundation's Synthesis Project concludes that "the balance of evidence" from past studies on hospital consolidation suggests it may raise prices and lower quality, the report also concludes that consolidating facilities may produce cost savings, and recommends further research to learn the effects of insurer market power on provider markets.

In the Feb. 9, 2006, issue of "The Synthesis Project," the foundation reported that consolidation:

- raised hospital prices by at least 5% — and perhaps much more;
- produced modest cost savings for merging hospitals;
- possibly resulted in lower quality.

The report calls the evidence on this latter point "limited and mixed," but did note that the majority of studies find that hospital consolidation does, in fact, lower quality. In fact, it adds, "The strongest studies also show this result." ■

AHRQ launches web tool for states

The Agency for Healthcare Research and Quality has launched a new interactive web-based tool for states to use in measuring health care quality.

The new *State Snapshot* web tool is based on the 2005 National Healthcare Quality Report (NHQR) and the 2005 National Healthcare Disparities Report (NHDR), originally released on Jan. 9, 2006, and provides quick and easy access to the many measures and tables of the NHQR from each state's perspective.

The *State Snapshot* tool features a special focus on each state's performance in the treatment of diabetes across three areas: quality of diabetes care, disparities in diabetes treatment, cost savings that states might accrue by implementing disease management for diabetes for State government employees.

To view the *State Snapshot* tool, go to www.qualitytools.ahrq.gov/qualityreport/2005/state. ■