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Study points out key barriers to compliance with CMS

Experts insist challenges can be overcome

An "Issue Brief" from Mathematica Policy Research Inc., published in March 2006, sheds some new light on the challenges that hospitals face in meeting compliance measures from the Centers for Medicare & Medicaid Services (CMS). The brief shares the results of its assessment of CMS's Hospital Quality Initiative, including a national telephone survey of hospital quality improvement directors, chief executive officers, and chief medical officers, on internal impacts of Hospital Compare. More than a quarter of the hospitals that showed a significant decline in a measure said the decline was due to documentation problems or bad outlier cases. For hospitals showing substantial room for improvement on one or more measures, survey responses revealed three main barriers to improving their scores:

- **Inaccurate documentation:** Cited as a barrier by 90% of responses from both quality improvement directors and senior executives.
- **Failure to involve physicians:** Reported by 76% of senior executives and 83% of quality improvement directors.
- **Insufficient resources:** Between 70% and 76% of survey respondents cited a general lack of financial resources.

(The entire Issue Brief is available at the following web site:

Key Points

- Documentation, physician involvement, inadequate resources top the list of barriers.
- Prioritization, accountability, and ownership cited as keys to improving compliance.
- Improving communication can help in addressing more than one of the key issues.

www.mathematica-mpr.com/publications/PDFs/hospcompare.pdf.)

Despite the large numbers of respondents who identified these barriers, quality experts assert they are not insurmountable.

"Actually, I view most of them as excuses rather than barriers," says **Patrice L. Spath** of Brown Spath Associates, Forest Grove, OR. "An example would be documentation. What will happen when we start getting paid based on how well we document charts? Hospitals have already spent quite a bit of time and money to address concurrent documentation enhancement to make sure they are documenting not just the right pneumonia, but including the organism, or if a patient has respiratory failure, making sure the code is properly documented so they will get a higher reimbursement."

The "documentation" referred to in the issue brief, she explains, involves issues such as smoking cessation counseling at the time of discharge. "If we can fix documentation for one reason, why can't we fix it for another?" she poses.

This carries over into physician involvement, and ultimately, resources, Spath says. "We should be setting priorities for what doctors ought to be involved in," she insists. "A lot of money has been spent on getting doctors trained to document correctly for higher reimbursement, but we don't seem to do it for higher quality care. If documentation, for example, is linked to payment — which it eventually may be — we will work a little harder to make sure things are documented the way they should be."

Accountability, ownership required

In addition to making these issues priorities, Spath continues, there are two other keys to improving compliance. "Yes, it does require, number one, that senior leaders and medical staff leadership say 'This is a priority,'" she observes. "Second, there needs to be a system of accountability. Senior leaders can't just say 'Nurses, you write this, docs, you write this,' and then never measure and monitor — or not have consequences when they *don't* to it."

She likens the situation to the improved DRG system. "The doctors do the records more quickly so they get paid quicker; it was a priority, and they put some teeth into it," she explains.

The third key, she says, is that compliance needs to be seen as an issue that everyone owns. "What I found interesting was, one of the questions was about whether the hospital lacks enough staff trained in QI," she observes. "The thing is, the QI staff doesn't *own* this issue; they don't own the responsibility for ensuring that patients get good, quality care. That's owned by the nurses, the physicians, the respiratory therapists, and so forth. In other words, it takes a team; it takes *everyone* having ownership."

For example, she notes, in some hospitals, case managers have become involved in aspects of ensuring proper documentation. "They are not process owners but members of the team who have some accountability," she notes.

One thing quality managers can do, says Spath, is to keep these issues in front of senior leaders — both medical staff and administration.

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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**.

Editorial Questions

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

"The comparative data are being shared with the public, so you can constantly remind them if your facility is not looking as good as everyone else," she suggests, "And that might prompt them to change their priorities. That's the first step; if they do not view this as a priority, the QI person will be running around trying to do it all by themselves."

Once priorities have been set and people have ownership, Spath continues, "The quality managers might be the ones who facilitate the group of people who get together and talk about how those priorities are going to be addressed."

Improving communication

At Palomar Pomerado Health in San Diego, **Opal Reinbold**, chief quality officer, says resources were not a problem when she joined the organization a year ago, but communication clearly was.

"There was not a clear understanding on the part of clinical staff in terms of what needed to be documented," she recalls. "I would fairly consistently run into nurses who said, 'I *did* that documentation; the quality people are collecting the data wrong.' The quality people, of course, said they weren't."

When they all sat down together, she says, there was a huge "Aha!" moment. The nurses who thought they were documenting what they should realized they weren't, and the quality people said they were looking for the documentation in the wrong places. "When you have 300 pages of instructions around what needs be documented, it's hard," Reinbold concedes. "People are not clear on what needs to be documented in order to get credit."

After the meetings, she says, "The nurses began documenting better and the quality people knew where to look. Everyone agreed to document in the same space at the same time, and we're trying to build some 'locks' in our system so that you can't go on with documenting until these sections are filled in."

One of the problems with physician involvement, she says, is that "people thought these were the quality department's initiatives," reinforcing Spath's point about ownership.

"They now realize these are research best practices, and eventually there will be pay-for-performance for physicians as well as hospitals," Reinbold says. "It's a shift in point of view we are helping the physicians understand through physician champions who are showing them how much better outcomes are, and how [compliance has] really made a big difference."

In the case of smaller community hospitals where it's hard to see every physician, Reinbold recommends "very strong partnerships with nursing and physicians, using standardized order sheets placed on the record by docs — with nurses checking and reminding them. In our case, case managers are involved, too."

From indicators to best practices

Opal Reinbold, chief quality officer for Palomar Pomerado Health in San Diego, has used the data generated by her system's participation in the Premiere Health/CMS demonstration project to move beyond measuring compliance with CMS measures to improving best practices.

"In the past year, I recognized that we were doing well with [CMS] indicators, but not with implementing best practices," she recalls. "We were chasing the data down, but we were we so engaged that not every single patient was getting best care every single time."

At the end of 2005, she pulled together a steering committee comprised of physician champions, quality improvement, nursing staff, pharmacy, case managers, and ancillary departments. "We looked at our data and established best practice work teams headed by nursing, physician champions, case managers, quality managers, pharmacy, and so forth," she reports. "Our goal is to get to 100% for every indicator and to hard-wire best practices." These groups put together PI teams, and all have action plans in place.

"We're also breaking the data down by physician and unit," she adds. "This is not punitive; it is to help them understand and build systems solutions so we can't fail. The order sets we are using are automatically put on, flagged, and everyone on the team is reminding the physician."

The teams also are conducting concurrent reviews on an ongoing basis as the patient goes through the care process. "We look at the chart and make sure the patient receives best practice care every time," says Reinbold.

So far, she says, "We've done very well." One of the groups that presented last week had 100% for every indicator. "That's our goal," she says. ■

At Calvert Memorial Hospital in Prince Frederick, MD, case management is intimately involved with compliance issues, says **Jennifer Stinson**, RN, CCM, director of case management.

The case management model

"Documentation goes hand in hand with physician involvement," she asserts. "And the degree of physician involvement depends a lot on the culture of the physician staff; some welcome change and some fight it all the way."

At Calvert Memorial, they have changed to what Stinson calls "a physician-centered case management model." This means that every physician is assigned a specific case manager, so they form a partnership. "Usually what happens is we allow the case manager to pick the physician they want to partner with; they contact them and set up a time to perhaps talk over the phone daily, or, if they are around later in the day, they can meet up in the unit and round with the physician," she explains.

Were there some physicians no case manager wanted as a partner? "We do have some challenging physicians," Stinson says, "But the case managers took them on as challenges. They have partnered with them and formed good relationships; we've seen not only financial improvement with utilization, but quality improvement as well."

The doctors have really taken to this initiative since it was introduced in January. "We've received nothing but positive input," she says.

The case manager, Stinson continues, is in a unique position. "Sometimes they are the only constant; you have different nurses on every shift, and docs may trade off, too," she notes. "The case manager has the unique ability to see globally what's going on with the patient."

Calvert has a clinical documentation improvement committee to help ensure compliance. "We use queries – little sticky notes put on charts — that are very diagnosis-specific," Stinson says. "For example, if a patient has anemia, we have a 'sticky' for the doctor to document if this is chronic or post-op. The post-op anemia generates a better payment, but you have to have the documentation there."

The staff are very data-driven, she adds. "They want data before they address *any* change," she says. "One thing we look at in documentation is case mix index — and it has been steadily going up."

Data also can be valuable in benchmarking your compliance against other facilities, says Reinbold. "We use Premier's data systems, and as part of that we have been participating in their demonstration project," she notes. **(For more on the demonstration project, see "Medicare P4P demonstration project shows significant QI," *HBQI*, July 2005, p. 74, and "Do demonstration project numbers really validate P4P?" *HBQI*, Feb. 2006, p. 14.)** "That has *really* helped us. There was a lot of focus and energy around this P4P pilot project in our organization, and a lot of energy came out of the quality department."

The good news, she says, is that their data look good. "We view it off the CMS web site, and have done spread sheets of our performance against all other hospitals in San Diego; we see how we're doing as the public might see it, as part of the demonstration project."

Reinbold says her system "looks good," although in some cases they are at 97% with certain indicators – which is not in the top two deciles (required for financial rewards).

"It's not just the data we're concerned about," she adds. "Our motto is, 'Every patient, every time, gets best practice care." **(Reinbold has used her data to address best practices as well as CMS indicators. See related story, page 63.)**

For more information, contact:

Opal Reinbold, Chief Quality Officer, Palomar Pomerado Health, San Diego, CA. Phone: (858) 523-9492. E-mail: opal.reinbold@pph.org.

Patrice L. Spath, Brown Spath Associates, P.O. Box 721, Forest Grove, OR 97116. Phone: (503) 357-9185. E-mail: Patrice@brownspath.com.

Jennifer Stinson, RN, CCM, Director of Case Management, Calvert Memorial Hospital in Prince Frederick, MD. Phone: (410) 535-8217. E-mail: jstinson@cmhlink.org. ■

How to guard against impostor JCAHO surveyors

JCAHO posts reminders about proper procedures

For the second spring in a row, imposter surveyors have sought access to American hospitals. Last year, there were more than half a dozen incidents, and this year there have

Key Points

- Proper security procedures are an important quality concern, asserts JCAHO official.
- JCAHO now providing same-day advanced warning of unannounced survey visits.
- Reporting incidents is critical to the development of new interagency database.

already been three.

"It seems to be that spring must be impostor season," says **Joe Cappiello**, vice president of accreditation field operations at JCAHO. "They started at about the same time in March last year; there were about seven to eight until the beginning of summer, then boom — they were gone."

Now, there have been two incidents in Southern California and one in Wisconsin. "The first one was at a facility in the Los Angeles area," Cappiello relates. "A group of five individuals entered a facility and said they were members of the Joint Commission who were there to do a survey. They were correctly challenged, asked to present identification, and they quickly disappeared."

In the second incident, a single impostor presented at a hospital in the LA area — that same week. "I don't know if they were part of the first group or not, but when they arrived, they said they were there to do some preparatory work because the Joint Commission would be doing a survey the next day. When the hospital representative said they had to contact security and check who he was, he, too, vanished," Cappiello relates.

Then, in early April, a well-dressed woman was seen wandering through a Wisconsin medical center. "When she was challenged, she said she was a surveyor, and they asked her for her ID," Cappiello says. "She said, 'Oh, my gosh, I left it in the car,' and she never came back."

A quality issue

Who *are* these impostors? "If I put on my Tom Clancy hat, I'd think it was preparatory work for terrorists, but I don't think it's that insidious myself," says Cappiello. "Hospitals are rich environments for theft; they have highly expensive narcotics and antibiotics, expensive equipment that is small and getting smaller, and hospitals by design are not secure facilities. The public can easily come and get into hospitals."

If the thieves are not interested in equipment or drugs, he adds, "They could be after data – patient lists, payer data, and so forth."

A quality issue

While such incidents seem on their face to be security problems, Cappiello says they should be the concern of quality managers. "I think, while it is uppermost a security issue, if you look at the standards of the Joint Commission, it is very much in alignment with the standards we have to safeguard the facility and to ensure there's adequate identification of staff," he says. "The other thing we worry most about is infant abductions; drugs and equipment are replaceable, but beyond our general security, we have to control our most precious assets – especially those who are vulnerable to abduction. So, I do think it's a quality problem as well as a security problem."

In fact, he continues, "the whole issue of ensuring safe care through adequate security and identification is a quality issue. Quality managers should work with security to develop a layered security plan."

By the same token, he adds, these incidents should also be thought of in terms of emergency preparedness. "What if you had to lock down the facility?" Cappiello poses. "This all needs to be morphed into one security plan."

JCAHO has put out a notice to all accredited facilities telling them what to do if someone presents at the facility saying they are a Joint Commission employee (The plan also is found on the JCAHO web site: www.jcaho.org.)

JCAHO has taken additional steps, in light of the fact that as of January all surveys are now unannounced. "In anticipation of that and in memory of the issues we had last year, this is what we have done," says Cappiello. "At 7 a.m. on the morning the Joint Commission is due to arrive at a facility, on the secure Extranet site we have established with each facility, we will post the fact that we will come that day. There will also be the names of the surveyors, the pictures of surveyors, their biographies, and a letter will be posted signed by my boss saying who is coming, why they are coming, how long they be there, and his phone number. If this is still not enough for you to validate and verify their identities, call us if you are concerned."

He adds that the Joint Commission also has

told its surveyors to conduct themselves in the following manner: "When you arrive, go to the front desk or security checkpoint — the first place where you could be challenged — announce yourself, tell them you are from the Joint Commission, and wait patiently while they call administration and someone comes to escort you," Cappiello relates. "Do *not* wander about."

Reporting an incident

In the most recent JCAHO alert about these incidents, instructions also were given to all facilities about how to respond to an incident. "The last person you want to investigate anything like this is me," says Cappiello. "We want you to let us know that the incident has occurred, so if you want us to send an alert to the field, we will do that. But you need to contact the police and have them come out and file a police report; this way we will have something that can go into our national data base. Your second call is the state's department of homeland security, because last year after the rash of incidents, we managed to talk with the FBI, with homeland security, and for the first time a database was developed to log and catalog and track suspicious activities in and around health care facilities. Now, someone who is knowledgeable could look at trends or patterns to better understand what is going on."

For more information, contact: Joe Cappiello, vice president of accreditation field operations, Joint Commission on the Accreditation of Healthcare Organizations. Phone: (630) 792-5757. ■

Georgia Blues launch new P4P program

Program follows in footsteps of Virginia initiative

Following in the footsteps of a successful program initiated by Anthem Blue Cross and Blue Shield in Virginia, Blue Cross Blue Shield of Georgia (BCBSGa) is piloting a new provider-directed quality improvement program — Quality-In-Sights: Hospital Incentive Program (Q-HIP). The program will recognize and reward hospitals throughout the state that meet and exceed quality measures in patient safety, patient outcomes, and patient satisfaction.

How much can the Georgia hospitals expect to earn? Anthem Blue Cross and Blue Shield in Virginia has said that it will award 41 hospitals around the state an estimated $12 million for improvements in patient safety and health outcomes.

The performance of the Virginia hospitals indicates that the Georgia facilities can hope to see significant performance improvement. For example, of the participating Virginia cardiac care hospitals with full data available, more than a 47% reduction was seen in serious complication rates for angioplasty, along with a 29% reduction of serious complications for cardiac catheterization.

During the same time period, hospitals nationally averaged reductions of 20% and 22%, respectively.

American College of Cardiology guidelines set the gold standard for door-to-balloon time at 90 minutes or less. The eight Virginia Q-HIP hospitals remain significantly better than the national average and have demonstrated an improvement of 17% against the 90-minute standard over the two-year time frame. The national average increased 12% over the same period.

Hospitals participating in Q-HIP voluntarily commit to improving programs and processes to reduce the rate of medical errors, improve patient health outcomes and better satisfy their patients. As they succeed, the participating hospitals earn financial incentives.

How the incentives work

"Blue Cross Blue Shield of Georgia's approach emphasizes accountability but takes a tailored approach to each hospital," says **Randy Axelrod**, MD, vice president, east region healthcare management, WellPoint Inc. (BCBSGa is an

Key Points

- In Virginia, 41 hospitals are being awarded $12 million for improvements in patient safety and health outcomes.
- The approach is tailored to each hospital, which can choose its own goals and objectives.
- Performance objectives are based on processes published by JCAHO, the Leapfrog Group, and other national organizations.

operating subsidiary of WellPoint Inc., as is Anthem.) "For instance, one hospital might focus more on reducing the incidence of hospital-acquired infections, while another might work toward developing an enhanced interventional cardiac program."

Performance objectives

The incentives the hospitals can earn reflect a percentage of their total revenues with the Blues, Axelrod explains.

While noting that exact percentages are confidential, he says they are "substantial enough that we get the attention of the hospitals. I don't think there will be much trouble encouraging hospitals to participate."

The Q-HIP performance objectives are based on safety and care processes as published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Leapfrog Group and other respected national authorities. BCBSGa, through its agreement with Anthem Blue Cross Blue Shield Virginia, also collaborates with the American College of Cardiology in identifying cardiac-related indicators.

Under Q-HIP, hospitals are evaluated annually on a series of performance objectives with a calculated Q-HIP score, on which the monetary incentives are based.

The score is calculated as follows: At the macro level, the scorecard is divided into three parts — patient outcomes or clinical outcomes; patient safety; and patient satisfaction. The latter, notes Axelrod, will be derived from CMS. "As they will have the tool, we will use their exact scores," he explains. "We try to use a lot of the things the hospitals already have in play."

A score grid is created for all the different metrics, he continues. "You might get no points, all the points, or half the points," Axelrod offers. "Your cumulative score will dictate the 'percentage of your percentage' you will receive."

Differences recognized

The scoring system recognizes differences in hospital services, Axelrod continues. "Take clinical outcomes, for example. We will take into account whether or not you are a cardiac hospital. Even further, we will look at whether or not you do open heart [surgeries]. So, we do not penalize you if you do not do these things; the points are re-allocated and redistributed."

For hospitals that perform bypass surgery, however, there are different measures. "We will soon be announcing a fairly comprehensive relationship with the Society for Thoracic Surgery," Axelrod shares, "And one of the things we will be embedding will be the collections of outcomes measures on their side, so those hospitals will be graded on something they should be submitting as well as on cardiac surgery; this is the best severity adjuster when you look at expected mortality and morbidity."

Smaller community hospitals, on the other hand, will be measured on JCAHO hospital quality measures for conditions like pneumonia, obstetrical care, congestive heart failure, and National Hospital Quality Measures.

Process orientation

The patient safety measures, says Axelrod, are "a little more process-oriented, as opposed to outcomes." They will use measures from organizations such as The Leapfrog Group, the NQF's recommended safe practices, and IHI's 100,000 Lives campaign.

Just as the evaluations are tailored to the hospitals, the hospitals themselves determine their major goals and objectives — as well as how they will use their rewards.

"One very large hospital in Virginia took their earnings, and from the get-go said they would be divided in three parts," he shares. "One third went to the bottom line of the system, another into improving the 'cath' lab under the direction of the physicians, and the third went to the support staff in the labs. So, the technicians would receive bonuses as employees for achieving improved rates for success."

This is a "great engagement tool" for hospitals, notes Axelrod. "Interestingly, that hospital scored the best of *all* the hospitals in Virginia – which was a pretty big eye-opener," he declares.

Axelrod says the program will continue to evolve. "We're in our third year, so someone is always getting the next, or best, version," he explains. "We started with "Version III" in Georgia, which has a little more emphasis on health outcomes and a little less on the other two categories, because we felt this really had to be about the 'proof of the pudding.'"

For more information on Anthem Blue Cross and Blue Shield in Virginia, please visit www.anthem.com and choose "Virginia." ■

Diabetes care program addresses specific needs

Program addresses cultural differences

Project Dulce, a diabetes care management program housed at Whittier Institute for Diabetes in La Jolla, CA, has successfully addressed not only the difficult challenge of helping patients manage their diabetes, but also another issue of growing concern to quality managers: improving outcomes among minority populations.

Using a combination of trained diabetes educators, endocrinologists, and peer educators (minority individuals who have successfully managed their own diabetes), the program has achieved impressive results.

Project Dulce, partially underwritten by Scripps Health (which owns the Whittier Institute), has cared for more than 4,000 individuals at 17 sites since its inception in 1997. In its initial 18-month pilot program alone, Project Dulce was able to reduce the average hemoglobin A1c in 300 patients from nearly 12 to 8.

"We developed an approach we thought would work," recalls **Chris Walker**, MPH, director of strategic planning and development at the Whittier Institute. "We brought together endocrinologists, plus people who had worked in the community setting and knew how to approach diabetes patients. The program combines clinical expertise and community-based knowledge about how to reach [minority] populations."

Originally designed to serve Spanish-speaking patients, project Dulce has expanded to include Vietnamese and Filipino patients. As a hospital-sponsored program, officials of the American Hospital Association and others believe it may offer a valuable model for other hospitals to emulate.

Key Points

- Experienced nurse peer educators are keys to program's success.
- Hospital-sponsored community program may be a model for others to follow.
- Program also benefits hospitals by reducing length of stay for diabetic patients.

Pilot sets model

"The New Jersey Hospital Association has called and asked us to present to their groups; they're thinking of doing something similar there," shares **Athena Philis-Tsimikas**, MD, executive director and chief medical officer of the Whittier Institute.

The staffing in the original pilot program created the model for the full-blown program, says Walker. "We had one team – a diabetes nurse educator, a dietician, and a peer health educator," she explains.

"They provided clinical management, and the nurse educator and dietitian developed the whole curriculum to train people with diabetes to deliver diabetes education," she says.

The peer educator curriculum involves a 10-week course. The peer educators also are complemented in-hospital by the nurse educators, who use hand-outs from the course in Spanish, English, Vietnamese and Filipino, adds Walker.

"The nurses and dietitians we work with are all certified diabetes educators; each has had about 10 years' experience in managing diabetes," Philis-Tsimikas adds.

When a patient is identified as having diabetes by a physician in one of the participating health centers (the community clinic system and primary care physicians are part of the program), they are referred to the project. "We explain the program to them in their native language, set them up for an appointment with the nurse, and enroll them in group education classes," says Walker.

The nurse conducts a comprehensive assessment, which takes about an hour. "The nurse works with the patient to develop a care plan and does the clinical management in collaboration with the physician; she takes charge of labs and medication judgment, under the physician's guidance," says Walker.

Specialization is key

Some of the nurses are not bilingual, but each has an assistant who is, she continues. "After all clinical exams are done, the patients come in as needed," she shares. "We collect all the data and put it in an electronic registry, which allows us to track clinical outcomes and also to track patient activities — which of them, for example, has not had a recent retinal exam."

The specialized knowledge of the educators and dietitians, as well as the special experiences of the peer educators, are keys to the success of the program, she says.

"Look at the ease with which [the nurse educators] use insulin," offers Philis-Tsimikas. "You have a lot of patients with Type II diabetes, of lower income, ethnically diverse, and they have let their disease go for quite a while; many have had the disease for 10 years and have had minimal care. You have primary care physicians who are very motivated but who deal with a lot of different diseases and conditions, and their level of expertise in insulin is not that great. So when you put in a person who can teach someone to start insulin 'in their sleep,' — or any of the meds required, for that matter — the patient looks at that person as an expert in diabetes."

Their experience also enables them to recommend the best possible combination of medications, she adds.

"And they are able to educate the patient about why it is important to take your meds, test your blood sugar, alter your diet, and so forth," she notes. "They *work* with them; that's important to the patients."

The peer educators complete the "package" of care. "They connect with them culturally," says Philis-Tsimikas.

Walker agrees. "They are from all different cultures; different belief systems impact their ability and willingness to manage their diabetes," she says.

"There might be the whole concept that the disease is their fate — which they might have done something wrong and there is nothing they can do about it. Yet studies show the key to improved self-efficacy is feeling your can control the disease. We address these issues in a culturally sensitive way and complete their education so they have more accurate information," she says.

It is that complete package that is so key, adds Philis-Tsimikas. "It is very hard to treat Type II diabetes and get people where they need to be with their goals *just* with the peer educator," she says. "You really need the combination, because they each attack things from a different perspective."

Hospital-based programs

Just as the Scripps health organization is underwriting Project Dulce, says Philis-Tsimikas, other hospitals and health systems can pursue a similar model.

"Hospitals need to know there's a program they can send their hospitalized patients out to," she explains. "They might be admitted with something else, but if their blood sugars are running around 200 to 300 you might have to keep them in the hospital an extra two to three days — unless you know you have someone you can send them out to with whom you feel comfortable. In our communities, *we* are the program. Other hospitals can have the same sort of program set up in their own location."

That's just what Scripps Health has done, she continues. "Yes, we are subsidized, but we are able to bill for services, and we have made a really good effort to try and get as much reimbursement as possible so as to be self-sufficient; and we are pretty darn close. Scripps does help us with a little bit of the rent."

Better outcomes

It's important to remember, says Philis-Tsimikas, that setting up such programs not only helps the community, but it also helps the hospital in the long run.

"For one thing, we conduct monthly professional education programs; we teach in-hospital nurses how to better care for diabetes patients," she says.

The ability to reduce LOS for patients with diabetes becomes even more significant, she says, when you realize just how many patients who are hospitalized also have diabetes.

"Our hospitals here have recently gained the ability to look at the percentage of patients who have diabetes," she shares. "It ranges from 12% of all admissions in one hospital all the way up to 35%." One cath lab, she continues, reported 40% to 45% of its patients had diabetes.

"So we're not talking about a small number of people, but a large percentage of those patients in a hospital who are affected," she emphasizes. "They have longer hospital stays — by a day and one-half on the average. If you have outpatient education plus better inpatient care, you will get better outcomes."

For more information, contact:

Athena Philis-Tsimikas, MD, Executive Director and Chief Medical Officer; Chris Walker, MPH, Director of Strategic Planning and Development, The Whittier Institute for Diabetes, 9894 Genesee Avenue, La Jolla, CA 92037. Phone: 1-877-WHITTIER. ■

Tool enables state quality comparisons

Tool represents vehicle for benchmarking

The Agency for Healthcare Research and Quality (AHRQ) has unveiled a new interactive web-based tool that provides each state a way to evaluate its health care quality, thus providing another resource for benchmarking.

The new State Snapshot tool breaks down data from the 2005 National Healthcare Quality Report (NHQR) and the 2005 National Healthcare Disparities Report (NHDR), released earlier this year, into state-specific snapshots. **(For more on the NHQR and the NHDR, see "Study: Quality improving at a modest pace," *HBQI* March 2006, p. 32.)**

There were several reasons for creating the tool, says **Dwight McNeill**, PhD, MPH, AHRQ's lead for the NHQR and the State Snapshot. "First, in doing the [NHQR] report, we create a lot of information —99 measures, and 33 data sources — and a lot of those are for states, so it was just wise and prudent to use those resources," he notes. "Also, the states have been very important partners in improving health care quality, and we have to do what we do through partners, as we are a small agency and do not have regulatory or financial control of things. Plus, the states are where the action is happening for reform — whether it's the Massachusetts health insurance reform or others, like Vermont or Washington, doing statewide plans to improve chronic illnesses."

Finally, he says, the states asked for it. "They saw our data, and asked us, 'What do you think the top 10 measures are that states should concentrate on?'" he shares. "We responded that we do not have all the pearls of wisdom, but if we worked together, we could get the data that's relevant for them."

Key Points

- Snapshots drawn from reports with nearly 100 measures and 33 data sources.
- Dashboard design enables user to click down for additional specificity.
- AHRQ says tool will provide quality managers with an additional vehicle for benchmarking.

A multi-layer approach

McNeill says that AHRQ has attempted to have a multi-layer approach to looking at the data. (To view the *State Snapshot* tool, go to www.qualitytools.ahrq.gov/qualityreport/2005/state.) "First of all, the states wanted to have a dashboard; as you know, these are currently very popular," he says. "They summarize and focus on the key information. So, we took the dashboard piece and presented the information on different 'dials' — for example, how the state did overall. Then, there are different dials if you just want to track nursing homes, for example, or just hospitals."

Under each of the major dials, the user can click down for more specificity, he explains, as different audiences are interested in different information. "For example, some of the press likes the rankings, while analysts are more interested in the data," he observes.

Interestingly enough, he continues, it's often not what the snapshots present but how it is presented that users value. "For example, we use measures that the QIOs use, but we present them in a different way; QIOs do not summarize the data," he notes. "People will tell us, 'This is not different data, but what we really like is the way you are presenting it.' This helps the data come to life; you can really see what's happening with hospital care."

Benchmarking for quality managers

For interested quality managers, the tool "does provide benchmarks for hospital data," McNeill says. "While hospital data are not uniformly available, it is possible to look at variations across the states to get an idea of benchmarks."

For example, he continues, in the areas of heart failure, heart attack, and pneumonia, it's possible to see how one state does relative to its neighbors. "You can also look at the top 10% and the bottom 10% of states, so there's a lot of comparative data you can look at," he suggests.

McNeill pulls up the state of California and reads the data to demonstrate how it might be used. "They are rated as relatively weak on hospital care nationally — and for the Pacific states, they are even worse," he observes. "Two things we found I think are relevant for hospitals: When we look at the weak measures, it's first of

all a surprise to see them weak in hospital care. I found it curious that, on the one hand, they were average on admission measures but way below average on many of the discharge measures. That raises a flag."

As he drills down to the tables, he obtains benchmark data for California. "If you look at one hospital measure, the percentage of Medicare heart attack patients getting aspirin at discharge, you can see state data, regional data, and top and bottom 10%," he notes.

Looking at the numbers, he notes that 85.4% of those patients received aspirin at discharge. "The average for the region is 90%; the top 10% is 95% and the bottom 10% is 83%. So, they were clearly below average, below region, and there is a lot of room to go — 10 points to be at the level of the best performing states," he declares. "There's a lot of room for improvement, and you can see what this means in terms of lives and dollars."

For more information, contact: Dwight McNeill, PhD, MPH, Agency for Healthcare Research and Quality, 540 Gaither Road Rockville, MD 20850. Phone: (301) 427-1364. ■

Remote monitoring leverages CMs' resources

Data determine who needs immediate attention

Every morning, a group of congestive heart failure (CHF) patients steps on a scale at home, then answers a series of questions asked by a device attached to their telephone.

The scales prompt patients by voice and on a digital monitor about shortness of breath, dizziness, swelling of the ankles, and other symptoms of heart failure.

The information is transmitted to their case manager at Montefiore Medical Center's Care Management Organization (CMO) in Yonkers, NY, which contracts with five regional HMOs to manage the care of more than 115,000 patients.

If the results indicate problems, such as rapid weight gain, the nurse contacts the patient immediately. The goal of the remote monitoring program is to manage the patient's conditions to keep small issues from becoming bigger.

"Medical expense in the [remotely monitored] group is currently trending at a rate that is 18% lower than the rest of the population managed under risk. This is mainly due to a reduction in hospitalization utilization," says **Ann Meara**, RN, director of medical management at the CMO.

"We have a financial risk associated with managing this group of patients. We are getting capitation revenue, and we are choosing to spend it on telemonitoring so we can identify episodes of decompensation much earlier and prevent hospitalization," she says.

Of the 200 patients in the CHF disease management program, about 130 have received a remote monitoring device.

Some patients have been using the remote monitoring equipment for more than three years.

"It's had a tremendous impact on patient outcomes," Meara says.

Telemonitoring allows care managers to manage the care of patients very intensely, while maximizing the resources of the organization, she points out.

"It's all about leveraging resources when you have a large number of people to be managed. It helps us identify the patients who are doing worse today than yesterday or a week ago and who may need some more interventions," she says.

For instance, one care manager could be monitoring the care of 150 patients but couldn't possibly know which ones needed intervention on a given day without calling them.

With remote monitoring, the nurse gets information on the weight and answers eight to 10 symptom-related questions and can zero in on the people who need a phone call.

"When she gets a list of people who weighed

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in and answered the questions, she knows who to call right away. If the patient's condition doesn't look good, she can call right away and connect them to the doctor or the emergency department or put an emergency plan in place and tell the patient to take extra Lasix," Meara says.

By the time the case managers come in each morning, many of the patients have weighed in and answered the questions. The nurse reviews the data and determines who needs a call.

The system generates reports of patients who haven't weighed in for two days, which prompts a phone call from the nurse.

"The patients have a sense that there is a partnership between them and the case manager. Standing on a scale and writing their weight on a piece of paper doesn't engage people, but with this program, they know if certain things happen, their case manager will call them," Meara says.

When a patient enrolls in the program, a care manager conducts an assessment, collecting clinical information as well as information about the patient's perception of the disease, the caregiver situation, and any psychosocial issues.

The equipment is delivered direct from the manufacturer with instructions on how to set it up. The patients have had no trouble setting up the equipment on their own, Meara adds.

The device asks questions about symptoms and compliance, such as "Are you more short of breath?" "Are your feet swollen?" and "Do you have a three-day supply of medication on hand?"

"The parameters for weight and other issues are customized for each patient. Three pounds in one patient may not be a crisis but for another, it's a major issue," she says.

The case managers work closely with the physicians in the network, alerting them when the data indicate that the patient is having problems.

"The physicians like the program because it cuts down on extraneous phone calls from patients. The nurse can intervene in some instances and that patient doesn't always have to come into the office," Meara says.

The CMO started out offering the remote monitoring device only to people with Stage 3 or 4 CHF, Meara says. "Over the course of time, the people using the scales did so much better that we began offering it to everyone. The cost of the equipment is minimal in comparison to hospitalization," she says.

The CMO is exploring ways to use a similar remote monitoring device for diabetes patients and patients with other chronic conditions.

"We see remote monitoring equipment as a tool to leverage our resources. We have a huge diabetic population that needs to be managed. Many are young and work during the day. They could upload glucometer reading and answer the questions at night," Meara says.

Instead of using a discrete clinical marker such as weight for other at-risk patients, the monitor may just ask a series of question on a regular basis, she points out.

For instance, the device might ask: Do you have medication on hand? Did you take your medication today? Were you able to exercise?

"This would allow the case manager to keep tabs on the condition of all patients who qualify for our case management programs without having to call all the time," Meara says.

The program is to the hospital's advantage as well, she points out. "Our hospital operates at close to 100% capacity almost all of the time. Heart failure accounts for a very high number of admissions, and these admissions are frequently avoidable with early recognition of worsening symptoms and initiation of treatment. It's a win-win situation," Meara says. ■