Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON AMERICAN HEALTH CONSULTANTS

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Demonstration project claims $1 billion in potential savings

Premier, CMS collaborative projects 3,000 fewer deaths

New data from Premier Inc.'s pay-for-performance demonstration project with the Centers for Medicare & Medicaid Services (CMS) indicate that improving the care of pneumonia and heart bypass patients alone can save as much as $1 billion a year, as well as thousands of lives. Projected outcomes include 3,000 fewer deaths, 6,000 fewer complications, 6,000 fewer readmissions, and 500,000 fewer days in the hospital.

Through the demonstration project, Premier collects a set of 33 quality indicators from more than 250 hospitals across the country. Because these indicators are not collected from all hospitals, Premier researchers extrapolated national implications using statistical methods. If patients receiving a smaller percentage of widely accepted care measures had instead received most of the measures — 76% or more — hospitals costs would have been approximately $1 billion lower in 2004, according to Premier's analysis.

"The first year the project collected data was 2003," says **Denise Remus**, PhD, RN, Premier's vice president of clinical informatics. Formerly, she was senior research scientist at the Association for Healthcare Research & Quality (AHRQ), where she was responsible for the development of AHRQ's quality indi-

Key Points

- Savings would be realized if 76% of patients received most of quality measures.
- Numbers may be conservative, since participants had higher than average quality care.
- Premier offering P4P readiness program on the Internet free of charge.

cators. "In spring of last year, we closed the first year data set, and results were released in November 2005. When I joined Premier, I took the first year of the demonstration project and began to do an analysis of the relationship between cost and quality."

Re-thinking the analysis

As she began her analysis, Remus recalls, she did not see a relationship between individual process measures and outcomes. "This actually made sense," she says. "Several of the measures have to do with discharge. For example, with heart failure, one of the measures is discharge planning; in AMI, one is beta blocker prescribed at discharge. So, it made sense to not see a relationship between individual process measures and outcomes during stay."

While her "gut" told her there *was* a relationship, Remus couldn't see it. "I stepped back and said, 'Let me ignore where the patient was taken care of and merge all the patients together and look at the quality on the patient level.'"

In essence, Remus says, she relied on a "pathways of care" approach. "What that says is, we know we have patients who are eligible for a certain number of measures. In my mind, high quality is when the patient gets everything they are supposed to get. So, instead of just looking at whether the patient was getting aspirin, we looked at a proxy — patient process measures — and the rate of how many interventions patients were eligible for and how many they actually received."

In other words, a patient who goes through the health system and receives all the recommended experiences around the measure is receiving highly reliable care. Accordingly, the patients were placed in four groups from low to high, in segments of 25% reliable care — the highest being 76% or more. "Then, we looked within each of the clinical conditions [pneumonia and heart bypass]," says Remus.

In order to come up with the estimated savings, she says, "We took the analysis we had done, and then estimated what the impact might be nationally, based on the Healthcare Cost & Utilization Project (HCUP) database of AHRQ — and identified how many patients were discharged in pneumonia and heart bypass. Then, we looked at the total number of patients discharged in those groups and estimated how many would be in the low, medium, and high categories based on how the patients in our projects were distributed."

Remus thinks her numbers are actually conservative, "because in our year of data, our hospitals tended to have higher quality than other hospitals in the country."

Using the data

These data carry an important message for hospital quality managers, says Remus. "As Medicare moves into value-based purchasing, or linking payment to quality, hospitals will have to manage their costs better," she says. "That's the group we want to address."

She continues: "We believe we've established clear evidence that higher quality can improve

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outcomes and save costs," Remus asserts. "We've also found that it doesn't cost more to get high quality, which, of course, reduces LOS and complications — all of which *increase* the costs of care for patients."

To help hospitals move in the right direction, Premier has launched a pay-for-performance readiness program, which is provided free of charge on the company's web site (www.premier-inc.com/). The program includes a pay-for-performance calculator.

"Anyone who has a Medicare provider number can enter it," says Remus. "Then, in the next screen it asks them to enter a numerator and denominator for the 18 process measures in AMI, heart failure and pneumonia."

Once those numbers are entered, the site will come back with a report that links cost and quality. "Using their information, we calculate an 'appropriate care score' at the hospital level," Remus explains. In other words, the report will show how many patients treated at your hospital for AMI and pneumonia received appropriate care. "Then, we model what their potential cost savings would be," she adds.

"This just helps support awareness that there is a changing reimbursement environment out there," she continues. "Payments can potentially be reduced or increased based on quality. In that environment, hospitals may be at risk if they do not provide high-quality care, so they need to take a look at the reliability of their care system."

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Project participants reaping the benefits

Improvements seen in CHF, AMI measures

Facilities that are participating in the Premier/CMS demonstration project already are seeing the benefits in improved quality — not to mention the attendant incentives. For example, Cleveland Regional Medical Center in Shelby, NC, has seen dramatic improvement in congestive heart failure (CHF), acute myocardial infarction (AMI), and hip and knee core measures.

"We started with CHF, because it had the biggest opportunity for improvement," recalls **Elizabeth Popwell**, CHE, vice president of systems management, who says the facility's baseline year was 2003.

"Our readmission rates were much higher than benchmark — 12.09%," she says. "We were really concerned, what with the advent of pay-for-performance."

One of the things that appealed to her about the demonstration project was its weekly monitoring tools. "We felt that would help us in our journey to improve," she says. "What we had done historically for QI initiatives was retroactive chart reviews. In CHF, for instance, that would probably mean looking back on a given quarter four to six months later. I knew of no way to meet our vision if things continued that way."

With the demonstration project, she says, "We'd be able to collect data concurrently, monitor results in real time, and make the necessary adjustments." Thus, her hospital's entire PI model was changed. "Formerly, PI teams would languish on for 18 months, which is very ineffective," says Popwell. "We already know the evidence and what best practices are."

So, as participation in the project began, Cleveland Regional decided to employ rapid cycle changes. "Then, we hired a staff person to do nothing but round on patients – review charts and see if they were getting what they needed," Popwell explains.

When the individual, who is an RN, started, she looked at issues such as whether a patient got his or her LVS (left ventricular systolic) function tests, or if his or her ejection fraction was on the charts. "If it was not, she would talk to the physician or nurse and ask why," says Popwell. "We call it an 'expediter' role; she made sure nothing slipped through the cracks."

Popwell admits that initially, some doctors would have given her a different, less flattering name, but that was before they saw the results. "We not only met the benchmarks, but we improved outcomes," she says. "In 2005, our readmission rate was down to 7.6%."

As for discharge instructions, in the baseline year 12% of patients went home with appropriate instructions. "After our first year, 96% were going home with them," notes Popwell.

The return on investment for the new position is "phenomenal," says Popwell, who is getting ready to hire a new "expediter."

Once she saw those results, Popwell and her

team moved straight onto AMI. "We had gained so much buy-in from the docs, once we showed that our 'aggravating' led to significant improvements," she shares.

The same held true for AMI. Mortality in the baseline year was 8.57%; in one year it was reduced to 6.47%. "We've had similar results for hip and knee," says Popwell. "Our 2003 baseline for knee surgery infection rates was 2.6% — the worst decile. In one year, we went to 0.9% — the best decile. Hip surgery infection rates were also reduced — from 2.8% in 2003 to 1.81% in 2004.

"We've maintained the improvements, too," says Popwell. "A lot of our core measures are in the top 10%; in fact, if we drop below 95% I get nervous."

At Aurora Sinai Medical Center in Milwaukee, WI, the quality improvement team has seen improvements in community-acquired pneumonia (CAP) through its participation in the program. (As we went to press, data still were being finalized.)

"As we received the data from Premier and CMS, we used it to look at what processes we could improve on," recalls **Ann Staroszczyk**, RN, MS, director of quality. "We started with CAP."

"Some of the processes we focused on were obtaining blood culture prior to antibiotics, antibiotic selection for ICU patients, and timing to first antibiotics and influenza pneumococcal vaccines," adds **Michelle Sarnoski**, quality coordinator for the pneumonia initiative.

One of the major activities embarked on was a monthly meeting with the ED, says Sarnoski. "We'd review the pneumonia charts from the previous month and look at processes and how we could improve," she relates.

One of the PI approaches selected was to have the ED director, John Whitcome, give positive feedback to the staff who performed well on the pneumonia initiative. "He also pointed out to them when they were not meeting the standards, but he gave them a lot of positive reinforcement when they met them," says Sarnoski. This reinforcement was given in writing, and the department created a "Wall of Fame" where their names were posted.

If patients come in with signs and symptoms of pneumonia and are treated within the appropriate time period (i.e., blood cultures, pulse oxymetry) there are forms that can be filled out that in essence say to the staff member, "Great job; we're proud of you," says Sarnoski. "When somebody sees someone else on the 'Wall of Fame,' it becomes and incentive for them to get up there as well."

The bottom line, she says, is that "It's the daily attention to detail that makes the program a success."

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Leapfrog Group, NJ Blues start recognition program

Hospitals to be given choice of two programs

Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), headquartered in Newark, in collaboration with The Leapfrog Group, in Washington, DC, has launched the Horizon BCBSNJ Hospital Recognition Program, offering New Jersey hospitals financial and public recognition for high-quality and effective hospital care.

Horizon BCBSNJ, reportedly the first health plan in the nation to implement a statewide hospital recognition program in collaboration with The Leapfrog Group, will offer all of its network hospitals the option of participating either in a program based on the Leapfrog Hospital Rewards Program or in a similar program created by Horizon BCBSNJ.

The Leapfrog program provides a nationally standardized methodology to assess the value of patient care by measuring performance along two dimensions — the quality of the care hospitals provide, and how effectively they deliver it. Its

Key Points

- Horizon looks to moderate some of the traditional tensions between hospitals, carriers.
- Program will not only offer financial incentives, but public recognition of top performers.
- Sponsors says program is one of the first P4P efforts to measure efficiency.

methodology utilizes standardized performance measures developed by the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare & Medicaid Services (CMS), and Leapfrog itself.

However, says **William Finck**, MBA, the director of physician and ancillary networks at Horizon BCBSNJ, "We recognized that there is a cost to participation in the Leapfrog program, and we did not want to force hospitals to incur a cost in order to participate."

Horizon already had its own recognition program, which included the reporting of compliance with the Joint Commission's National Patient Safety Goals and CMS's 20 core measures for disease states. "We added compliance with the IHI's 100,000 Lives campaign and some patient satisfaction and administrative measures," says Finck.

"We aim to catalyze change, and in Horizon we've found a willing partner," adds **Suzanne Delbanco**, PhD, chief executive officer of The Leapfrog Group. "The significance of this partnership is that we are working together from the 'buy' side of the market to create a more sustainable and more potent pay-for-performance program than most of what's out there."

Part of the innovation that comes with Hospital Rewards, she continues, is that it is not entirely based on purchasers or payers needing to put all 'new' money on table. "It's not like new funds have to be found to create incentives or rewards," she explains. "Instead, much of it is paid out from the savings that occur as the hospitals improve. That's a shift from what the typical pay-for-performance program is designed to do."

Recognizing improvement

Horizon BCBSNJ had been producing its report based on CMS core measures and JCAHO safety goals for the past two years, Finck relates. "Internally, we were trying to determine whether it was having any effect," he shares. "What we were delivering to the individuals hospitals was, 'Here's how you compare to the network.' We felt we should develop some form of recognition to go along with the reporting."

As they looked around, Horizon ended up with Leapfrog. "In the areas of heart attack/aspirin on arrival and discharge and how much more important one was versus the other, Leapfrog had done some actuarial work," he explains. "In addition, from the perspective of hospital participants, this would no longer be 'Horizon's program.' These are nationally valid measurements, actuarially proven, that show improvements in outcome based on financial and public recognition."

"What this means is that when we looked for what clinical areas to focus on, we wanted to choose not only areas where there were clinical shortfalls, but also where we knew there was potential for significant improvement," Delbanco explains.

"We knew, for example, that LOS and readmission rates for these areas had that potential. When we see a lot of variation in LOS, it means that some hospitals have to figure out how to do it better and more efficiently use their resources. So, actuarially, we looked very carefully at the data in areas where we knew there were opportunities for reducing LOS and readmission rates," she says.

Leapfrog has chosen five clinical areas (coronary artery bypass graft, community acquired pneumonia, percutaneous coronary intervention, acute myocardial infarction, and deliveries and newborn care) "that are significant to the private sector — either because their performance tends to change tremendously — with some hospitals performing below what we know is possible — and/or because they are known to be expensive," Delbanco observes. "By highlighting the importance of improving in these areas and creating an environment more conducive to improvement, we will see a lot of unnecessary waste being reduced."

Actuaries at Towers Perrin analyzed hospital quality and payment data to identify these areas. These five areas represent approximately 33% of admissions and 20% of inpatient expenditures for commercial payers and present significant opportunities for improvement. To measure the efficiency of resource use, Leapfrog examines severity-adjusted average length of stay and readmission rates for each of the five clinical areas.

Another thing that's unique about the program, Delbanco says, is that "It's one of the first to use efficiency measures; we will look directly at resource use. And, it's a completely open methodology, which, I would argue, is meaningful to patients. If someone wants to get care, the last thing they want to do, for example, is go to a hospital with a high readmission rate," Delbanco says.

Open evaluation process

The evaluation process itself likewise will be transparent. "Hospitals currently report to their core measure vendor for the Joint Commission and CMS," Finck notes. "The core measure vendor then sends it to Leapfrog's data aggregator — Thomson Medstat — which runs the data and returns the results. The hospital can question the results if they wish, and nothing is finalized until the hospital agrees with the data."

The hospitals then are ranked in levels I through IV, in increments of 25%.

"The maximum a hospital can earn is between $100,000 and $200,000," says Finck. In addition, he notes, the rankings will be put on Horizon's web site. "We will report twice a year and recognize facilities once a year," he says.

Finck is convinced the program will help improve quality. "We think it will, because in order to get recognition you have to have improved your performance standard; you have to move from the current level to next," he says, adding that a hospital that is already in the top tier will be recognized if it remains there.

"But if you improve more than 10% from the previous report period, we want to say 'thank you,' and let people know what you've accomplished," he says.

(Leapfrog estimates that potential savings due to lives saved and avoided readmissions for six types of admissions for the entire Horizon patient population could amount to as much as $138 million.)

"We think that because of Leapfrog's vetting of performance standards, plus the efficiency resource component, this is a good, strong program," Finck adds. "Payers and their hospitals are not always the best of friends; during negotiations, especially, they can get antagonistic. We're trying to take that [antagonism] away."

Leapfrog is looking to establish similar partnerships in other states — and with other payers and purchasers as well, says Delbanco. "The initiative does not have to be statewide; we already have a lot of movement in the Memphis marketplace, and we are also working with a couple of national health care insurance carriers," she shares.

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Patients at this hospital have a 'ticket to ride'

Hand-off problem addressed with form

A new program at Doctors Hospital in Coral Gables, FL, helps move patients seamlessly from one department or unit to another, helping address the challenging issue of handoffs. Patients get a "ticket to ride" whenever they leave their hospital room — be it a transfer to another unit or a roundtrip down the hall for an X-ray. With checklists for tests, procedures, and nurse's observations, the new peach-colored form helps relay patients between staffers.

Pat Blanco, RN, MPH, CHE, CPHRM, the risk manager at Doctors, first learned of this approach on the National Patient Safety Foundation listserv. "Someone mentioned they were using it, or planning to use it," she recalls.

Blanco felt such a vehicle was important because "patients are handed off so many times throughout the day without a real opportunity to give information and ask and have questions answered."

The classic example, she says, would be a patient going to radiology who is a fall risk — but that information has not been communicated to the technician. "So the tech takes the X-ray, leaves the patient on the table, and comes back and finds the patient on the floor," Blanco suggests.

The technician, she explains, "Will not go through a four-inch chart to find this information. Nurses have a Cardex, and so forth, but when a patient is handed off, what really is needed is that opportunity to give information." The fact that

Key Points

- Strategy helps hospital comply with JCAHO's National Patient Safety Goals.
- Rapid cycle approach used to test, modify the structure of the form, checklists.
- Use of tickets helps transporters feel they are an integral part of the care team.

this is one of the Joint Commission's National Patient Safety Goals, she notes, was naturally an important driver in the initiative.

Committee creates forms

Blanco put together a handoff committee, which started to meet in fall 2005. She jointly chaired the committee with the manager of one of the patient care units. The members of the committee were nurse clinicians from each unit and other parties Blanco felt had an interest in handoffs — i.e., the managers of radiology and respiratory therapy.

"We met about every two weeks," says Blanco. Using the PDCA (plan, do, check, act) rapid cycle approach, "We added a certain set of items, tried the ticket, then after two weeks clinicians would come back and say they needed some more information on the form or that some step was cumbersome and needed to be taken out."

At one point, for example, the committee felt it was important to note whether a patient was a monitor patient. "In the next cycle, it was added, but we noted that when we take the patient out of 'tele' to go somewhere else, you want to call the monitor tech to tell them they were leaving the floor."

The form kept growing, says Blanco. "At first, to indicate precautions, we would just check them off," she says. "Then, next to the box, we would put 'aspiration,' 'bleeding total hip,' or 'knee,' so we knew what kinds of precautions were needed."

It's still a short list, says Blanco, although it is more complete than it was. "We've met many times since the last change, and we have not had any need to add or subtract anything," she notes.

Blanco said she did not need to seek formal approval to institute the new system. "The director of nursing periodically attended our committee meetings and could have said something if she was opposed," she notes. "Since she didn't, we assumed we had nursing's approval."

In addition, the committee took the form "everywhere" — i.e., to a whole series of committees, include QI, as an informational measure.

How the form works

Blanco explains how the "ticket" works in practice. "If a patient needs to go to radiology, the floor calls and says, 'Bring down Mrs. Smith in room 3427, and call transportation.' Transportation takes the ticket to the floor, finds the patient's nurse, and then fills out the ticket."

The nurse signs the form and the transporter signs the form. (Below the section where the nurse signs the form is a place for comments.) The nurse signs both her name and phone number, so if a radiology tech gets the ticket and does not understand something, he knows exactly who to call. "That's part of the National Patient Safety Goal — to have the opportunity to ask questions and to have those questions answered," Blanco notes.

When the patient leaves radiology and goes back to the room, there is a section for the tech to make comments — such as, "IV infiltrated'' or "We could not do the test because the patient was too nervous."

The tech signs his or her name and the transporter signs it again and then sends it back with the patient. The nurse who receives the patient has to sign it again, because the ticket goes back to transportation.

The ticket is used "whenever a patient travels," says Blanco. It's good from midnight to midnight. If a patient travels a second time during the 24-hour period, on the next trip there is a place for the nurse to put additional comments, and the transporters bring back the same ticket.

The earliest version of the ticket was used in November 2005. As of this March, the staff started using the current version.

The staff reaction has been very positive, Blanco says. "They realize its importance," she says. "Transportation knows they can't move a patient without a ticket. Even if a nurse did not want to use it, they would have to do so, but they realize there is a lot of information that should be communicated on some patients when they leave the floor."

The transporters, she continues, have been made to feel they are an important part of the team. "They are not just regarded as robots; they take responsibility for the patients, and they have been made to feel like they are important," Blanco observes.

It is far too early for quantitative proof the ticket has improved safety, "But qualitatively the nurses feel like if they are sending someone with critical information, it will be readily available to the receiver — and those receivers say they truly appreciate that, when they receive that patient,

they have that information. They know if the patient is combative, if they are a falls risk, or if they need a specific amount of oxygen."

Since the receivers have to sign the paper as soon as they have received the patient, "This means they must do an immediate review of the patient," Blanco summarizes.

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Facility uses Six Sigma to improve quality

Isolation management initiative earns recognition

New York-Presbyterian Hospital recently received top honors in two categories at the Global Six Sigma Summit & Industry Awards — "Best Achievement of Six Sigma in Healthcare" (sponsored by CIGNA Corporation), and the Platinum Award for "The Most Outstanding Organizational Achievement through Six Sigma." After a review by an independent, international panel of 14 leaders from business, industry, and government, New York-Presbyterian received the top award in the health care category and also took the Platinum Award for being the best overall of all seven category winners for using the quality methodologies to achieve major advances in patient safety, cost savings, innovation, and efficiencies. The Global Six Sigma Awards program received 65 entries from organizations based in India, Saudi Arabia, Singapore, South Africa, the United Kingdom, and the U.S. for the 2006 competition.

The 2,224-bed academic medical center is affiliated with Columbia University College of Physicians & Surgeons, and Joan and Sanford I. Weill Medical College of Cornell University.

Key Points

- Initiative demonstrates a 23% improvement in first bed assignment to a private isolation room.
- Keys to improvement found in enhanced communication and staff training.
- Staff develop reporting mechanism to sustain and institutionalize project results.

The hospital's initial investment in Six Sigma was $8 million. In 2004, the first full year of the program, a savings of $47 million was realized from bottom-line expenses — a direct result of the Six Sigma initiatives. The 130 projects initiated that year included length of stay reduction, financial performance, and constraints in an increasing regulatory environment.

The facility's initiative in isolation management IT solutions was a key factor in its earning the awards, says **Michelle Evangelista**, RN, MHSA, a Six Sigma Black Belt at the facility. (New York-Presbyterian has more than 20 Black Belts on staff.) "We received a request to apply for the award, and we applied in the health care category," she recalls. "As we put together our application, we used the isolation management project as a specific example of our Six Sigma programs."

The demand for isolation beds had been growing at New York-Presbyterian in response to the hospital's ability to identify patients who required isolated environments, as well as the increasing number of patients who were colonized with resistant organisms. In 2004, contact isolation bed utilization increased 25% for MRSA (methicillin resistant *Staphylococcus aureus*) cases and 27% for VREF (vancomycin-resistant Enterococcus faecium bacteremia) cases at locations studied, while isolation bed capacity remained unchanged.

The isolation bed placement data analysis for November 2004 to November 2005 demonstrated a 23% improvement in first bed assignment to a private isolation room. "We have also seen improvement in the percentage of patients transferred after first bed placement for isolation purposes, as well as the percentage of patients that were cohorted [placed in a room with a roommate that meets the policy for cohorting patients], and the percentage of patients isolated in blocked bed rooms [placing the patient in a semi-private room and blocking the other bed from use by non-isolation admissions]," says Evangelista.

Using DMAIC approach

Using the Six Sigma DMAIC (Define - Measure - Analyze - Improve - Control) process, staff identified an opportunity to improve and then gathered the "voice" of the customers (internal or external) to fine-tune the scope of

focus to ensure a greater impact.

"We did a measurement system analysis, which we think is always critical; you *have* to know how good your data is," says Evangelista. "We looked at the critical factors that were impacting our ability to perform optimally, and it really came down to communication and staff training. That, in turn, drove the improvement initiative."

It became clear that the facility had to have a reliable, automated methodology to identify patients who would need isolation. "This population does not arrive with acute illness — which is easy to identify — but is transferred or returned to us and have been colonized, or had infections," explains Evangelista. "They are a little harder to identify."

Fortunately, says Evangelista, the hospital has a very strong epidemiology department. Once a patient is known to be positive, a staff member can go into a database established by the epidemiology department.

The database has logic built into it and can be applied to specific organisms. Utilizing the hospital standards (based on CDC and other national guidelines), a treatment plan is then created for the individual patient according to those standards.

"One of our goals was to improve first bed compliance — to be sure that as soon as you entered you were immediately placed in an appropriate isolation bed to reduce the risk of spreading the infection, as well as the impact of having to move people multiple times," Evangelista notes. "I was able to work with the IT staff and create an interface between that database and our Eagle registration system."

No more manual collection

The database gets uploaded on a daily basis and feeds the Eagle system, she explains. "So, there is a field the bed assignment people can look at, and a code is generated. The patient is designated as either active or inactive. If you have been coded as active, the field is populated and the bed assignment person can see you've been colonized, and according to our rules, you require isolation."

The facility, she adds, also has a pre-admit tracking system that interfaces with the database, "So we can look at it in both ways."

Evangelista says she had excellent support from the IT department. "They had to write the interfaces, and I and the managers of the discharge and billing and bed management departments trained the staff on how to identify the patients. Now, fortunately, we've been able to add an automated piece, and every month we can see how we're doing."

Reporting mechanism

Originally, says Evangelista, the data collection was "somewhat" manual. "We ran the report that identified infected patients, and then went to the admitting paperwork and looked at bed assignments," she relates. "Now, I get a report directly from the database that gives me all the information in an Excel format — including the room assignments. We run that against a 'lookup' to identify the percentage of patients who went to a private isolation room — and I can request a second report that will also tell me how many were cohorted or placed in a blocked room."

To sustain and institutionalize project results, a reporting mechanism was developed in the control phase of the Six Sigma process to integrate and include isolation management measures in the hospital's Intranet site. This involved the creation of a new portal so that the epidemiology department can take this success even further. "Now that we've achieved a certain level of compliance, they will build it into their processes to monitor if they are maintaining gains or improving upon them," Evangelista says.

To date, she adds, "We have maintained this [improved] level of performance."

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'Learning Exchange' promotes staff awareness

Employees walk in others' shoes

A Six Sigma project involving four different departments was the impetus for a "Learning Exchange and Appreciation Program" (LEAP) that allows patient financial services

employees at Wake Forest University Baptist Medical Center to "walk in the other person's shoes" and gain a better understanding of the way things are done outside their own work area.

While it's more typical for Six Sigma projects to have participants in one, or maybe two, departments, a recent patient financial services initiative included staff from four, says **Margaret Currie-Coyoy,** Medicaid program specialist, who led the project as part of her requirements for becoming a green belt.

The departments represented were the ED, patient financial resources, admissions, and verification quality services, she adds.

During that experience, "we found there was a need for some awareness of each group's individual process," she notes. "For example, when the financial counseling group received a defective account from the ED group, they might have questioned why it was done that way."

In the ED, on the other hand, Currie-Coyoy says, "maybe there was not as much awareness of who is receiving those accounts and what they will be needing — that they could benefit from having [an explanatory note] on the account."

As the project progressed, she says, team members made comments such as, "Wouldn't it be great if this person could come and see what I do, sit with me, and see everything I face?"

The discussion that ensued led to having two ED staff members sit with a financial counselor and a Medicaid worker for a couple of hours, Currie-Coyoy continues. "They talked about their roles, their responsibilities, what they did on a daily basis, and how they gathered information."

The latter two employees then took a turn sitting with a registrar in the ED, to get a feel for the different scenarios that arise in that area, she says.

All of the people who participated in the work exchange weren't necessarily on the Six Sigma team that met each week, Currie-Coyoy adds, "but they were willing to participate, were aware of the project, and we got their input."

In March 2006 — about midway through the Six Sigma pilot looking at more quickly identifying patients initially listed as self-pay but later found to have insurance — Currie-Coyoy and the team put together a proposal calling for the creation of LEAP, she says.

"Our idea is for everyone to eventually be a part of it," Currie-Coyoy says. "We're all affected by what each department does." ■

Alliance seeks to improve cardiac care in hospitals

ACE sets aggressive goals to improve patient care

Twenty-nine leading health care organizations have joined forces to form an organization called the Alliance for Cardiac Care Excellence (ACE), whose goal is to ensure that all cardiac patients in the United States receive care consistent with nationally accepted standards.

The new coalition includes leaders from the American Hospital Association, the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality, the American Heart Association, the American College of Cardiology, and the Heart Failure Society of America. ACE members hope to help bridge the gap between clinical procedures and treatments proven to be most effective and the care many adult cardiac patients actually receive.

The coalition will begin its focus on care measured by seven basic quality measures. Today, according to ACE, only about 85% of eligible adult cardiac patients treated in U.S. acute care hospitals receive such care. To ensure that all hospitals are consistently delivering quality patient care aligned with recommended standards and guidelines for heart attack and heart failure, ACE has established the following target goals:

- By Dec. 31, 2006, 95% of eligible adult patients hospitalized for heart attack and heart failure in U.S. acute care hospitals will receive care that meets all of the seven basic quality measures currently reported on the Hospital Compare web site.
- By Dec. 31, 2007, 95% of eligible adult patients hospitalized for heart attack and heart failure in U.S. acute care hospitals will receive appropriate care on the full set of the 12 quality

Key Points

- Coalition says only 85% of patients receive care that meets basic quality measures.
- Awareness being raised of hands-on programs to help hospitals improve cardiac care.
- Hospitals performing below par will be approached with offers of assistance.

measures that apply to the patient.

"ACE is committed to improving the quality of cardiovascular care in a number of areas, but at the moment we are focusing on the hospital environment," notes **Rose Marie Robertson**, MD, Chief Science Officer of the Dallas, TX-based American Heart Association.

One of the reasons ACE came together, she says, was to focus the efforts of a number of groups that are already working on quality improvement and agree upon their next set of goals. "If we all get together, we hope we can speak with a louder voice and help more people," she says.

Many ACE partner organizations — including the American Heart Association, the Institute for Healthcare Improvement, the American College of Cardiology, CMS's Quality Improvement Organizations, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Premier and VHA, Inc. — already are conducting hands-on programs with hospitals to help them achieve the ACE goals.

For example, the American Heart Association's "Get with the Guidelines" program is in more than 1,000 hospitals.

"A lot is being done, and the hospitals have really been enthusiastic, but that's not *all* the hospitals," says Robertson. "We want to make it clear which programs you can call to help with a new QI program."

Hospitals, she notes, need to report on many of these measures, and these programs can be of tremendous help. "Some of them — including ours, provide web-based tools — reminders of all quality indicators for physicians. And, you can look up how your hospital is doing and get reports back."

To ensure that every adult hospitalized for treatment of heart attack or heart failure receives appropriate, quality cardiac care, ACE member organizations will work to:

- develop and communicate common messages about the appropriate care for adult heart attack and heart failure patients to health care providers and hospitals;
- support public reporting of compliance with nationally accepted standards of care, and those agreed upon by ACE;
- identify hospitals not successfully engaged in quality improvement programs and inform them of those programs that may work best in their unique facilities;
- remain knowledgeable about — and align tools or programs in accordance with — the most current developments in cardiovascular science;
- monitor and publicly report progress toward established goals and develop new goals that improve cardiovascular patient outcomes;
- remove barriers, such as regulatory, payment or other policies that may impede improved patient outcomes;
- share successful strategies resulting in improved performance and patient care.

Using good evidence

Many of the ACE quality measures have solid evidence behind them, says Robertson. "We have spent a lot of time developing evidence-based practice guidelines with the American College of Cardiology that are considered the gold standard for cardiovascular care, and we are working closely with CMS and JCAHO in that regard, so we will bring forward the same messages," she says.

"We know so much more than we used to, and keeping everything in mind rapidly becomes impossible in modern health care; patients are not in the hospital as long, things are done more rapidly, and we are besieged with guidelines," Robertson notes. "We recognized the need to make things easier for physicians — not harder."

ACE plans to be proactive, she continues. It will identify hospitals that are performing below national averages and contact them, indicating its willingness to help. "We hope to engage these hospitals; there are so many organizations that can help them," Robertson asserts.

COMING IN FUTURE MONTHS

- Can you respond to patients' demands for alternative medicine and still keep quality high?
- IOM issues new report on ways to reduce medication errors
- AQA and HQA establish new quality alliance
- Louisiana launches collaborative to redesign health system after Katrina

As for closing that gap between evidence-based best practices and actual performance, Robertson says the ACE members have learned much about what it takes to succeed. "You need to engage champions in the hospital, who in turn will help engage their colleagues," she says. "You've got to identify the barriers to improvement and talk about how you can overcome them; that's often extremely helpful."

Over the next two years, ACE will announce additional goals to improve the quality of cardiovascular care in focus areas such as discharge instructions for hospitalized patients, appropriate screening for cardiac risk factors in outpatients, and incorporating quality improvement into medical education and certification.

For more information, contact:
Rose Marie Robertson, MD, Chief Science Officer, the American Heart Association, Dallas. Phone: (615) 804-8056. ■

CMS releases final rule for FY 2007 IPPS

On August 1, the Centers for Medicare & Medicaid Services (CMS) issued a final rule regarding the hospital inpatient prospective payment system for FY 2007 that differs substantially from the proposed rule released earlier this year.

According to CMS, the payment reforms included in the final rule will "align hospital payments more closely with the costs of a patient's care by using hospital costs rather than charges, and by accounting more fully for the severity of the patient's condition."

The transition from using charges to using hospital costs to set payment will be phased on over three years, beginning Oct. 1, 2006.

With regard to severity-adjustment, in 2007, CMS will add 20 new groups to the current DRG system.

"In preparation for FY 2008, CMS will conduct an evaluation, with public input, of alternative systems for more comprehensive severity adjustment as a prelude to making more comprehensive changes to better account for severity in the DRG system by FY 2008. In selecting an alternative to the current system, CMS will require that hospital stakeholders have easy access to the new system," according to CMS statement. ■

Ripe job market for health information coding staff?

According to Kforce Professional Staffing, the national demand for health care labor coupled with the overhauling of the International Coding Directory (ICD) has created a market ready and waiting for coding professionals.

Group president of the company health information management division **Sam Farrell** says, "Hospitals already find it difficult to meet their needs for inpatient coders, outpatient coders, and coding managers, and now will be faced with the need to find staff who are prepared for the new ICD-10 standards…"

Salaries have jumped in the last six years for these professionals. According to the American Health Information Management Association (AHIMA), the number of positions with annual salaries exceeding $40,000 has nearly doubled.

In fact 62% of coding professionals earn between $30,000 and $50,000 per year. Nearly half (49%) of managers earn between $40,000 and $60,000. ■