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Medicare final rule calls for increased reporting of quality data

Preprinted order sets, electronic systems used to meet new data demands

Quality professionals at many organizations soon will be collecting additional data, as a result of the Centers for Medicare & Medicaid Services' (CMS) final rule on the inpatient prospective payment system. The final rule aligns payment for Medicare beneficiary inpatient hospital stays more closely with the actual hospital costs but also requires increased reporting of quality data.

Hospitals will be required to report on the full set of Hospital Quality Alliance measures to get full payment updates. The rule is effective for discharges on or after October 1, 2006. (A fact sheet on the final rule is available at the CMS web site, www.cms.hhs.gov.)

Originally, CMS proposed to require hospitals to submit data beginning with the first quarter of 2006, but this was changed to making submissions due February 15, 2007, relating to discharges occurring in the third calendar quarter of 2006. "This was done to reduce the amount of retroactive data retrieval hospitals felt would be required, time to obtain and train new abstracting staff if necessary, and to potentially renegotiate their contracts with their vendors," says **Rhonda F. Walker**, RN, BA, MBA, CHC, senior consultant at Courtemanche & Associates in Charlotte, NC.

Although CMS agreed to push back the collection period and reporting date of the additional quality indicators, many hospitals say that the February 15, 2007, submission deadline does not allow for sufficient time to train and financially support new abstracting staff, says Walker.

Regardless of size, hospitals will be required to acquire the expanded quality data beginning the third quarter of 2006. "This may prove to be a difficult hardship for hospitals that are already short on resources," says Walker. "Many will need to decide if they are prepared to spend money to make money."

Do a cost-benefit analysis

Some organizations will need more abstracting personnel to meet the new requirements, especially those who have not been voluntarily submitting data for the 21 quality measures already, says Walker. "For those hospitals who are required to retroactively gather data from July 2006, this

will represent a potentially large addition of resources," she says.

As a result of the new requirements, smaller hospitals will now need to perform their own cost-benefit analysis for data abstraction and real time data collection, says Walker.

Comments contained in the final rule indicated that some hospitals believed that the increase from a 0.4% reduction in the annual payment update to the proposed 2% payment reduction was too great and would cause some small hospitals to close. "The two percentage point reduction is mandated by the Medicare Modernization Act," says Walker.

Therefore hospitals' cost benefit analysis must determine the difference between losing a 2% payment and the costs necessary to gather and submit the required data.

"CMS admitted to the challenges it faces in minimizing the length of time between the receipt of and the ability to provide feedback to hospitals, on the data they submit. Hospitals also face the same issue on the data they collect," says Walker. "At some juncture, health care organizations will be required to have electronic medical records. It is clear that CMS supports this initiative."

Major IT upgrades needed

Despite the additional costs, it is clearly in the best interests of organizations to position themselves to collect data as quickly and efficiently as possible. This may require investment in their information technology (IT) infrastructure and personnel, says Walker.

"Hospitals who may have hoped to delay major IT upgrades may wish to accelerate those timelines," says Walker. "Hopefully these expenditures will not only allow for the collection of additional federal health care program revenue, but will accomplish its primary task — to improve the quality and safety of health care."

If hospitals are to maintain the 2% payment, they must be capable of collecting and submitting the CMS-required data. Manual abstraction is time- and labor-intensive; however, significant IT updates also may prove too expensive for hospitals, especially smaller hospitals or those with limited resources.

"This presents a financial dilemma," says Walker. "Many hospitals are now in the throes of some form of IT upgrades. My personal experience is that I have yet to be in a hospital for the past year that has not been involved in some IT project."

CMS apparently believes the cost to hospitals is offset by the tremendous benefit brought to the consumer, says Walker. "Case in point is the 127,000 Medicare beneficiaries that develop surgical-site infections annually — one-half of which CMS contends could be prevented," she says.

Since much of the data has to be collected manually, the challenge for the quality professional is the timely completion of data collection, says **Paula Heinz**, quality assurance manager at Jewish Hospital in Louisville, KY. As hospitals are switching over to electronic medical records, they are

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Editor: **Staci Kusterbeck**, (631) 425-9760.
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: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).

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Editorial Questions

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

CMS and Joint Commission measures are aligned

The Centers for Medicare & Medicaid Services (CMS)'s final rule on the inpatient prospective payment system requires hospitals to report on the full set of 21 Hospital Quality Alliance measures to get full payment updates, effective for discharges on or after October 1, 2006.

However, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has worked with CMS to standardize the measures so staff won't have to collect data for two different measurement sets, reports **Sharon Sprenger**, project director of JCAHO's group on core performance measurement.

In 2001, when JCAHO's four initial core measurement areas for hospitals — acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), and pregnancy and related conditions (PR) — were announced, JCAHO began working with CMS on the AMI, HF, and PN sets that were common to both organizations.

CMS and JCAHO worked together to align the measure specifications for quality improvement organization contracts and JCAHO-accredited hospitals that began collecting these measures for patient discharges beginning July 1, 2002.

"Since November of 2003, CMS and the Joint Commission have worked to precisely and completely align these common measures so that they are identical," says Sprenger. "Where we have common measures, then we have worked to have the exact same specifications."

A single common set of measure specifications documentation, *The Specifications Manual for National Hospital Quality Measures*, is used by both CMS and JCAHO, with an identical data dictionary, measure information forms, and algorithms. "Since we have common specifications, you only need to collect the data once to meet both the needs of CMS and JCAHO," says Sprenger. "The goal is to minimize data collection efforts for these common measures and focus efforts on the use of data to improve the health care delivery process."

There are other initiatives collecting data on a national level which are currently working to align quality measures, adds Sprenger. "There is certainly work in progress. All of us involved in measure development are very cognizant of the need to standardize where possible," she says.

For example, two organizations might have a measure on a similar topic but with different age groups, such as using 14 or 15 years as the definition for pediatric patients.

"One of first things to do is review measures in use or under development for use, that address similar aspects of quality but have different specifications — and develop a plan to align the specifications," says Sprenger. ■

looking for designated fields where quality data could be collected electronically instead of manually, she says.

"Pay-for-performance is the emphasis. As more and more of these quality measures are developed and accepted by JCAHO and CMS, they will be included into the pay-for-performance arena," says Heinz. Organizations will then have to develop mechanisms to monitor compliance.

"Hospitals are going to have to search for less expensive ways to collect this data," says Heinz. "Additional resources will have to focus on ways to electronically collect the data and store the data. This is a consideration when we look at electronic medical records." Additional staff or upgrade of computer systems to electronically collect some of the data may be needed, she reports.

"As quality improvement professionals, our role will now be focused on improving these specific indicators," says **Tom Knoebber**, director of quality and performance improvement for Mission Hospitals in Asheville, NC. "I'm sure some will see it as intrusive, while others will applaud the prioritization and support for improvement science such as Six Sigma and Lean concepts."

One concern that could be raised among low-volume hospitals or hospitals that already excel in these diagnoses is that resources may be diverted from other internally identified priorities to react to public reporting, says Knoebber. "Overall, quality of care will improve through the promotion of evidence-based practice and consistency of care."

Although the only official measures to report are the 21 indicators, a great deal of additional screening and analysis is performed to get to those specific indicators, notes Knoebber.

Organizations that already have been collecting the data are in a better position because they have resources and systems in place. "Within the Baylor Health Care System, the additional reporting requirements will not impact our work load," says **Pat Cooper**, director of health care improvement at

Baylor Regional Medical Center at Plano (TX). "Since opening our facility in December 2004, we have been collecting data on these measures for quality improvement purposes."

As the organization moves toward an electronic medical record, the plan is to hardwire queries relevant to the core measure elements into the system. "Currently, we scan all of our records into the computer," says Cooper. "We anticipate having an on-line documentation system in late 2007."

However, for most hospitals, the collection and coordination of these data will require additional resources since it is a new activity, says Knoebber. In some institutions, it will require a shift of personnel from other areas of focus to collect, analyze, and then improve the care reflective in the public indicators, he adds.

"Our institution has been fortunate relative to the CMS ruling's impact, since we have been an active participant in the Hospital Quality Incentive demonstration project for the past three years," he says. "We have been refining our processes and systems to collect and report data."

For example, there has been a shift from retrospective to concurrent data collection, since many of the measures being evaluated need to be identified, provided, and documented before the patient leaves the hospital.

At Baylor Regional, care coordinators concurrently collect data relevant to "impact measures" which can affect the delivery of care in real time, as follows:

- **Pneumonia:** Vaccination; blood cultures prior to initiation of antibiotics; and antibiotics initiated within four hours of admission.
- **Acute Myocardial Infarction:** Assessment of left ventricular systolic dysfunction and documentation of contraindications to medications.
- **Congestive Heart Failure:** Assessment of left ventricular function, documentation of contraindications to medications, and discharge instructions.

"Retrospectively, additional data are collected by the health care improvement department," says Cooper.

At Mission Hospitals, there is broader use of concurrent case management to monitor the selected patient populations through the system. As patients are identified, essential documentation points are monitored to ensure compliance. "Following discharge, timely abstraction identifies any variances that can quickly be communicated with case managers to validate the discrepancy or educate staff as needed," says Knoebber. "We also have created preprinted order sets with the default being our expected behavior and process."

At Baylor Regional, a discharge instruction sheet for congestive heart failure is used by the nursing department, which contains the required discharge instructions for core measures. Additionally, a cardiology progress note was created for congestive heart failure and myocardial infarction. "This becomes a part of the attending physician's permanent record, which prompts physicians to document the required core measure indicators," says Cooper.

For other indicators related to JCAHO or more general compliance issues, scan forms may be created for documentation that can be quickly summarized for reporting. "We are also looking at a software package that will link the patient with an independent data collection tool that will allow us to document at the bedside and create task lists for staff to flag or follow up on," says Knoebber.

[For more information, contact:

Pat Cooper, Director, Health Care Improvement, Baylor Regional Medical Center, 4700 Alliance Boulevard, Plano, TX 75093. Telephone: (469) 814-6671. E-mail: PatCoo@BaylorHealth.edu.

Paula Heinz, Quality Assurance Manager, Jewish Hospital, 410 South First St., Louisville, KY 40202. Telephone: (502) 587-4935. E-mail: paula.heinz@jhsmh.org.

Tom Knoebber, Director of Quality and Performance Improvement, Mission Hospitals, 509 Biltmore Avenue, Asheville, NC 28801. Telephone: (828) 213-9194. E-mail: CIATXK@msj.org.

Rhonda F. Walker, RN, BA, MBA, CHC, CLNC, Senior consultant, Courtemanche & Associates, PO Box 17127, Charlotte, NC 28227. Telephone: (704) 573-4535. Fax: (704) 573-4538. E-mail: ronnie@courtmanche-assocs.com.] ■

Address growing problem with credentialing

Difficulties arise in obtaining needed data

With the advent of hospitalists, credentialing and privileging for medical staff members who no longer care for inpatients is a growing challenge for many organizations.

The problem is that physicians may want to retain active medical staff membership with privileges, but they no longer want to be involved in

committee activities. Also, at the time of re-credentialing, there is nothing on which to judge the physicians' competence since they haven't cared for any inpatients and no data are available.

This problem has intensified in recent years as primary care physicians spend less and less time in hospitals, says **Alice Gosfield**, a Philadelphia, PA-based health care attorney who works with organizations on issues including medical staff credentialing. "There is no single answer to this dilemma, but it is increasingly a problem," she says. "It is especially problematic since many managed care organizations look to medical staff membership and privileges as a safeguard for quality."

It is less of a problem for integrated delivery systems that employ physicians through affiliated entities directly, because they are evaluating what they do in their offices more than in stand-alone hospital settings, Gosfield explains.

There is a misconception that the National Committee for Quality Assurance (NCQA) requires all physicians who are credentialed by an accredited health plan to have privileges. "This is not true," says Gosfield. "NCQA says that if you have privileges, you must maintain them in good standing."

Hospitals face potential liability exposure if they hold physicians out to the public as being members of the medical staff and fail to evaluate their current competence, adds Gosfield.

Some hospitals have established separate membership categories without clinical privileges. "Other hospitals have actually decided that they will seek to look at the physicians' activities in their offices if they are to be considered members of the medical staff. This is a very small minority of institutions," says Gosfield.

Low volume of inpatients

As primary care physicians became able to care for much sicker patients in their offices, their hospital admissions decreased, says **Frederick P. Meyerhoefer**, MD, a consultant based in Canton, OH.

For many physicians, volume of inpatients decreased to almost zero, making it difficult to document the physician's continued ability to care for hospitalized patients, particularly as the acuity of these patients increased.

"As a result of this shift in where and how patients were treated, a physician's reliance on the hospital as the place where the sicker patients were cared for was altered," Meyerhoefer says. "Patients that the physician had previously admitted to the hospital for care could now be provided excellent treatment in the physician's office."

This contributed to the further development of the budding hospitalist program, which initially was meant to provide in-house coverage for the hospital and the admitting physician, with the primary care physician maintaining the responsibility for the care of the patient.

"It fairly quickly headed toward true specialty status as the hospitalists began developing as a true specialist with expertise in inpatient care," says Meyerhoefer. "Due to frequent resistance from private practicing physicians, a hospitalist program has now commonly been embraced as a strong adjunct to the care provided by the primary care physician."

As practicing physicians realized the worth of the hospitalist program and became confident in the services provided, they increasingly have voluntarily given up some, or all, of their privileges — including the right to admit patients. This has increased the hospital's responsibility, under its custodial oversight for the inpatient, to provide constant and appropriate medical care for its patients, says Meyerhoefer.

"As yet, there is no universally recognized method for handling these privileging issues involving no privileges or very simple privileges, with or without admitting privileges," says Meyerhoefer. "Hospitals and medical staff leaders are struggling with meeting the needs of the patient and balancing the concerns of possibly affected physicians."

To allow physicians who may not have recently exercised the use of privileges that have continued to be granted over the years or have been voluntarily relinquished also raises the question of one standard of care for all patients, adds Meyerhoefer.

"None of these privilege concerns have affected the current necessary credentialing requirements for any physician granted membership to the medical staff," he says.

Some physicians still attach a major part of their identity to their hospital staff membership and privileges, but others recognize that the overall practice of medicine has changed and acknowledge their role as ambulatory care specialists, just as the hospitalists are now becoming recognized for their expertise in managing the hospital patient, says Meyerhoefer.

As soon as the medical staff and hospital board grant privileges to any physician who does not have current clinical data supporting those privi-

leges, it crosses the boundary of its fiduciary responsibility, says Meyerhoefer.

If any hospital-specific privileges are granted, the medical staff and hospital must be able to support the granting of the privilege with objective evidence of current clinical competency to exercise the privileges and manage inpatients, says Meyerhoefer. "This is the critical sticking point of allowing physicians to have medical staff membership with privileges," he says. "There is yet no clear answer."

There are creative ways of approaching this issue by looking to data that managed care plans maintain, pay-for-performance program data, or NCQA certification programs for diabetes, cardiac and stroke, says Gosfield. "But few hospitals have moved in that direction," she says.

Medical staff can only be granted privileges to do things for which the hospital has evaluated their competence in some capacity, says Gosfield.

"What that would be depends on the data they have available to them," says Gosfield. "If they do site visits or record reviews or look to other kinds of data, they could be given privileges to manage that kind of care."

They also can be given privileges "more of a social nature," says Gosfield, such as visiting patients, questioning them, and doing vital signs. "The real issue is that they should be given privileges only to do those clinical services which they are actually performing in the hospital," she says.

To obtain performance data for the credentialing process, have physicians sign releases for the information, and seek it from the parties who hold it, says Gosfield. "Look to report cards in the community, or go into their offices and do record reviews on your own," she says.

The other dilemma is that in most states, the organizations who may hold the necessary information are not obligated to provide it for another organization's credentialing unless it is generally made public, adds Gosfield.

Creative solutions needed

"Health care organizations are trying to come up with solutions to this evolving issue," says **Fay A. Rozovsky**, JD, MPH, a Bloomfield-CT-based consultant.

Here are some possible solutions:

• Using a courtesy-style privilege, with care providers not expected to take part in committees or attend meetings.

This could include all the "perks" associated with other medical staff categories, such as CME credits, library access, voluntary attendance at medical staff committee meetings, and reserved parking. "Whether or not these members have any political rights such as voting rights or membership on medical staff committees is a determination to be made by the medical staff," Meyerhoefer says.

For this type of category, the medical staff is not vouching for any current clinical competency of the physician, says Meyerhoefer.

"The push back on this approach is that as long as a hospital grants an appointment, it is holding that care provider out as having met established standards," says Rozovsky.

Thus, the bylaws, rules, and regulations of the medical staff need to be changed to accommodate this new approach while being certain that these changes conform to CMS, JCAHO, and AOA requirements, Rozovsky says.

• Performing a limited review of the physician's practice patients in some specific diagnostic categories.

"This would accord some credence to clinical competency to these physicians without granting hospital privileges," says Meyerhoefer. "However, this has not been met with great enthusiasm by the practicing physicians."

• Including procedures in ambulatory care settings or other hospitals when verifying performance thresholds.

As it becomes more difficult for care providers to meet the bylaw-required thresholds at the hospital, "outside" performance can be used as a surrogate, says Rozovsky. The danger is that the "outside measures" may not be data equivalents, and that is an issue that must be examined closely, she says.

"One thing is certain," says Rozovsky. "Before making any changes, health care organizations must be clear that the revised process will be compliant with applicable state law, the CMS Conditions of Participation, and accreditation requirements."

[For more information, contact:

Alice G Gosfield, 2309 Delancey Place, Philadelphia PA 19103. Telephone: (215) 735-2384. Fax: (215) 735-4778. E-mail: AGGosfield www.gosfield.com.

Frederick P. Meyerhoefer, MD, 1261 White Stone Circle NE, Canton, OH 44721. Telephone: (330) 966-6717. E-mail: meyerorg@aol.com.

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'Basics' may be pushed aside in rush to trendier remedies

Patient throughput efforts could benefit from DP principles

Discharge planning starts at admission. It's one of the most basic tenets of the discipline, notes **Jackie Birmingham**, RN, MS, CMAC, but one that is increasingly brushed aside as hospitals focus on utilization review (UR) and bed management in an effort to enhance patient throughput.

As health care providers redesign emergency department (ED) processes and cancel elective surgeries in response to the capacity crisis, they often overlook the power of proactive and comprehensive discharge planning, according to Birmingham, a veteran discharge planner who now is vice president of professional services for Curaspan Inc.

"Whenever I hear [providers] talking about patient throughput, they sort of [add] 'and, oh, discharge planning,'" she says. "When I listen to patient throughput scenarios, there is talk about bed management tools and ED fast track, and what's happening is that the case manager is spending a lot of time doing UR and not enough time counseling on the patient's readiness for discharge."

Birmingham says she recently came across a situation in which a patient was in the hospital for 10 days, but not until the morning of discharge did staff begin to go over diet and medication issues. At that point, she adds, the family learned for the first time that the patient — who was being treated by several specialists, including a cardiologist and a pulmonologist — had developed prednisone-induced diabetes during the stay and was on insulin.

"I think that the case manager was very involved with getting approval for the nursing home stay and tracking continued stay [criteria]," Birmingham says, "but when it came to the simple discharge plan, that kind of got shunted off."

If UR staff are thinking that a patient is getting close to the end of what will be considered an appropriate hospital stay, she advises, the discharge planner should be actively involved in the process.

"This [concept] is so old — discharge planning rules were proposed in 1986 and passed in 1988," Birmingham says. "But now the admitting staff are looking at what beds are available and predicting how long the patient should be there so they can book the next surgery, and the case manager is looking at the clinical processes that justify the continued stay.

"When it comes time to discharge the patient," she adds, "it seems to be a surprise."

There is a mindset among many patients admitted to the hospital, Birmingham suggests, that they are not going to leave until they are totally independent.

"They don't understand that acute care is a very short part of their episode of care, so they want to stay longer," she says. "It's not all patients, but it's the elderly person with a cardiac condition who has a child [providing care] who might also be elderly with a cardiac condition.

"The fact that patients come into the hospital and are not the way they were before and probably never will be is kind of a shock to the family,"

Birmingham adds. "The family still pictures the hospital as where you go and get better, but it is where you go and get stabilized. [The patient] is like, 'I'm not well enough to go home, but I don't want to go to a nursing home.'"

Meanwhile, she says, the family is not brought up to speed on short-term nursing homes or home health or adult day care.

"In the tweaking of patient throughput," Birmingham continues, "they're not putting enough emphasis on discharge planning. It was intended to move patients. Some people look at discharge planning as writing a plan and being done with it."

She recalls talking to a group of engineers who posed the question, "If discharge planning starts on admission, why does it take so long to discharge a patient?"

What is lost sight of, Birmingham says, is that "discharge planning" is an active term. "It's *planning,* not a *plan.* It's assessing a patient: If you're going home, well, what do you need to go home? Do you need to see a physician? Do you need equipment? Do you need medications? Do you need to be taught how to test blood sugar?"

Without proper attention to those questions and others, she says, within a short time "the family is clamoring for information, calling the physician back — and the readmission rate from home health care is almost 40%."

"Patients going to a nursing home get a lot more scrutiny than those going to home health care," Birmingham adds. "I'm putting the blame on discharge planners. They may think home care is fairly routine, but it's really risky [for patients] going to an environment where there is not 24-hour care."

A discharge plan is more like a video than a snapshot, she notes. "It's a moving reel, and then you take a snapshot at the end.

"It can be done along with other tasks and fits quite nicely with case management, utilization review, and clinical pathways," Birmingham says. "Capacity management is so important now that a little more emphasis is needed on how you do discharge planning."

Patient choice: 'It's required'

The importance of patient choice is another principle that case managers should keep at the forefront of the discharge planning process, says **Jackie Connor**, RN, MS, CCS, director of case management at St. Joseph's Medical Center in Towson, MD.

"In the whole scheme of trying to facilitate discharges rapidly, this has the potential to be overlooked, she adds. "When you offer choice, give the patient options, it can slow the process down."

Nevertheless, Connor cautions, case managers should not only present available options to the patient but document that choices were offered.

"In a case where a physician wants the patient to go to a skilled nursing facility," she says, "the case manager or social worker may go in and say, 'I have a facility that can take you today, and I can get you all set up.' Certainly patients don't always know they have a choice."

More correctly, she adds, the patient should be told something like, "I have two, or three, or five facilities that have availability."

Medicare guidelines mandate that patients be given choices, not only Medicare patients but any patient, Connor emphasizes. "It's at the heart of the discharge planning process. It's required."

Be alert to red flags

Including orientation, it takes about two years on the job before new case management staff are "fully functional," suggests **Kate Tenney**, RN, manager for case management at Sutter General Hospital in Sacramento, CA. That's the point, she adds, at which they "understand all the red flags that catch their attention, know the resources and how to move patients through the system."

Until about that time, Tenney says, "you can expect that they will miss things." She cites the recent case of a man in his 40s whose face sheet showed that he had Medicare coverage — a red flag that was missed by a novice case manager.

As a result, there was no initial assessment for discharge planning, and the patient — who had a disability, financial problems, and needed a post-acute placement — stayed in the hospital longer than he would have if the situation had been identified sooner, Tenney adds.

In many cases, she says, physicians don't mention those kinds of details, but just say something such as "a 47-year-old man admitted with a broken leg."

"Those little flags are what make or break an effective discharge plan," Tenney notes.

Such oversights can occur even with experienced case managers, points out **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health. They typically occur, she says,

"when you're implementing a new software package or putting pressure on meeting criteria — anything that draws you away from doing the same procedure over and over again."

"You could be focusing so hard on InterQual that you get to a Medicare patient and say, 'I don't need to see this one,'" she says. "That's when [cases] fall through the cracks."

Seasoned case managers often have their own system and "bag of tricks" in place, adds Tenney, and are subject to overlooking things when a new methodology is introduced.

"For example, first I open the face sheet, then I look at the first order, then I look at the history and physical assessment," she says, describing her own routine. If management comes in with a new process for staff and says, "This is what you will do and how you will do it," Tenney continues, "it takes away their routine or tricks to identify potential patients that need additional discharge planning or social work."

That disruption can occur, for instance, when the department goes from a written methodology to a computerized one, she says. "You don't necessarily put all those little notes you write into the computer, and that's another opportunity to miss something."

Another frequent challenge to effective discharge planning has to do with knowledge of community resources, Tenney says. "These resources change over time, and we may not be kept abreast of what's available and what's not available.

"I was in a meeting a while back and someone mentioned a nurse who worked for a board-and-care facility," she recalls. "That is very unusual — typically [those facilities] just provide food and a place to live.

"This one not only provides a much higher level of care but has a nurse who works there and gets a higher level of reimbursement," Tenney notes. "We weren't aware that it even existed. Keeping up with what's available in the community is a big problem."

Typically, a case management nurse will put notes on this kind of information in her folder, Leach adds, and the person who covers for her won't necessarily have it. Similarly, she says, "when you transfer a patient from one service to another — say, from the intensive care unit to a med-surg unit — the bag of tricks with the thing that fits that patient might not be there."

Keeping case managers constantly informed of developments in the field — "growing" your staff — is another discharge planning basic that can fall between the cracks, Tenney says.

"With the kinds of caseloads they carry these days, there's not a lot of time to read literature or periodicals," she notes. "You need people in the organization who summarize what's available and send out tidbits to staff. That's missing in acute care, especially."

While it's hard to calculate the benefit and justify the cost of allocating staff for such a function, Tenney adds, there are ways to address the issue.

One is to look at ways to get staff talking with each other about cases so they're in a position to share their expertise, she says. "One of the things we've tried here is having a huddle with multiple staff — both experienced and inexperienced.

"When you watch them talk, you can see other case managers paying close attention to how someone solved an issue," Tenney continues. "You will see them writing down little notes. If you do it well, you have your senior case managers constantly mentoring new case managers without even thinking about it."

Leach says she holds a team meeting every week that includes case managers, nursing staff, and representatives from other disciplines. Attendees look at difficult cases and "hand off the easy wins from person to person. We've incorporated the ones for difficult patients," she notes, "so now the 'difficult' patients have to be 'very difficult' patients.

"There is a lot of learning that happens in that arena," Leach adds. "We've even brought in experts for, say, tuberculosis care in Sacramento County, and we've had the physician who is the head of health and welfare to talk about the expectation for acute care for patients."

Meetings where information is shared between case managers teaches them how to concisely describe a situation, the problems involved, and their recommendations, Tenney says.

Such gatherings work best if the sharing is kept brief and to the point, she adds. "If they get in the habit of doing that well, it teaches them to dialogue with physicians and nurses. It also allows for other people in the room to come up with ideas that might help them."

[For more information, contact: Jackie Birmingham, RN, MS, CMAC, at jackiebirmingham@sbcglobal.net. Jackie Connor, RN, MS, CCS, can be reached at jackieconnor@chi-east.org. Kate Tenney, RN, can be reached at TenneyK@sutterhealth.org. Barbara Leach, RN, can be reached at LeachB@sutterhealth.org.] ■

Maryland facility begins 'discharge by appointment'

Plan 'truly' begins at admission

This month, St. Joseph's Medical Center in Towson, MD, will begin discharging patients by appointment, in the latest phase of a three-year effort toward capacity maximization, says **Jackie Connor**, RN, MS, CCS, director of case management.

When Connor was hired in April 2005, she was asked to take over the part of the project that included improving the discharge process, "the back end of patient flow," she adds. "Other teams were working on the emergency department [ED], the front end. We had an issue with 'boarders' in the ED, and as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80% of the problem should be fixed."

Connor says her sense of the situation, however, was that a more comprehensive solution was needed. "We put together a multidisciplinary team last June, started working on the problem and, as we moved forward, put together subgroups as issues arose."

'Bolus' admissions

When the Discharge Task Force was established in June 2005, one of the main goals was to increase the percentage of patients discharged by noon, Connor adds. But even with that specific intent, several months of data collecting revealed little change.

"What we found was that it was causing what we called 'bolus' discharges," she says. "It was a rapid, concentrated effort, a massive amount of patients, trying to get it all to happen before noon.

"Later in the day, we would have 'bolus' admissions as the ED and the catheterization lab would empty out," Connor adds, "so there was not an even workload throughout the day."

That's when the decision was made to move to discharge by appointment, she says. "What we're attempting to do — and I haven't seen this in any of the literature on the subject — is to try to schedule discharge for *all* patients, not just surgical patients."

The idea has been piloted on the surgical unit with some success, and then with interventional cardiology patients, and is now being expanded to all patients, Connor notes. One group that will not be included is the maternal/child patient population, she adds, because there are no throughput issues there. The process works as follows:

1. Planning begins on admission for the anticipated discharge. "I know everybody says they do that, but we truly are going to begin — meaning we will assess the patient, discuss the plan, and then set the anticipated date."
2. Nursing, case management, and physicians work daily on evaluating the plan and the anticipated date.
3. Ancillary departments will be notified of the anticipated discharge date and time and their turnaround of tests and procedures, and their goal is to meet the deadline — to prioritize based on the date given.
4. The patient is informed all along the way of what the plan is.

"We're trying to plan from Day One to get everybody moving in the same direction," Connor adds.

The team will monitor:

- The percentage of patients who have a discharge appointment.
- The percentage of patients who have an appointment who are discharged within 30 minutes of the appointment.
- The percentage of patients who are identified as potential discharges at least 22 hours prior to the actual discharge. ■

Katrina survivors suffer limited access to care

Survivors of Hurricane Katrina continued to suffer emotional and mental trauma and limited access to care and medications for months after the storm, largely because of a sharp reduction in charity care and lack of insurance, according to a recent report.

The Kaiser Family Foundation interviewed low-income victims of the storm five to six months after the hurricane struck, and found that many went without or experienced gaps in care, had difficulty accessing mental health services, lacked transportation to needed health care, or could not afford both health care and other basic needs. ■

Fay A. Rozovsky, JD, MPH, The Rozovsky Group, Inc./RMS, *272 Duncaster Road, Bloomfield, CT 06002. Telephone: (860) 242-1302. Fax: (860) 242-1075. E-mail: fay@therozovskygroup.com. Web: www.therozovskygroup.com.]* ■

Insurers using publicly reported quality data

Payers offer top hospitals public, financial benefits

A growing number of health insurers is using publicly reported quality data to reward the best-performing hospitals, both publicly and financially. Horizon Blue Cross Blue Shield of New Jersey and the Leapfrog Group have launched a program offering hospitals financial and public recognition for high-quality hospital care, tied to the JCAHO and CMS measures.

"Quality managers need to be prepared to incorporate the growing set of standardized measures for health care performance into their internal benchmarking as well as in public reporting programs," says **Suzanne Delbanco**, PhD, CEO of the Leapfrog Group.

Horizon Blue Cross Blue Shield of New Jersey is the only plan with which Leapfrog is offering its Horizon Recognition to all its contracted hospitals, but the program is at work in various smaller formats in Memphis, TN; Seattle; southeast Michigan; and Raleigh-Durham, NC.

The Horizon Recognition program can be customized for local markets, and many markets beyond New Jersey are considering implementation of this program, as part of a growing trend to award financial and public recognition for high-quality hospital care, says Delbanco.

Determining reimbursement based on quality, best practices, and positive outcomes is a growing trend, says **Thomas W. Rubino**, director of public affairs for Horizon Blue Cross Blue Shield of New Jersey. "Most likely, other states will soon have similar programs," he says.

This is a positive development for hospital-based quality professionals, who often are viewed as "expendable, expensive" resources, says Rubino. "When cuts to administrative overhead expenses are under consideration, this program demonstrates in a very real way — more revenue — the value these professionals and their programs and initiatives can and do add to the hospital's bottom line," he says.

The best performers will be rewarded with public recognition, which can increase a hospital's market share of patients, as well as financial awards. The performance measures for which it is appropriate to adjust for the severity of the patient's condition have been severity adjusted.

"For each clinical area, length-of-stay averages are standardized for disease severity, weighted and inflated by the rate of readmission following discharges," says Rubino. "An overall composite resource efficiency score for the clinical area is calculated."

Methodist Le Bonheur Healthcare, a seven-hospital system based in Memphis, is participating in both CMS and Leapfrog. "We are a big proponent of transparency and share our data with a variety of organizations," says **Donna Abney**, the organization's executive vice president. "With the CMS demonstration project, we wanted to run with the fastest players and knew some of the best hospitals in the country would be entering."

With Leapfrog, the organization's goal is to bring skilled professionals from other industries in order to apply quality improvement lessons to health care. The Memphis Business Group on Health is organizing several health plans in that market to use the Leapfrog measures as the foundation of their hospital recognition and reward efforts. The group was an early adopter of the Leapfrog program and now serves as an intermediary between the business community and local hospitals.

"They serve as a forum, where we as a hospital provider and Federal Express as a purchaser can sit at the same table and talk about process design or business problems," says Abney. "We are very fortunate to have a broker that creates an environment for us to have that kind of dialogue on a regular basis."

The organization is still in the beginning stages of its first data exchange with Leapfrog but has already met with executives from Federal Express. "They in particular have been very amenable to come in and work with us on specific problems, not necessarily tied to pay for performance," says Abney. "What we hope to get out of it is improvement. We are interested in anything that helps us do a better job."

The organization takes full advantage of knowing where it stands in comparison to its competitors, says Abney. "When we get a blueprint or map that says, Methodist Healthcare, here's where you are, and here's where someone else is, we immedi-

ately go to those benchmark hospitals and try to deconstruct what they do differently," says Abney.

Quality leaders ask: Do they use the same tools? Are they training people the same way? Are their underlying clinical processes the same or different?

"Then we do a gap analysis and try to understand what things they do that deliver better results," says Abney. "For the CMS initiative, we have profiled and modeled and stolen from some of the best hospitals on any number of fronts, and I expect we will do the very same thing with Leapfrog."

Here are some of the changes that have been made as a result of the process:

- Intensive care units were redesigned using multidisciplinary rounds and care bundles.
- A variety of automated tools were implemented to prompt clinicians to deliver certain procedures or tests.
- The medical staff bylaws were changed so that flu vaccinations are given automatically without the need for a physician order.

The organization has no specific plans to use the quality data for marketing or public relations campaigns. In fact, it's much more effective to have a third party do the "bragging" for you, says Abney.

"We have not purposely been going out and giving statistics to the public saying our quality is better. But as others measure us and do report cards on us, we find that we fare well on them, and they go to the public on our behalf. We don't have to toot our own horn — they do it for us," says Abney.

Several area insurance companies are including publicly reported data on their web sites to share with consumers. "What they are doing now is considerably more sophisticated than what they may have started out with," says Abney.

In the Memphis area, United Healthcare, Cigna HealthCare, and Blue Cross of Tennessee are among the insurers who are in the process of launching web sites posting quality data on local hospitals. "It's a growing trend, and they are all aggregating around pretty much the same information, using the CMS and JCAHO measures, and reporting to their respective customer bases how hospitals they use are faring against those measures," says Abney.

Cigna HealthCare has made a grant of $125,000 to help Methodist create more resources to collect data related to obstetrics for a Leapfrog patient safety initiative. "They have been very active with us in the Leapfrog program and have helped us fund and launch a lot of initiatives in QI with their resources," says Abney. "They have given us grants to beef up our data collection capabilities."

For both CMS and Leapfrog, all data are exported to Premier prior to submission. "They are an accredited intermediary, and they scrub the data and export it either to CMS or to Medstat, which is the information vendor for Leapfrog," she says.

Even data collected electronically are first sent to an electronic clearinghouse to be sure the format is correct.

"There has been some cost associated with this, including cost to pay vendors to act as data scrubbers, and cost to beef up the quality assurance we do internally before the data is exported," Abney says. "There is a cost to provide data to the external world, but we think it's well worth the investment."

The organization's clinical informatics department has grown from a tiny department to eight full-time staff members. "We are about halfway through a five-year journey to a complete electronic medical record," she says. Nursing, pharmacy, radiology, and laboratory results are in the electronic record, so data from those areas can be exported electronically.

"However, sometimes the documentation of measures that an external body wants, such as antibiotics within four hours of arrival, may not easily transfer electronically," Abney says. "So we might have to put manual processes in place in addition to the electronic processes, to create a complete picture for the external world."

Even after the hospital is 100% electronic, there probably will always have to be some manual oversight to ensure that data are collected and arranged properly, she says.

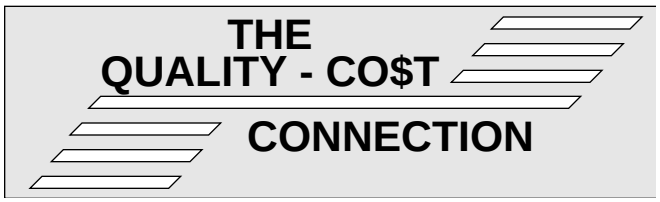
The financial implications of improving quality aren't the main issue, Abney says. "There are theories about whether quality improves the financial status of an institution or adds to the cost. We haven't spent time getting lost in those arguments," she says. "We have gone down this road with some level of financial analysis, but with more of a commitment that it's the right thing to do."

[For more information, contact:

Donna Abney, Executive Vice President, Methodist Le Bonheur Healthcare, 1211 Union Avenue, Suite 700, Memphis, TN 38104. Telephone: (901) 516-0549. Fax: (901) 516-0558. E-mail: AbneyD@methodisthealth.org.

Thomas W. Rubino, Director of Public Affairs,

Horizon Blue Cross Blue Shield of New Jersey, Three Penn Plaza East, Newark, NJ 07105-2200. Telephone: (973) 466-8755. E-mail: Thomas_Rubino@horizon-bcbsnj.com.] ■



Don't declare QI victory too soon

Evaluate the effectiveness of QI initiatives

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

Hospitals are making numerous changes in an attempt to improve the quality and safety of patient care services. These interventions could be a new program, practice, or initiatives such as staff training. Changes are occurring at a rapid pace in different levels within the organization, including management and at the front lines. Unfortunately, people often don't take the time to critically analyze and evaluate the changes to see if intended improvements are actually realized. The sense of urgency for change is not coupled with the resolve to conduct post-intervention evaluations. With health care organizations taking an ever closer look at their overall expenditure levels, it is increasingly important to evaluate the effectiveness of quality and safety initiatives.

No change should be implemented without a plan for conducting an effectiveness evaluation to determine whether the initiative had the intended effect. Such an evaluation might answer the question: Does the new medication reconciliation process instituted for the purpose of decreasing medication errors actually reduce errors? This type of evaluation is the "CHECK" portion of the PLAN-DO-CHECK-ACT (PDCA) continuous improvement cycle. Although outcomes often are measured in an effectiveness evaluation to determine whether the initiative had an effect or not, this may not always be the case. For example, if medication error data are unreliable, a surrogate measure could be used (i.e., completeness of reconciliation documentation). Three types of measures can be used to evaluate the effectiveness of actions:

Completion of action — Easiest to measure, but weakest. Example: Measure that staff received training in the new medication reconciliation policy and procedure.

Compliance with process changes — Harder to measure, but more meaningful. Example: Measure how often reconciliation is done within established timeframes.

Outcome (result) of actions — Often hardest to measure, but best indicator of success. Example: Measure how often a near-miss or adverse event occurs because of inadequate reconciliation of a patient's medications.

It may be necessary to make tradeoffs when choosing which outcomes to measure. Issues such as resource limitations and potential availability of quality data must be taken into consideration. If a very complete effectiveness evaluation is warranted, pertinent data would need to be collected for all important variables.

Measurement plan

Plans for evaluating the effectiveness of a change should be developed while the intervention is being chosen or designed. Measurement starts with a clear understanding of what people are trying to achieve. The individuals involved must clarify what they hope the intervention will change and the mechanism by which that will happen. Next, have them tell you how they will know if the action made the situation better. It can often be useful to also identify potential unintended outcomes of the intervention. To do this, ask people to look at the changes that are supposed to happen following the intervention. Then have them think about what other effects could possibly result from the changes. For example, an intervention to reduce needle injuries by eliminating recapping prior to disposal into containers might not only have the intended effect of decreasing recapping injuries, but also an unintended effect of increasing disposal-related injuries if disposed into poorly designed containers.

Once the intervention effects (both intended and unintended) have been identified, measurement methods are selected. To clearly demonstrate intervention effectiveness, outcomes should be measured using quantitative methods (i.e., rate of patient injuries, percent of medication reconcilia-

tions completed on time). Quantitative measures are used to determine how big an effect the intervention had on the outcome(s) of interest and whether the effect was statistically significant. The presence of a demonstrated statistically significant change or difference in a measurable variable provides good evidence of intervention effectiveness. Qualitative evaluation methods also can be used. These measures are helpful in determining how the intervention achieved desired results and the reactions of individuals expected to adopt the change.

After the measurement methods are defined, it is time to select the sample that will be evaluated after interventions are implemented. The evaluation sample is obvious when an intervention is being introduced in just one department and all 30 employees will be affected by the change. However, often interventions are implemented across the organization and it may not be feasible to evaluate everyone's involvement. In these situations, a smaller study population must be identified. Lower numbers can provide you sufficient statistical power to measure an intervention effect if the study sample is chosen carefully. The sample should be representative of all involved groups and their particular circumstances (i.e., time, place, discipline, etc.).

Suppose a training intervention is being implemented to improve communication among members of the health care team and you will evaluate it by observing people interacting before and after the intervention. It is not feasible to observe everyone who received communication training, so you limit the evaluation to a smaller sample. It would be easier to observe everyone who works in one area, but this group is unlikely to represent the whole population of trained individuals. The best method is to choose a random sample, which increases the chance of a representative sample. Random selection involves choosing the groups to observe in such a way as to ensure every group has the same probability of being selected. When evaluating the effect of communication training, you'd want a stratified random sample that takes into consideration the particular circumstances that might influence communication practices, such as professional discipline, time of the day, unit, etc.

Measure over time

Often, it is necessary to take multiple measurements over time to reliably judge intervention effectiveness. But how long must you keep

CE *questions*

13. Which is true regarding quality data reporting required by the Centers for Medicare & Medicaid Services?
    A. Fewer hospitals will be required to report quality data.
    B. Hospitals will only be required to report on certain measures to get full payment updates.
    C. Hospitals will be required to report on the full set of Hospital Quality Alliance measures to get full payment updates.
    D. Less quality data will be reported by each hospital.

14. Which is recommended for data collection of quality measures?
    A. Do retrospective data collection only.
    B. Avoid use of electronic medical records.
    C. Electronically collect and store the data.
    D. Avoid using preprinted order sets.

15. Which is true about quality measures?
    A. CMS and JCAHO have aligned their measurement sets.
    B. Hospitals have to collect different data for CMS and JCAHO measure sets.
    C. CMS and JCAHO measure sets are different.
    D. JCAHO requires additional performance measures.

16. Which is true regarding credentialing and privileging of medical staff members?
    A. Physicians must be involved in committee activities to retain privileges.
    B. All physicians credentialed by an accredited health plan must have privileges.
    C. Organizations are required to provide data on physician performance in all 50 states.
    D. Procedures performed at other facilities can be considered to meet performance thresholds.

Answer Key: 13. C; 14. C; 15. A; 16. D

CE instructions

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

measuring? The answer depends on several variables. If you are making small incremental changes as part of a rapid cycle improvement or Six Sigma project, you need to gather data long enough to be relatively certain the change was successful at achieving the intended effect. Once success is confirmed, you can spread the change to other areas and move forward with the next incremental change.

Significant changes often require a longer period of measurement to determine if the new practices have been internalized by those involved. For instance, medication reconciliation is a new practice for nurses, pharmacists, and physicians. Thus, it will take awhile for the reconciliation process to be followed consistently.

Occasional measurement of compliance will be a necessary part of the implementation process for several months. If the intervention is replacing a long-established habit, such as the use of abbreviations in medication prescriptions, an even longer period of measurement may be needed. People newly trained to a practice change are more likely to comply if they know they will occasionally and randomly be observed.

The effectiveness of large scale interventions intended to positively impact patient outcomes can require measurement over several years. An integrated health system systematically embarked on a multi-faceted initiative to improve pediatric asthma outcomes. Data were gathered at each step of the process to assess the effectiveness of each new intervention at achieving desired practice changes, such as appropriate use of anti-inflammatory medications. In addition, outcome data were gathered for several years to determine if pediatric hospitalizations and emergency department visits were declining.

After an intervention is in place and appears to be running well, it is usually not necessary to continue evaluating compliance with process changes. Periodic review of outcome results may be sufficient to ensure that nothing is disrupting what appears to be a well functioning process. For example, the rate of patient falls can be monitored to determine if fall prevention interventions continue to be successful. If the outcome data are reasonably accurate, use a control chart to plot the results. Often, monthly rates vary considerably because of random variability and you'll want to know if results for a single month are significantly out of line with previous experience. Control chart methodology will alert you when the number of patient falls in a month is so high that there seems to be a real problem, or when the pattern over two or three months is a cause for concern.

If the intervention is expected to have a positive impact on important outcomes, quite likely some of those outcomes already are measured regularly. Thus the data collection burden may be minimal. Improvements in hand washing are expected to decrease nosocomial infections and the rate of infections often is routinely measured by hospitals. The success of interventions intended to improve patient satisfaction can be measured indefinitely through the hospital's existing satisfaction survey process. Length of stay and cost data can readily be obtained from the hospital's claims database, and this information can be used to evaluate interventions expected to impact these results.

People look forward to completion of any task, so it's no wonder that it is tempting to congratulate all involved and proclaim success once interventions have been implemented. However, if the results of the change are not adequately evaluated, it's like declaring victory before the war is over.

COMING IN FUTURE MONTHS

- Error reporting strategies that really work
- Put a stop to redundant data collection efforts
- Make the most of publicly reported quality data
- Update on health insurers and pay-for-performance
- Show surveyors that patients are involved in care

Improvement projects that essentially end at the DO phase in the PDCA cycle may only produce a fraction of the possible results. Or, worse yet, six months after the end of the project, it will become clear that immediate gains were not sustainable. ■

ACCREDITATION
Field Report

Surveyors like process used to reconcile meds

During a January 2006 survey at Merrimack Valley Hospital in Haverhill, MA, Joint Commission surveyors looked closely at patient safety, medication reconciliation, fall prevention, handoff communication, and changes made as a result of performance improvement activities.

The organization chose option three for its periodic performance review (PPR), which consists of an onsite survey of about one-third the duration of a full survey. "Our PPR survey was approximately 15 months prior to our triennial survey," says **Gloria Swanbon**, director of quality improvement and risk management. "The surveyor was very informative and served as an instructor as well as a surveyor. It was a very positive experience."

The PPR survey was a good "dry run" for the actual survey, says Swanbon. "It's more consultative in nature, and there is no written report on file," she says. "We received a verbal report; hence there was nothing for the surveyors to look at when they came for the triennial. We did not have to prepare any measures of success for them."

During the actual survey, surveyors traced a surgical patient, a psychiatric patient, a critical care patient, and patients who transferred from one unit to another, looking for the continuum of care and the handoff sharing of information.

Handoff communication was a topic of discussion during all of the tracers and during individual sessions in specialty areas, such as radiology and nuclear medicine. "The expectation was that all caregivers share common knowledge about their patient's needs," says Swanbon. "The most common queries were 'How did you find out about this patient?' and 'What were you told about this patient?' This was very similar to the PPR survey."

The surveyors were impressed with the consistency of the medication reconciliation process. A single form is used to document a patient's medications on admission, on transfer, and upon discharge, with forms color-coded and placed in the same spot in every record.

"They liked our format and could see that everyone was working with it including the medical staff," says Swanbon. "It is a combined effort between nursing and medical staff and is a great tool for assisting medical staff both upon admission and at discharge." ■

CE objectives

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

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■