Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON AMERICAN HEALTH CONSULTANTS

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'100,000 Lives' campaign hits its target ahead of deadline

IHI sought participation; more than 3,000 have signed up

The Institute for Healthcare Improvement (IHI), based in Boston, has reported that U.S. hospitals taking part in an 18-month effort to prevent 100,000 unnecessary deaths by dramatically improving patient care have exceeded that goal. Hospitals enrolled in the "100,000 Lives Campaign" have collectively prevented an estimated 122,300 avoidable deaths, according to IHI and, as importantly, have begun to institutionalize new standards of care that will continue to save lives and improve health outcomes into the future.

The campaign, initiated by IHI in December 2004, has enrolled more than 3,000 hospitals — representing an estimated 75% of U.S. hospital beds, and far surpassing the original enrollment goal of 2,000. About 86% have sent in mortality data.

How did IHI determine how many lives were saved? Campaign workers examined 2004 data for the participating hospitals to determine how many people were expected to die during the 18 months of the campaign. Then they checked the count of actual deaths reported. They also made mathematical adjustments for severity of illnesses and for volume of cases, to make a fairer comparison of the two time periods. They also made estimates for participating hospitals that did not report data.

Key Points

- Major improvements are possible even without the benefit of technology.
- Implementing all six initiatives appears to heighten chances of success.
- IHI plans to raise the bar again when new goals are announced at year's end.

"We get the data directly from the reports supplied by the participating hospitals," says **Joe McCannon**, IHI's campaign manager for "100,000 Lives." "We refer to that as the baseline data — the year before the campaign. Then, we look at data [hospitals provide deaths over discharges on a monthly basis] from January 2005 to June 2006, compare the performance, aggregate the data nationally, apply acuity adjustment to the hospital data, and create an aggregate estimate."

Mortality rates drop

It's a little trickier for hospitals to individually determine lives saved, he says, because they lack the acuity information needed. "However, individual hospitals may be looking at their mortality rates over time," he notes.

One campaign participant, Contra Costa Regional Medical Center in Martinez, CA, has seen a significant drop in mortality rates, according to **Steve Tremain**, MD, senior medical director for the Contra Costa Health Services system and director of system redesign for Contra Costa Regional Medical Center.

"By using ChartRunner, which IHI taught us how to use, the data show the mortality rate has dropped from 0.85% to 0.67%. That's truly significant; it's a 21% reduction," Tremain observes.

Tremain went to IHI's first annual meeting on redesigning hospitals in 2005. "They focused on systems solutions — helping people not make mistakes they did not want to make," he recalls. "We brought their ideas back to our organization, and we very quickly got support of the medical staff-run PI committee to sponsor our participation in all six initiatives."

The six "100,000 Lives" initiatives are:

- Activate a rapid response team (For more on rapid response teams, see the cover story in our July 2006 issue.)
- Prevent patients from dying of heart attacks by delivering evidence-based care.
- Prevent medication errors by ensuring that accurate and continually updated lists of patients' medications are reviewed and reconciled during their hospital stay.
- Prevent patients who are receiving medicines and fluids through central lines from developing infections by following five steps, including proper hand washing and cleaning the patient's skin with "chlorhexidine" (a type of antiseptic).
- Prevent patients undergoing surgery from developing infections by following a series of steps, including the timely administration of antibiotics.
- Prevent patients on ventilators from developing pneumonia by following four steps, including raising the head of the patient's bed between 30 and 45 degrees.

The first initiative implemented was medications reconciliation, and the others followed shortly thereafter, says Tremain.

In addition to lowered mortality rates, Contra Costa can point to a number of other successes. For example, it has lowered its ventilator associated pneumonia (VAP) rate significantly. "On patients on ventilators 48 hours or more, it dropped from about 20% to 1.8%; that's a 90%

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drop," says Tremain. The main reason the CCU gave for its success, he says, was that it was using the entire bundle of steps recommended, not just individual pieces. "One of the things IHI talks about is there is no 'partial credit,'" Tremain explains. "This is not a smorgasbord; the impact of each step is synergistic when you use them all."

A number of the successes at Contra Costa were achieved without the aid of technology, Tremain notes. "For example, our nurses were puzzled as to exactly what a '30% head of bed elevation' looked like [one of the interventions in the bundle]," he recalls. "They measured where it was, brought in a roll of red tape, and put it on the wall behind the head of the bed. If you could see the red line, the bed was not at the right level. So, for $3 [the cost of the tape] they identified the correct level on all potential ventilator rooms."

The last thing the staff did, he adds, was to put up a poster in the unit explaining the red line to family members, and asking them to inform the staff if they could see the line. **(This strategy also helps put the facility in compliance with one of JCAHO's 2007 National Patient Safety Goals; see the article on p. 88.)**

In another instance, the director of respiratory therapy made a clear model to represent the trachea, put a tube in it, inflated the cuff, and put pea soup in the tube. "They showed the staff that *everything* gets past the cuff," Tremain relates. "So, the staff realized they couldn't put *all* their trust in the cuff."

Involving the community

Another facility that has been a successful participant in the campaign, Brattleboro (VT) Memorial Hospital, is looking to improve on its success by involving the local community.

"We are moving medication reconciliation to another level," explains **Jan Puchalski**, quality specialist. "We have information on our web site, we've done newspaper articles, and educational programs," she shares. "In our quarterly report, which goes out to 'the world,' we are really trying to get the patients to make these lists and check their accuracy while they are *at home and well,* and to get used to taking them with them. We hope to [improve things] at the front end."

Brattleboro Memorial also has been involved with the campaign for more than two years. "We were in on surgical site infection prevention at the ground level, and we've also done rapid response teams," Puchalski relates.

For myocardial infarctions, the facility now gives aspirin on arrival and at discharge 100% of the time, she reports. "Discharge instructions for CHF [congestive heart failure] were at 31% last year; now they are at 100%. We've had similar improvement in adult smoking cessation classes," she adds.

CHF, she says, probably represents their greatest area of success. "We've worked out things so it's part of the process," she explains. "The nurse has a discharge summary sheet, which cues her as to the discharge instructions. Before, it was just by reminder or memory."

The same is true with pneumonia vaccinations, she says. "We were quite low with giving it — about 18%," she recalls. "We included it on our sheet and incorporated a standing order so nurses do not have to rely on docs; they can give it on their own." The protocol, she says, is based on CDC recommendations.

In the area of preventing surgical-site infections, antibiotics are given within one hour 100% of the time. "Before, we 'knew' we were giving it, but we weren't really sure — because there was no documentation," Puchalski explains. "We added it to the flow sheet that the anesthesiologist actually uses, so it cues him to put in 'antibiotic given' and 'time given,' so we now have that documented."

Use all the initiatives?

In order for a hospital to participate in the "100,000 Lives" campaign, it only has to agree to implement one of the six initiatives. However, according to IHI statistics, most of the hospitals appear to have implemented more than one. Here are their figures, broken down by initiative:

- Rapid response teams: 1,781 hospitals participating.
- Heart attacks: 2,288 hospitals participating.
- Medication errors: 2,185 hospitals participating.
- Central line infections: 1,925 hospitals participating.
- Surgical infections: 2,133 hospitals participating.
- VAP: 1,982 hospitals participating.

Roughly one-third of the facilities said they were implementing all six measures, and more than half committed to at least three, the IHI

notes.

"It's an important question," says McCannon. "Our assumption is [they will save more lives] if they do more, and participate in more of the initiatives." However, he notes, some initiatives, like the rapid response teams, have really great potential to save lives. "The thing is, you can look at each of the interventions in your hospital, and that would give you a very strong sense of the changes happening on the hospital level," McCannon notes.

"I think there's real value in using all six of the initiatives," says Tremain. "After all, the concept is called opt *out,* not opt in. When we have the science that tells us what's best for the majority of patients, you have to turn it around."

He offers the example of providing patients with aspirin. "You would opt *not* to give aspirin to someone with a bleeding ulcer, but everyone gets the proven care unless the patient brings something unique to the situation, where the best care is not best for them. We learned that this methodology is transportable to any specific set of interventions."

Did the IHI exceed its goal, at least in part, because it enrolled more hospitals than anticipated? "That could be a factor," McCannon concedes. "We've tapped into a lot of energy and frustration among providers of care who are anxious to make improvements — and have done so in a proactive way. Also, it's easy to get involved; there's a low goal of entry, and it's pretty straightforward."

The IHI is definitely *not* going to rest on its laurels, he continues. "Our feeling is there is still a great deal of room for improvement; our work is still in its early stages," says McCannon. "We will encourage hospitals to completely do all six initiatives, show them how to sustain them broadly, and in December we will announce a new level of the campaign — likely some new interventions."

Won't things be a bit anticlimactic, now that the goal has been met? "Part of the charisma of the campaign has definitely been associated with its aims," McCannon admits, "So we will be mindful of that in the new phase."

The IHI has hinted that the new phase may include the goal of having all hospitals participating in all of the initiatives by the end of 2007.

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Joint Commission releases 2007 NPSGs

The 'devil,' as always, is in the details, experts say

The 2007 National Patient Safety Goals (NPSGs) recently announced by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) do not at first glance seem to impose any onerous requirements on quality managers — nor do they seem to call for any dramatic changes in what are probably fairly standard practices. However, notes one quality expert, the "devil is in the details" when it comes to compliance, and when you drill down beyond the basic standard outlines, the picture becomes more murky.

The 2007 NPSGs actually include only one new goal that applies to hospitals. The Joint Commission also extends to hospitals a 2006 goal that at first did not apply to them. The new goal, 15/15A, is as follows:

"The organization identifies safety risks inherent in its patient population.

"The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]"

The extension is for goal 13/13A. It reads:

"Encourage patients' active involvement in

Key Points

- Determining the precise meaning of phrases like "emotional and behavioral disorders" poses a compliance challenge.
- Is suicide assessment required when emotional disorder is a secondary diagnosis?
- Know *all* the patient safety goals — even those that don't currently apply to hospitals.

their own care as a patient safety strategy.

"Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so."

Concerning the new goal, **Richard Croteau**, MD, executive director for patient safety initiatives at the Joint Commission International Center for Patient Safety, says: "The requirement is that these patients be assessed for risk of suicide, and based on that assessment, that appropriate precautions be taken." Usually, he says, these precautions involve continuous observation and checking for any kind of 'contraband,' such as pills or knives.

"A lot of people in psychiatric hospitals conduct assessments, and based on those assessments, provide continuous observation," says **Patrice L. Spath**, of Brown Spath & Associates, in Forest Grove, OR. "The difficult part will be determining what is meant by 'emotional and behavioral disorders' in general hospitals. What if this is a secondary diagnosis — if, for example, they are really being treated for CHF but they also have a personality disorder? That will be the hard part to sort out."

Spath continues: "I don't know how in the survey process something as nebulous as this is measured." In other words, she explains, the goal could mean that if the patient has *any* diagnosis that suggests an emotional or behavioral disorder it needs to be part of the nursing assessment at the time of admission, and an assessment of risk for suicide should be conducted. "There are formal assessment tools available, but I don't know if they are used in a general hospital when seeing someone who has an emotional disorder," says Spath. "After all, what *is* an emotional disorder?"

Spath says she's thinking, for example, about patients such as a teenager who comes in for a broken leg and who is also known to be anorexic. "Based on what the Joint Commission is requiring, I would say that teenager needs to be assessed as to whether they are at risk for suicide," she declares. "How in-depth that is will be dependent on the protocol the hospital uses."

An acute care general hospital, she suggests, may need to develop a more detailed assessment "to play it safe for the Joint Commission, as well as to keep patients safe." However, she notes, since JCAHO does not specify an assessment tool, "You get to pick the one you want to use. I would guess that most facilities that don't have a psych unit have a pretty minimal risk assessment tool — if at all — but the assessment needs to be done."

Partnering with patients

As for goal 13, says Croteau, "The patient needs to be advised as to how they can express concerns about their safety. If they observe anything they think is unsafe, they need to be able to report that, so the hospital needs to provide those means and encourage them to do it."

He suggests that a nurse might say, if appropriate, something like this: "Here at 'St. X Hospital' we are very concerned about safety. We want everyone and anyone to be alert and to help us keep everyone safe — including you." Accordingly, he continues, the patient can be advised that if they see something that doesn't look right or appears hazardous, they should tell the first nurse or doctor they see. "Your don't want the patient to feel you are transferring the responsibility for their safety to them, but you should state your philosophy of safety and engage them in the process," he adds.

But, notes Spath, "although the NPSG of involving patients in patient safety seems to suggest that we are supposed to embrace patients as partners, the implementation expectation actually reads more like a compliance or grievance process, e.g., 'educate patients/family on methods available to report concerns related to care, treatment, services, and patient safety issues,'" she says.

The goal and its implementation, she continues, seem to be two different things. "The expectation is that patients and families should report concerns. But to me, this expectation is more like a reporting process — like Medicare has a process for complaints," Spath observes. "To me, having a method to report concerns and educating patients and families on that method is different than involving the patient in his or her own care."

The word "report" is what gets in the way, says Spath. For example, she notes, one hospital "has a poster up on all the walls in patients' rooms that says, 'Here's what we are going to do to keep you safe,' and lists certain processes, like validating the patient's name. Then, at the bottom it says, 'And if we forget, remind us.' Does a patient 'reminding' you cover the goal?"

Let's say, Spath posits, that a family member was told to make sure caregivers wash their hands, and if they forget, to remind them. "If the

family member says, 'You did not wash your hands,' is that a 'report' or a 'reminder'"? Spath asks. "Does that constitute a report? The goal sounds like it's talking about some formal way of filling out a grievance."

In some ways, Spath says, the goal doesn't go far enough. "The problem with just telling people to report concerns is, if you don't also tell them what's supposed to be happening to them, the patient will not have a good understanding about what to report," she notes.

Spath further advises that quality managers look at *all* the goals — not just the ones that specifically apply to hospitals. "Some of the goals that are not directed to hospitals may be extended down the road, so consequently quality managers should look at all of them," she says. "Also, I think that instead of simply having a 'checklist' mentality when it comes to these goals, we need to keep making *safety* as our goal. If something recommended for ambulatory care is something that would be a good thing to do for your patients, you should *do* it; you don't necessarily wait until the Joint Commission enacts it."

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Coding changes could affect benchmarking

New DRG system may be imminent

Potential changes in DRG coding and a proposal to move from ICD-9 to ICD-10 could significantly affect quality managers, especially in the area of benchmarking, and will make proper coding even more critical to hospital reimbursement, say coding experts.

"CMS [the Centers for Medicare & Medicaid Services] has been proposing for a year to move to a severity-adjusted DRG system," notes **Deborah K. Hale**, CCS, president of Administrative Consultant Service, LLC, in Shawnee, OK. "The current system of DRGs does not provide a clear picture of severity of illness; the changes would be designed to help pay hospitals more appropriately based on costs and to make a better delineation of actual severity of illness."

"The proposed rules are out, and the comment period is over," adds **Susan Wallace**, Hale's director of inpatient compliance. "The final rule will be published the first week in August, with implementation set for October 1."

The "earliest possible time frame for ICD-10 coding is October 2009, says Hale. "It will require hospitals to be more tuned in to documentation of quality improvement activity," she says. "More specifically, the way a physician documents can more positively impact reimbursement; in many instances hospitals get higher pay for quality, and ICD-10 will allow the coder to assign more specific codes. Many times that also impacts the benchmark data."

Judy Sturgeon, CCS, hospital coding manager at University of Texas Medical Branch in Galveston, agrees. "The way I understand it, an awful lot of health care benchmarking and indicators are based either on diagnosis and procedures for high risk conditions, or on DRGs that are CMS-driven as core measures, such as CHF," she says.

DRGs: More immediate impact

Clearly, the new DRG system will have a more immediate impact on quality professionals. "We currently have 527 active DRGs," notes Hale. "There are two proposed new methodologies – one a proprietary system by 3M [APR-DRG], which has over 1,258, and a severity refined system proposed by CMS [CSA-DRG] that is very similar — with 861 DRGs."

"The CSA codes are based on the 3M system, but they looked at the volume of patients within the Medicare population," notes Wallace. "They

Key Points

- CMS intends to move to a severity-adjusted system for DRGs; number of codes may double.
- ICD-10 will allow for more specific codes, which could affect benchmark data.
- Understanding the new codes and data will be critical to uncovering opportunities for improvement.

are consolidated in areas where there is not a lot of volume, so where 3M might have four different codes, CMS might report only one." In addition, she says, 3M adjusts for risk of mortality, which CMS has not addressed.

It's unclear which system will be selected. "CMS could choose to go with 3M instead of their own," says Hale. "It would mean every hospital in the country, in order to code and group correctly, would have to have the 3M system. If CMS uses their model, all the vendors would have to get together and develop to the software product; October 1 is an incredibly short period of time. We think most likely it will be delayed until October 1, 2007, but they also possibly could do it by mid-year."

How will this affect quality managers? "The savvy QI coordinator, and one who does a lot of benchmarking, will identify the [new] DRGs in which the mortality rate is higher than would be expected; examine costs of care; LOS; costs per case; and may even look at charges per case," Hale advises. "If they are benchmarking, as they should be doing, they will look at those performance measures and see where opportunities for improvement are. These new DRG methodologies will give them better data."

If the physician is not documenting properly and/or if the hospital is not coding in a way to get full credit, she warns, "their data are going to be skewed; but the new system will give them a much better, more accurate picture."

"The people who do reporting and questioning are going to have to learn new sets of data," adds Sturgeon. "The coding rules will not change, but how they group them into severity adjusted areas will, so all report forms, queries, and analyses will have to be reformatted. From now on, a CHF patient is not going to be just *any* CHF patient."

Astute quality managers, she continues, will need to "learn the new code set for ICD-10, and the differences between the new severity adjusted DRGs versus reimbursement DRGs."

These changes ultimately can be beneficial to quality managers, she continues. "As in our CHF example, if you are looking at the core measures and trying to find out why your CHF stays are longer than those at other hospitals, you will now have severity-adjusted data that split up them. That data may support the fact that you have higher severity compared to other facilities with the same principal diagnosis."

The new codes also will provide handy tools to identify problems, Sturgeon continues. "Say your report suddenly shows patients with low severity illnesses are staying too long — or those with high severity illnesses are not staying long enough," she poses. "It could be a coding issue, a quality of care issue, a medication compliance issue; it will make you look closer to get to the answer. This way, you can spot problems upfront — before they come onto Medicare's radar."

The bottom line, she concludes, is that these proposed changes mean "new education for anybody who runs reports, who asks for the reports, or who analyzes the data. You have to know what you're asking for to get what you want; you have to know how things are entered into the system if you are setting up program reports. If you make a decision off of the data, you have to understand what the new data mean or you will draw erroneous conclusions."

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More care not necessarily better care, study says

Study focuses on care of chronically ill

Budget-conscious quality managers might want to take a good, hard look at the findings in the latest report from the Dartmouth Atlas Project, in Hanover, NH. It indicates that providing chronically ill Medicare beneficiaries more care at a higher cost does not translate into higher quality care. To the contrary, the study shows that beneficiaries in high-utilization areas end up with lower quality of care.

The project used a new, free database built with Medicare data that helps provide benchmarks for highly efficient care. (The database, funded by the Robert Wood Johnson Foundation, the long-time principal underwriter of the Dartmouth Atlas Project, is available to the public

Key Points

- High-intensity care also results in lower patient satisfaction levels, according to study.
- High-intensity care also results in lower patient satisfaction levels, according to study.
- Benchmarking is necessary to obtain a truly objective view of your performance.

at www.dartmouthatlas.org.)

Using this database, the researchers calculated significant savings to the Medicare program if all U.S. hospitals provided care at the levels of highly performing health systems.

"The database has 100% of Medicare hospital claims," notes **Megan McAndrew**, MBA, MS, editor of the Dartmouth Atlas Project. "We also have samples of part B claims, census data, AMA data, and so on. The reason why we study Medicare is it's the only uniform national claims database."

The study is based on records of more than 4.7 million beneficiaries who died from 2000 to 2003 and had at least one of 12 chronic illnesses, including: solid tumor cancers, lymphomas and leukemia, chronic pulmonary disease, coronary artery disease, congestive heart failure, peripheral vascular disease, severe chronic liver disease, diabetes with end organ damage, chronic renal failure, nutritional deficiencies, dementia, and functional impairment.

Using three health care regions identified as "highly efficient" as benchmarks (Salt Lake City, UT, served primarily by Intermountain Healthcare; Rochester, MN, served largely by the Mayo Clinic; and Portland, OR, the largest and most metropolitan region in a state that has made improvement in end-of-life care a public policy goal), researchers used the database to compare care provided in all other regions of the country. Highly efficient health care was defined as high-quality/low-cost.

An ongoing effort

Researchers determined that Medicare could save an estimated $40 billion — or nearly one-third of what is already spent on chronically ill Medicare beneficiaries — if all U.S. hospitals practiced at the high-quality/low-cost standard set by the Salt Lake City region. By the Mayo Clinic benchmark, savings would have been $19 billion; by the Portland benchmark, $38 billion.

Founded in 1993, the Dartmouth Atlas Project "is an ongoing project, started as a way to determine where people go for health care," explains McAndrew. "The original concept was to be the managed competition model of health care purchasing; if you put people into markets and cooperatively buy insurance, then you'd have to follow patterns of wherever people seek care."

The project pointed out that the model did not work, but in the process, found itself headed in a new direction. "Once we figured out by matching zip codes of residents in hospitals we had defined all these markets, we saw we could compare them," McAndrew relates. "So, we started to compare what happens with different populations — classic epidemiology."

While epidemiologists usually study the incidence of disease, however, the project studied surgery and hospitalizations. "What you find is there are these really remarkable variations in what happens to people, and it depends on where they live, rather than on their medical needs or desires for care," McAndrew shares. "For most conditions, medicine is practiced very idiosyncratically in different parts of the country — and even in contiguous markets. In some areas of Florida, for example, heart surgery practices vary radically within a few miles."

This particular study was driven by the fact that "over time, in a broad sense, people couldn't see any benefit for individuals who lived in regions where they got a lot more services, and where Medicare spent a lot more money per capita — for example, twice as much in Miami as in Minneapolis," says McAndrew.

It also was argued that other studies hadn't significantly accounted for differences in population health status. "This report looked at people with at least one of 12 medical conditions who had died. We worked backwards and examined what had happened to them in the last two years of their lives — the differences in the health care resources they consumed," says McAndrew. "We found enormous differences in the likelihood of how many days in their last years of life they would spend hospitalized, in the ICU, and in how many specialists they saw."

Besides the disconnect between dollars spent and health care quality, the report also noted that individuals in high-spending areas had lower patient satisfaction levels.

"This data, from the state of California, came from the California Health Care Foundation

[CHCF]," says McAndrew. She asserts that California is a valid model for the rest of the country. "You can find markets at both ends of the spectrum; for example, L.A. is like Miami, and San Francisco is like Minneapolis," she explains.

When the CHCF did its survey, she continues, "they found an inverse correlation between how happy patients were with care in high-intensity places. In additional studies, researchers here asked providers in high-intensity regions what *their* level of satisfaction was, and those in the highest-intensity areas said they had the toughest times; they used many more referrals, saw more hospital days [per patient], and so on."

Seek the best model

It's very difficult, McAndrew concedes, for someone right in the middle of things to recognize system flaws unless they compare their system with others. "Otherwise, you do not have a frame of reference for what other people are doing and what works," she says. "But you need to care about what the best model is for the best management of people with severe chronic illness."

Quality improvement professionals, she notes, "say every system is designed to get the results it gets; but the way Medicare is designed is in reverse. It encourages you to do more stuff; they won't pay for diabetic counseling, but they pay really well for amputations."

One step toward a better model, she notes, is for government to think hard about how it incentivizes different types of care. "On a moral and medical basis, academic medical centers should also take some responsibility for trying to figure out what the optimal model of care is," she adds.

Meanwhile, she says, hospital quality managers should study the models used in places like Oregon, "which has very consciously tried to manage end-of-life care."

But it doesn't have to be a statewide effort, she continues. Quality managers might consider models such as Salt Lake City's Intermountain Health Care, the Mayo Clinic in Rochester, MN, or the Danville, PA-based Geisinger Health System. "They've really thought about where to put their resources and what the best model is," McAndrew observes. "They've thought about how to do it better — which is also less expensive and closer to what people say they want."

The three aforementioned organizations are group practice models, McAndrew notes. "They are pretty well run by doctors," she says. "Historically, they were started by people who went out and trained with the Mayo brothers and then started rural multispecialty practices. What they have are salaried physicians, so they are not in head-to-head competition with other tertiary care hospitals."

If you are not locked in "mortal combat" with other facilities, she adds, "It becomes easier to share patient records."

Tools for benchmarking

The Dartmouth Atlas Project web site has a number of tools available on it for quality managers interested in benchmarking. "These tools enable you to 'slice and dice' the data in all different ways," says McAndrew. "Just yesterday someone called from New Jersey and wanted to know how many fewer hospital days they would have in their state if they looked more like Intermountain Health."

Using the tools, for example, you can compare things like Medicare spending and excess hospital days between your area and others, says McAndrew. "What you can also find, importantly, is population-based rates. What we're talking about is trying to use the methodology to define which patients go to which hospital. We can track patients who are loyal to your hospital — where they might get 90%-95% of their care."

Such data, she continues, can give you insight into your hospital's management style and quality factors associated with the physician staff. "It gives you a very legitimate look at how patients who are loyal to your hospital are being managed," McAndrew asserts.

Finally, she says, the report shows that some of the well-publicized "crises" in health care don't have to be as serious as they seem to be. "Everyone says Medicare is going broke, and we have a shortage of doctors," she notes. "We say, if everybody looked like Intermountain Health, they wouldn't need more doctors. And if Medicare were saving 30% of the money we estimate it has wasted, it would be a lot longer before it was financially in trouble."

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Staffing only one element in quality challenges

Errors can occur easily in emergency care

[Editor's note: In 1999, the Institute of Medicine (IOM) published a report, To Err is Human: Building a Safer Health System, *that led to a radical shift in the way health care organizations and agencies address patient safety. Now the IOM has turned its attention to the nation's emergency care system. Its three-year "Future of Emergency Care" project has resulted in the publication of three reports totaling more than 800 pages.*

The reports — on hospital-based emergency and trauma care, emergency medical services (EMS), and pediatric emergency care — were derived from 11 studies commissioned by recognized experts in emergency care. The overall themes were quite broad, focusing on the key issues of coordination, regionalization, and accountability.

Among the reports' major sub-themes were, not surprisingly, quality and patient safety. The following article, adapted from a special IOM report in our sister publication, ED Management, *focuses on some of the key quality and safety challenges in emergency care today, and strategies that can help address these challenges.]*

As outlined in the Institute of Medicine report, there are three major issues hindering patient safety and quality in our nation's emergency health care system, says **Mary M. Jagim**, RN, BSN, FAEN, internal consultant for emergency preparedness planning at MeritCare Health System in Fargo, ND. Jagim identifies these issues as environment, staffing, and competency.

"Overcrowding and boarding issues make the ED a place in which errors would easily occur, whether they are medical errors, missing changes in a patient's condition, or a misdiagnosis because some X-ray or lab was not read in the chaos or someone left before they could read it," she says. "It's a recipe for disaster."

The problem with staffing, she says, is that appropriate staff levels are not always being achieved. "If you do not provide appropriate levels of staffing, this will be a safety issue," she asserts. One of the reasons there is a shortage of ED nurses goes back to the environment, she says. "If you feel you can't care for a patient appropriately, if patients swear at you and swing at you, why would you want to work there?" she poses.

The study also points out that there are varying levels of competency across EDs — be it nurses, physicians, nurse practitioners, or physician assistants. "If you care for a population with certain needs, you have to demonstrate a core level of competency for caring for them," says Jagim. "The vision of this report was that we create a system that is coordinated, regional, and accountable, and core competency is part of accountability."

Crowding, being understaffed, and an often striking lack of access to informatics contribute to a reputation of the emergency department as an unsafe environment, says **Arthur Kellerman**, MD, MPH, professor and chairman of the Department of Emergency Medicine at the Emory School of Medicine in Atlanta, GA. "The report also points out understandable distractions: interruptions, acuity, and other factors that conspire to undermine the kind of safety we want," Kellerman says.

Key Points

- Moving toward improved quality and patient safety requires that managers address three key issues: environment, staffing, and competency.
- Make sure the competencies of your staff match the needs of the specific populations they serve.
- Develop a method for determining the most appropriate levels of nursing staff.

Learn flow techniques

Looking to the future, Jagim has several recommendations. "If managers don't have knowledge in [patient] flow management techniques, they need to learn them," she asserts. "If they don't have a good method for determining the most appropriate level of nursing staff, they need to learn that."

Another of the report's recommendations is the development of national core competency standards for emergency staff, says Jagim. Even before those standards are developed, however, managers still must focus on this important issue. "As an ED manager I looked at the populations I served," she shares. "We are a level II

trauma center, so I looked for staff who had taken the Trauma Nursing Core Course. In pediatrics, you want staff to have taken the Emergency Nurse Pediatric Course. For emergency response, you look for training in areas such as HAZMAT awareness."

Kellerman adds that ED managers must have access to decision support systems and monitoring technology — "communications systems that don't require you to leave the department to get your results. Elements of that sort can significantly improve quality," he asserts.

Also, the ED should *not* be turned into a holding department for other units, Kellerman maintains. "That is a mission placed on many EDs by default, perhaps because we've been dumb enough to accept it."

Rub your hospital's nose in the boarding problem, adds **Robert L. Wears**, MD, professor of emergency medicine at the University of Florida (UF) College of Medicine and director of medical informatics at UF Emergency Medicine, both in Jacksonville.

"The report gives a lot of support for the contention that nothing of value can be accomplished until the boarding problem is resolved," Wears says. "It should be raised in every venue and at every opportunity until some action occurs."

In addition, managers might look for "minicatastrophes" that can be publicized to dramatize the issue, he says. This strategy is potentially risky and might be best employed internally, Wears advises. "But there is a need to counterbalance the feeling that, yes, there are lots of complaints, but no one is dying," he says. "For example, one might begin reporting overcrowding episodes as sentinel events to [the Joint Commission on Accreditation of Healthcare Organizations] or state reporting systems."

The one report recommendation that will really help ED managers in the short run is the "command" to stop boarding patients in the ED, and to stop ambulance diversions, says Wear. "However, saying 'stop it now' is not much good without providing some sort of mechanism to actually do it."

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NEWS BRIEFS

Stakeholders happy with QIO assistance

The Centers for Medicare & Medicaid Services recently released the results of its baseline survey to gauge stakeholder satisfaction with quality improvement organization (QIO) interactions. Results indicate that stakeholders are happy with the assistance offered — more than three quarters "strongly agreed" that "providers were providing better care because of the QIO."

The survey data were developed by an independent party, Westat, under contract to CMS.

COMING IN FUTURE MONTHS

- Results from demonstration project on core measures
- New York hospital takes top honors at Global Six Sigma Summit
- Can technology really improve the inter-shift report?
- New heart care alliance sets aggressive goals

Westat interviewed a group of more than 1,200 small, medium, and large stakeholders, which were about evenly split between those identified by CMS and those recommended by QIOs. The baseline survey was conducted between January and February of 2006 with a response rate of 82.3%. A re-measurement survey will be conducted between June and July of 2007, and results will be part of the overall QIO evaluation, expected in November 2007.

Other significant findings in the report include:

- 73% agreed that they were making greater progress because of the QIO, while only 8% disagreed.
- 89% were satisfied with QIOs' topic-specific knowledge.
- 92% agreed that their QIO seeks out opportunities to work cooperatively with their organization and others.
- 92% were satisfied with the information and assistance they received from the QIO.
- 90% were satisfied with the amount of contact they had with the QIO.
- Stakeholders who have on-going partnerships with QIOs reported the highest levels of overall satisfaction with the QIOs.
- Respondents reported their most common QIO interactions were for planning or implementing a joint project, QIO offers or provision of training and information, and meeting/teleconference attendance. ■

Fewer workers enroll in employer health plans

Three million fewer workers elected to enroll in their employer's health insurance plan between 1998 and 2003, a period when the cost of individual premiums increased 42%, according to a recent study by the Robert Wood Johnson Foundation (RWJF). More than half of all adults without health insurance cite the high cost of coverage as the reason, the study notes.

"This report should be as alarming to Congress as it is to the American people, because employer-sponsored health insurance is the backbone of America's health care system," said **Risa Lavisso-Mourey**, MD, RWFJ president and CEO. "If trends continue, this could dramatically increase the number of working but uninsured people in this nation." ■

Home care, assisted living upstage the nursing home

A trend seems to be growing. More seniors are leaving nursing homes in favor of other types of care, including home care and assisted living facilities.

New York, like many other states, has applied for a federal waiver to allow up to 5,000 elderly and disabled nursing home patients on Medicaid to get that care elsewhere. **Mary Kahn**, a spokeswoman for the Centers for Medicaid & Medicare Services, says too often elderly patients sent to nursing homes for short-term treatment wind up staying there much longer.

"Also, hospitals tend to discharge patients to nursing homes rather than look for more appropriate alternative care options that might be in short supply," she says.

With the federal waiver system, social workers and nursing home administrators try to identify those seniors and disabled patients who can thrive in assisted living centers or at home with aides. ■