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Avoid quick fixes for improvement: Don't let surveyors find reoccurring problems

Take the next step to sustain your gains

It's a situation you don't want to have during a survey by The Joint Commission — surveyors discovering previously identified problems are still occurring. Or just as bad — the problem was fixed but the solution was only temporary.

"We are finding that some previously non-compliant elements of performance are found in subsequent surveys," says Mark E. Schario, The Joint Commission's senior field director for surveyor management and development.

Quality professionals need to pay close attention to the improvement process and the coordination of the details surrounding it, says Schario. "If you have non-compliance with a standard related to patient safety and you are not implementing improvements, then you can be placing patients at risk," he says.

After the evidence of standards compliance is submitted, the organization may then track performance with measures of success for the standard that was non-compliant.

"That's the first step where things can fall off," says Schario. "After a survey, a lot of organizations say, 'They found something wrong,' and they rush quickly to fix it. Then they have trouble keeping that improvement sustained," he says.

Since Joint Commission surveyors view recurring problems as a potential leadership issue, they expect that hospital leaders keep their eyes on sustained improvements. "They will want to make sure that leadership has a plan so improvements do not fall though the cracks," Schario says. "Just finding out there is a problem and putting in a fix is only part of it; you have to sustain those gains and monitor it. And that is the responsibility of leaders in the organization."

Quality professionals have the tough job of "managing upward" to make sure that leadership has priorities established, says Schario. "Organizations will tend to drift away from key issues, especially for areas like the National Patient Safety Goals, which we have found a lot of non-compliance with," he explains.

Since surveyors are aware of past recommendations, they will be looking to see if prior problems still exist during patient tracers. "That is where a

surveyor is really going to do a more detailed exploration," says Schario.

If a problem is identified as a recurring problem, it can become attached to the leadership standards. "Surveyors will take the view that leaders are really responsible for this. If we found a problem, it was supposed to be fixed, but here it is again — that's when you will get a lot of discussion at the leadership level during the survey," says Schario.

Sustained performance is really what it's all about, says Schario. "A lot of people think performance improvement is just going to the next level. But to reach that next level, you need to sustain improvements you have already made," he says. "That is really where hospitals need to be focused."

The Joint Commission's tracer methodology is very effective at finding recurring issues, adds Schario. "You are going to an organization and looking not at documents, but at the provision of care. Our primary focus is the point of care, and reoccurring problems are going to be discussed in the following context: 'If you fixed them in the past, talk to me about why they keep occurring,'" says Schario. "It will all come down to what we observe when we perform a patient tracer activity."

Here are effective strategies used by quality professionals to ensure that necessary changes don't fall through the cracks:

• Challenge your data

At Christus Spohn Health System in Corpus Christi, TX, once an area has been identified as needing improvement, a group of staff is gathered to look at the issues surrounding the problem, including both frontline staff and managers. The leader of the group, usually a manager, guides the team to look at the issues, then brings the information back to the leadership group to look at the issues from the system perspective.

"Based on the nature of the improvement opportunity, we include the physicians, licensed independent practitioners, and other pertinent departments into the discussions to ensure we have the correct information and perspectives of their areas," says **Pamela Hockett**, RN, MSN, vice president of clinical quality.

Once a solution is determined, its impact is evaluated and a plan developed to roll it out to the various areas, based on the complexity of the issues.

To avoid loss of momentum, specific target deadlines are used, to prevent the issue from becoming lost among many other priorities. "Although the pressure of the deadline can be difficult, it forces the decision-making process and minimizes the 'analysis paralysis' that occurs with challenging issues," says Hockett.

Data are most helpful when they are vigorously challenged with questions, says Hockett. "The more questions we pose to the data and its process of collection and interpretation, the more likely the data will be a true presentation of what was measured," she says.

For example, tracers are performed on the unit level to ensure regulatory compliance of the environment and staff. "If the results of that activity were to be accepted at face value, it would indicate that we were at 100% compliance every

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month," says Hockett. "If you question the data, as we did, we realized that the tracer process was not as robust as it should be. We needed to have staff trace units that they do not usually work on and have them rotate."

Having staff trace in unfamiliar territory produced a fresh set of eyes to more accurately score the tracer and provided a more accurate picture of compliance.

Have multiple staff review the findings, to help the group identify issues that are measurable and significant to the organization. Challenging data in this way gives you the chance to adjust processes in the data collection and interpretation phases. "Data is a valuable tool in driving changes, but it must be accurate in order to drive changes in the right direction," says Hockett.

The hospital recently reformatted its organizational structure with a service line approach. Service line directors meet weekly to discuss operational issues and projects to improve patient care. "Having a multidisciplinary approach to the process improves the odds that the change will be embraced by the health care team," says Hockett.

• Use report cards

At Franciscan Health System in Tacoma, WA, a LEAN process improvement project is designed by the actual staff involved. An intensive workshop is held, followed by sequential Plan-Do-Study-Act cycles to fine-tune the improvements. Sixty and 90 day follow-up workshops are held to sustain achievements.

"We have committed to rapid process improvement as a systemwide response when system design fails," says **Tony Haftel**, MD, the organization's vice president for quality.

All requests for process improvement go through the clinical effectiveness department, and a process improvement facilitator tracks all requests and facilitates all projects. This individual provides LEAN training to all levels of staff, assesses opportunities for improvement, does initial screening of requests and monitors the progress of teams.

To ensure changes are made, "cascading" report cards are used. "These are intensive for all of our service lines, and are benchmarked against national and local indices, and also our parent health system," says Haftel.

Each service line works off a "local" report card with 15-20 parameters relating to clinical outcomes, safety, satisfaction, and fiscal performance. Each of these service lines reports up to an aligned interdisciplinary team.

This brings several related service lines, such as the emergency department, trauma, and critical care, under a single team. That team tracks only the three to five most important parameters from the reporting service lines, which reports to the quality council. "Therefore, there may be hundreds of parameters tracked at the service line levels, but only about 20 — the most important — get reported up through to the system quality council," says Haftel.

The service line reports are filtered up through the quality chain — shared with the interdisciplinary teams first, then the medical executive committee, and then on to the board. "At each echelon of this hierarchy, only the most significant data is passed on," says Haftel. Examples are mortality rates, return to hospital rates, complication rates, return to OR rates, length of stay, cost per case, anything related to the Centers for Medicare and Medicaid Services and The Joint Commission outcome reporting, and patient satisfaction data.

• Use a "trigger" tool to ensure progress

At OSF St. Joseph Medical Center in Bloomington, IL, opportunities for improvement, once identified, are forwarded to the quality and safety council — an oversight group comprising administrative staff, medical staff department chairpersons, and directors of key service areas — for their recommendations as to how to proceed. For example, they may make a recommendation to form a team or send the issue to the specific unit involved or medical staff department for action steps.

To avoid delays, a "referral" is made for the issue, using a Situation, Background, Assessment, and Recommendation format. Once the recommendation is received from the quality and safety council, this is added to the referral. Follow-up on the recommendation is accomplished by the quality resource management department in the form of a memo to the person or department involved.

"The referral is a paper 'trigger' tool to the quality resource management department to assure feedback on progress," says **Kathy Haig,** director of quality/risk management/patient safety officer. The paper itself is filed after the meeting into a folder for the specific group needing to provide the input or address the recommendation. For instance, if a recommendation was made for the department of medicine, the referral would be put into that department's folder to be sure that the issue was addressed at their next meeting.

Additionally, the hospital's operations council reviews the quality and safety council meeting information to assure quality, safety, and service at the microsystem level.

"They have responsibility to not only be aware of

the recommendations, but to assure and monitor the action steps being taken in a timely manner," says Haig. "So if the quality and safety council makes a recommendation to a certain group, the operations council does follow-up to make sure action is being taken. Whoever collected the data initially would continue to see if improvement is being noted."

• Team up with an administrative sponsor

At Williamsburg, VA-based Sentara Healthcare, when an opportunity for improvement is identified, the organization employs the appropriate performance improvement method to accomplish the task, such as Six Sigma, LEAN, root cause analysis, or rapid cycle improvement teams.

If the performance improvement opportunity is deemed appropriate to benefit all the hospitals, a systemwide team is formed, with representatives from each facility to participate in the process redesign as needed.

"If an issue is initially expected to predominantly impact one facility, a local hospital-based team will be developed," says **Carol L. Sale**, RN, MSN, director of performance improvement. "However, opportunities that spread to the other facilities are always considered as the team progresses."

Performance improvement teams have an administrative sponsor who follows the team and receives regular updates on progress and data management as needed. "This administrative sponsorship provides oversight and helps keep momentum going for the team," says Sale.

For example, when the decision is made to do a root cause analysis, the executive sponsor meets with the quality manager. They develop a charter with expected outcomes and timelines. The administrative sponsor helps determine the best compilation of multidisciplinary team members, and periodically meets with the team to review progress toward the expected outcomes of the charter.

Key strategic initiatives are integrated into system and hospital quality goals, which are reviewed via monthly performance improvement council meetings and are directly linked to individual annual performance reviews.

Initial data indicating a need for improvement provide a baseline for the team to begin their work. As the team assesses the data, they identify gaps in the current process that need to be addressed. "Use of rapid cycle and other performance improvement methods allows teams to collect data as changes are being implemented, to determine impact and adjust improvement strategies moving forward," says Sale.

• Focus on "high-yield" opportunities

At Jewish Hospital and St. Mary's HealthCare in Louisville, KY, the Lean Sigma process is used to implement high-leverage improvements and sustain gains. "We have developed a tool we call a 'prioritization matrix' to help us identify opportunities," says **Mark Dean**, PhD, vice president of performance improvement. "An executive steering group uses this tool to ensure we focus on high-yield opportunities."

A high-yield opportunity is one for which a minimal investment in time and money will yield a high rate of return, explains Dean. The return may be financial, but it also can mean a significant improvement in patient care.

For example, the hospital had a lot of demand for additional lab work, but was limited by the capacity of the central processing unit. "With a minimal investment of time and dollars, we were able to achieve a 90% improvement in central processing area time, reducing the cycle from 19 minutes to 1.3 minutes," says Dean.

This increased the lab capacity by 16% with no additional FTEs, enabling the lab to perform 2,500 additional lab tests per week. The percentage of inpatient labs completed by 7:30 a.m. increased from 65% to more than 80%, improving patient care and physician satisfaction. "That is what I call a high-yield opportunity," says Dean.

Next, a "kaizen" event, also called a rapid improvement event, is initiated to rapidly study the process and implement improvements without long delays or loss of momentum. "We plan for and document follow-up actions on a tool called a 'rapid improvement newspaper,' and hold regular follow-up meetings to ensure we follow through with our improvement ideas and hold the gains," says Dean.

The rapid improvement event is a five-day process in which team members focus on the smaller parts of the process and what actions can be taken to improve patient value and satisfaction.

The result is significant process improvement, increased patient satisfaction and staff satisfaction, and improved patient care, says Dean. "When you get all of the right people in the room with all the right ideas to make change, and they study the process innately and have the motivation to take action and make change, you're bound to be successful," he says.

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Coming soon: Better data on hospital-acquired conditions

Document a patient's pre-existing conditions

New requirements from the Centers for Medicare and Medicaid Services for "present on admission" designations will have significant implications for quality professionals.

CMS is requiring hospitals to report secondary diagnoses that patients present with upon admission for Medicare beneficiaries. The new law takes effect Oct. 1, 2007, and illustrates the federal government's increasing focus on linking reimbursement to quality and performance. The goal is to hold providers more accountable for complications that occur after a patient is admitted to the hospital.

In May 2006, CMS announced its intention to work with Congress and health care organizations to reduce payments for care during which a "never" event occurred — a list of 28 serious reportable events identified by the National Quality Forum. Each is considered preventable in the hospital setting, such as surgery performed on the wrong body part or leaving a foreign object inside a patient after surgery. The Leapfrog Group is asking hospitals to refrain from seeking reimbursement for any costs directly related to a "never" event that occurs within their facility.

To comply with the new CMS requirement, quality managers will need to improve their ability to separate the pre-existing conditions a patient has upon arrival from conditions acquired during the hospital stay.

Quality managers should be taking steps now for a smooth transition to the new requirements, says **Patti Muller Smith**, RN, EdD, CPHQ, a Shawnee, OK-based consultant working with hospitals on performance improvement and regulatory compliance. A key step is reviewing hospital-acquired conditions present in your patient population and determining methods for improvement.

You'll also need to define your organization's "present on admission" indicator — a flag that identifies a diagnosis as present at the time of the inpatient admission. The indicator can include a patient's conditions known at admission, conditions which are present at admission but are not diagnosed until later, and conditions that develop during outpatient encounters at the emergency department, observation or outpatient surgery.

Those additional data are critical components to understanding which conditions were present at admission vs. those that were acquired during the hospital stay, such as infections and other complications from procedures, says **Catherine Eikel**, director of programs for The Leapfrog Group.

"These data will help identify hospital-acquired infections and other complications that happen within a hospital, so hospitals can hone their quality improvement efforts and prevent future harm," says Eikel.

As a result of the new requirements, your database of information about discharged patients will become a richer source of quality and patient safety data.

"Understanding what a patient entered the hospital with — and what may have developed during her or his stay — helps paint a much clearer picture of hospital quality and safety," says Eikel. "The billing data will become more powerful and accurate tools for identifying errors and adverse events occurring in the hospital."

If the patient's initial admission documentation demonstrates the patient's condition on admission, there is decreased probability that what occurs during the patient's stay in acute care contributed to a longer length of stay or increased use of resources, says Muller-Smith.

"The hospital's quality ratings will also be more accurate, since problems that might arise with the patient during their hospitalization are not a result of the quality of care they received, but due to conditions that were already present and beyond the control of hospital staff," says Muller-Smith.

If documentation is complete and accurate, it will be easier to determine what was a hospital-acquired problem, and reflect more accurately on

the quality of care being delivered.

"Quality professionals will be better able to focus their activities on issues that need improvement, rather then dealing with statistical reporting that arises from inadequate documentation of the patient's pre-existing condition," says Muller-Smith.

As for reimbursement, hospitals will benefit from identifying patients who will require more care. Hospitals will receive reasonable compensation for the actual care delivered to patients who, by virtue of their admitting condition, will require more care then the 'average patient' who is in the same DRG category, explains Muller-Smith.

"Overall, it comes down to complete and accurate documentation that paints a true picture of the patient when he or she presents to the hospital," says Muller-Smith.

When reporting additional diagnoses for accurate DRG assignment, the current system does not provide information as to whether the condition was present on admission or developed during the hospital stay, explains **Deborah K. Hale**, president of Shawnee, OK-based Administrative Consultant Service.

"Interpreters of the data who seek to identify potentially avoidable complications may unfairly attribute a condition to inadequate care in the hospital, when in fact, the condition was present when the patient was admitted," says Hale. Examples of these conditions include decubitus ulcer, dehydration, and congestive heart failure.

The present-on-admission indicator also will identify other providers of care that aren't adequately meeting the needs of the patient. "For example, CMS is particularly interested in home health agencies, which have high hospital admission rates, suggesting inability to adequately manage the patient's care," says Hale.

If coders are carefully trained to identify clinical signs of a condition that was also present on admission, these data will be very valuable to quality measurement and improvement. Since coding will be more precise, data can be used to better identify hospital-acquired conditions and analyze the impact on length of stay, disposition, and other factors, explains Hale.

"It will help them to identify error reduction, without having to do extensive and expensive chart reviews using valuable nursing time," says Eikel.

Unfortunately, physicians do not always list every condition that is present on admission, although they may later document the condition. Therefore, the coder must determine that even though a condition such as a urinary tract infection wasn't mentioned until the third hospital day, the condition was actually present on admission.

CMS is proposing to identify two infections that should not develop during the hospital stay. Paying the hospital for care of these infections will not be allowed because the infection was avoidable if evidence-based medicine had been practiced. "Correct reporting of the present-on-admission indicator would avoid inappropriate payment penalties," says Hale.

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Survey: Quality managers enthusiastic about P4P

A clear financial benefit is seen

A survey of hospital quality improvement directors and senior executives found that the vast majority were enthusiastic about a future pay-for-performance (P4P) initiative by the Centers for Medicare & Medicaid Services. Many said that they viewed P4P as an opportunity to stimulate quality improvement. Ninety-three percent supported CMS in moving forward with a P4P program over the next couple of years.

P4P is likely to be good news for hospital quality professionals, since it strengthens the business case for the activities they have been undertaking, or hope to undertake, to improve quality, says **Suzanne Felt-Lisk**, a senior health researcher at the Washington, DC-based Mathematica Policy Research, which conducted the survey.

"They may be better able to secure or retain resources for quality improvement activities, due to top hospital administrators seeing a clear potential financial benefit from achieving high performance," says Felt-Lisk.

Many hospital executives said their main reason for participating in P4P was that they viewed the program as an opportunity for gaining financial

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State goes extra mile with new charity policy

'It's more inclusive than the norm'

All the community hospitals in the state of Washington are voluntarily expanding their financial assistance guidelines in what is being described as one of the more far-reaching policies of its kind in the United States.

"It's fairly comprehensive — more inclusive than the norm," says **Cassie Sauer,** MSW, vice president of communications for the Washington State Hospital Association (WSHA) in Seattle. "We didn't do extensive research, but that is the indication from conversations [with colleagues] in other states."

The new guidelines ensure that the low- and moderate-income uninsured are charged a moderate fee for their care, she adds. "At most, they are charged what a typical insured patient would be charged."

Patients who fall within 300% of the federal poverty guidelines, meaning those with an income of up to $60,000 a year for a family of four, qualify for the program, Sauer says. "We didn't go above that amount because we do believe that above that income level people can afford to purchase insurance and not having it is more of a choice."

That conclusion is supported by a Robert Wood Johnson study indicating that about 20% of those who are without insurance actually could afford to buy it, she adds.

The American Hospital Association is featuring the Washington state program as a leadership model, Sauer notes.

Another goal of the program is to better inform patients of available assistance, she says. "Some hospitals provide charity care, but do patients even know about it? What are the standards in place to make sure they know it exists?"

With that in mind, the policy states that hospitals must provide more information to that effect, Sauer says. "Every patient will receive written notice about financial assistance, either at check-in, upon discharge, or with the bill."

The highlights of the new policy, which provides three levels of discounts depending on the patient's income level, are as follows.

- Patients whose income is between zero and 100% of the federal poverty level ($20,000 for a family of four) receive free care.
- Uninsured patients whose income is between 100% and 200% of the federal poverty level ($40,000 for a family of four) will be given a discount. The discount is calculated so that, on average, the most these patients will be asked to pay is the cost of care at that hospital.
- Uninsured patients with limited assets who are at between 200% and 300% of the federal poverty level ($60,000 for a family of four) also qualify for a discount. The discount is calculated so that, on average, these patients are asked to pay what an insured patient may pay, even though the uninsured have no one negotiating on their behalf.

Commercial insurers typically negotiate a discounted rate because they drive volume and referrals to the hospital, Sauer notes.

One of the key provisions of the policy specifies that hospital boards will increase their oversight of collection policies, she explains. "Every year, [boards] should receive a report on what collections actions were taken on behalf of each hospital."

In addition, hospitals will establish clear and consistent procedures that must be followed before accounts can be sent to a collection agency, Sauer says. The idea, she adds, is to eliminate instances in which, for example, one financial counselor sets up a payment plan for a patient while another sends an identical account to collections.

Part of the impetus for the new policy was a bill proposed in last year's state legislative session that would have expanded financial assistance requirements "beyond what we thought reasonable."

The proposed legislation "was overly burdensome and would have put a lot more regulations on hospitals," Sauer adds.

Although the bill did not pass, the state hospital association responded by assuring legislators that it would address the issues that it deemed reasonable, she says.

"A lot of times, the initial bill is good but then they start adding this and that," Sauer points out. "We told [legislators] we would work to address

their main concerns."

Those concerns centered around whether the uninsured were being charged a fair price or given the very highest bill, whether people were being informed about the availability of financial help, and whether collection practices were fair, she says.

Over-the-top collections practices — such as a $10,000 bill turning into a $100,000 bill because of interest charges or people being arrested or losing their homes — were not identified as a problem with the hospitals that WSHA represents, Sauer says, but the association highlighted the issue as a preventive strategy.

While CEOs at all the community hospitals have signed the financial assistance pledge, she notes, some did so more readily than others. **(See pledge, below.)**

"Some signed in August and September [2006] and some signed in the middle of December," Sauer says. "We started the effort in May and spent about six months asking them to sign. For some it was an easy choice, and for some it was more challenging."

Hospitals expressed legitimate concerns, she says. "Some were already providing [financial assistance] at this level or close to it, but for some it was a big expansion. In rural areas, 300% [of the federal poverty level] includes almost everyone."

Because all of the hospitals did agree to participate regardless of those concerns, Sauer says, "we pledged to them to go back and let legislators know the impact of this on providers."

Although the legislation referred to above did not pass, Washington is one of a few states that does have a law, enacted in 1990, governing charity care, she points out.

But while other states with charity care laws typically have developed mechanisms to fund the care provided, that has not been the case in her state, Sauer says.

Charity care pledge signed by WA hospitals

All the for-profit, nonprofit, and public district hospitals in the state of Washington have signed the following pledge as part of an initiative aimed at expanding financial assistance guidelines to offer discounts to more residents.

Footnotes to the pledge explain that "uninsured" means no third-party insurance and health savings accounts are considered insurance. They also specify that income for those under 100% of the federal poverty level includes both earned and unearned income but excludes assets; income for those above 100% of the poverty level may include assets.

Finally, cost-to-charge ratios are based on the previous year's year end reports filed with the Washington State Department of Health.

Hospital voluntary effort on billing to the uninsured

These proposals are meant to supplement existing charity care policies and are not intended as a replacement. There are already requirements in law governing notification, collection practices, and sliding scale discounts. These proposed standards would be added to the current requirements. We are also proposing minimum standards for hospitals and anticipate many hospitals will be able to offer broader policies.

Notification (applies to all patients)

- All hospitals will provide a written notice to all patients informing them about the availability of financial assistance.

Collection practices (applies to all patients)

- All hospitals will have their governing board or commissioners receive and review an annual summary report on collection actions taken.
- All hospitals have a written policy as to when and under whose authority an account is sent to collections.
- All hospitals have a written policy as to when a lien is placed on a primary residence.

Discounts (applies to the uninsured for medically necessary inpatient and outpatient services):

- No uninsured patient with income under 100% of the federal poverty level is required to pay for care.
- No uninsured patient with an annual income under 200% of the federal poverty level is required to pay more than the estimated cost of their care. (Cost is the charge multiplied by the hospital's average cost-to-charge ratio.)
- No uninsured patient with an annual income under 300% of the federal poverty level is required to pay more than 130% of the estimated cost of their care. (Cost is the charge multiplied by the hospital's average cost-to-charge ratio). ■

In Washington, the Medicaid program gives only limited funding to a few hospitals that provide a large amount of charity care and small grants to hospitals for a portion of their charity costs, according to a report prepared by the state hospital association. However, the report continues, there is no charity care pool to pay hospitals for all their charity care costs.

The report points out that hospitals often charge more than the cost of care for insured and self-pay patients, and that low government payments are a primary reason for the high charges. Since government payers do not cover the cost of care, the report continues, the unfunded burden must be shifted to patients with insurance.

(Editor's note: Cassie Sauer can be reached at CassieS@wsha.org.) ■

WA hospitals adjust to meet aid guidelines

Change 'not that big' for some

At Yakima Valley Memorial Hospital in Washington the implementation of new statewide financial assistance guidelines "wasn't really that big of a change," says **John Vornbrock,** FACHE, senior vice president and CFO.

With the focus in the past couple of years on nonprofit hospitals promoting community benefits, including charity care, he adds, "we had been emphasizing that and trying to make charity care applications much more accessible to the public."

The goal at Memorial Hospital is that any patient who is registered for a service but for whom no insurance has been identified is provided with a charity care application, Vornbrock says.

That effort, begun in early 2006, has increased the volume of financial aid applications so much that it has been necessary to add a new staff position, he notes. "We actually have an individual whose full-time job is to go through those applications and ask additional questions to determine [whether patients] meet the criteria."

Despite the additional volume, the overall amount of uncompensated care at the hospital has not increased, but has gone down a bit, Vornbrock says. "The difference has been that a higher percentage of uncompensated care is charity care as opposed to bad debt that goes to collections."

When the state program came along, he adds, "we tweaked our guidelines to go along with that. The bottom line is that we previously had not offered any charity care [to patients] above 200% of the federal poverty level, but now those between 200% and 300% are included."

While the effect of that category change has not been determined, Vornbrock says, he doesn't expect that difference to be a significant amount.

About two-and-a-half years ago, he notes, Memorial instituted a policy whereby any individuals without insurance were automatically given a 25% discount on hospital charges

"That came at a time when there was a lot of criticism of hospitals that only the uninsured were paying full charges, and then clarification from Medicare [on what constituted] fraud and abuse," Vornbrock says. "It was the first time hospitals ever considered doing anything other than full charges. We had always been told we couldn't do that, that it was a violation."

Implementing the 25% discount "also had a big impact on changing the composition of uncompensated care," he adds, "so [the state program] has not really resulted in more charges being written off. This is a really poor community to begin with."

When the national discussion on charity care heated up, it was not as big a deal in Washington because of the state's existing statute on charity care, Vornbrock points out.

"[Hospitals] had to comply," he notes. "Some hospitals have actually bumped up their limits. Quite a few are at 400% of the federal poverty level."

When the new financial assistance guidelines were implemented at Grays Harbor Community Hospital in Aberdeen, WA, in early 2007, it meant a dramatic increase in the number of people who are eligible to receive aid, says **Jacquie Shay,** director of patient financial services.

"There's a real satisfaction in the business office because a lot more people in higher income levels qualify," add Shay, who oversees the business office, registration, and medical records. "There's more paperwork, more phone calls, more people asking for assistance as more people become aware that they may qualify. It's very gratifying that we can help them."

Her department hasn't yet increased staffing, but is "feeling burdened," she says. "It's only been a couple of weeks, but it's quite noticeable. It takes a little longer on our end to figure out [who qualifies]. There is a learning curve to learn how to do the task differently."

For her hospital, the new guidelines open up the possibility of financial aid to one category of patients while placing tighter restrictions on another, she explains.

"Up until January, we were providing a 100% write-off [of charges] to people at or below 200% of the federal poverty level," Shay says. "Not everyone was doing 200%, but we were being generous."

That means that before a one-person "family" making $19,000 might have had its entire hospital bill written off, but under the new guidelines would get only 58% written off, she explains.

"Now we are spreading [the help] out, giving it to people who are at up to 300% of the federal poverty level," Shay adds. "A lot of people make a decent wage, but there is not enough money to go around. Now at least they can get a percentage of the bill written off.

"The general consensus is that we support [the new guidelines]," she says. "We are pleased to offer help to those we couldn't help before."

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WA and other states give on-line price, quality data

Various comparisons offered

The latest initiative by the Seattle-based Washington State Hospital Association (WSHA) and its 97 member hospitals is a web site that provides hospital-specific price and quality information.

The site, made public in late January, provides information on hospital-specific charges for more than 500 types of hospital treatments; hospital-specific performance on quality indicators related to treatments for heart attack, heart failure, pneumonia and prevention of infections; and answers to common questions about hospital bills and the availability of charity care and financial assistance.

The site was created in response to requests from state lawmakers and the public for more hospital-specific data, says the WSHA.

In a similar step, the Arkansas Hospital Association has launched Hospital Consumer Assist (www.hospitalconsumerassist.com), a web site that provides Arkansas residents with information on the average prices that individual hospitals charge Medicare for 25 types of inpatient stays.

The prices are based on claims data from the federal Medicare Provider Analysis and Review tapes, and can be used to help patients gauge how much they might be charged for similar care, the association said. The reports also show how the hospitals compare nationally and statewide on each of the 20 measures developed by the Hospital Quality Alliance and posted on the Centers for Medicare & Medicaid Services Hospital Compare web site.

Prices will differ for each patient, the association cautioned, as discounts may be applied to the price based on negotiated rates with insurance companies or the hospital's discount for the uninsured. It said variation in health plan coverage and discounts also impact patients' out-of-pocket costs.

The Iowa Hospital Association, meanwhile, has unveiled Hospital PricePoint, a web site that gives free access to data on inpatient charges and services at Iowa facilities.

For each hospital in the state, the web site provides data on average and median inpatient charges for more than 60 diagnoses, and "discount" information for private insurance, Medicare, and Medicaid.

It allows users to compare inpatient charge data for up to four hospitals at once and inpatient charges by severity of illness within a service area. ■

CMS offers guidance on HIPAA security rule

The Centers for Medicare & Medicaid Services has released guidance to help organizations comply with HIPAA security standards when they allow remote access to electronic protected health information (EPHI) through portable devices or external systems or hardware.

Entities covered by HIPAA should be "extremely cautious," CMS said, about allowing offsite use of or access to EPHI , and must implement policies and procedures to protect EPHI that is stored on remote or portable devices/media or transmitted over an electronic communications network.

CMS said it may rely on the guidance in determining whether actions by a HIPAA-covered entity are reasonable and appropriate for safeguarding the confidentiality, integrity, and availability of EPHI. ■

(Continued from p. 34)

benefit or stimulating quality improvement. About a third of hospital quality executives cited lack of resources as a major barrier to further improvement on quality measures.

P4P holds the potential for channeling more resources to quality improvement initiatives. However, at the same time, P4P will likely increase the pressure on the already stressful job of the quality director, in particular, says Felt-Lisk. "Top management will now have a clear measure of their success — did they 'win' under the P4P system?" she says.

It may be difficult for hospitals that are "behind the curve" on quality measurement to catch up to those who have been leaders all along, adds Felt-Lisk.

Selecting the right measures will be a critical element of future success in the P4P arena, says Felt-Lisk. "CMS has hired a contractor to help with measures selection, so the process is under way," she says. "In choosing measures, CMS will need to strike a balance between including a large number of measures to estimate hospital quality accurately in important clinical areas and overwhelming hospitals with new measures they have not been reporting."

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Enlist staff to find system flaws before errors occur

Reward staff for interventions that prevent mistakes

Do clinical staff feel truly comfortable reporting near misses and potential errors at your organization? The answer could have a major impact on patient safety.

At M.D. Anderson Cancer Center in Houston a "Good Catch" program was created with the goal of identifying safety issues and reporting so solutions to potential errors can be developed and implemented. Clinical nurses play a key role in this, says **JoAnn Mick**, PhD, RN, associate director of nursing research.

The program uses a baseball theme to organize units as teams in one of four "divisions," with three divisions comprising 14 inpatient units and a fourth division scheduled for implementation. "Each unit chose a team name and some of the teams have developed team logos," says Mick.

One goal of the program was to increase the number of safety reports submitted to the Close Call Reporting System (CCRS). The strategies implemented include:

- Changing terminology related to nurses' identification of potential errors from "near miss" or "close call" (which acknowledge error) to "good catch" (which acknowledges practice).
- Implementing an "end-of-shift safety report" to help nurses identify concerns related to patient safety that occurred during the shift and to provide a reminder to submit a CCRS report to document the nursing intervention.
- Promoting incentives such as "safety awards" sponsored by executive leadership to acknowledge individual nurses.

Each close call report that identifies a Good Catch by a team member results in one point for the team engendering friendly competition between the team and divisions. The team that submits the greatest number of close call reports during a six-month "game" is recognized and awarded with a pizza party. "MVPs" are identified on each unit and receive a patient safety award certificate.

The vice president and chief nursing officer in the division of nursing visits each unit after they have joined the program, and distributes Good Catch pins to participating team members. Units prepare patient safety storyboards and share information about the types of Good Catches recorded in their end-of-shift safety report logbooks.

Initially, many of the teams expressed concern that a high number of potential error reports would "look bad" for the unit. "Reinforcement was provided to assure teams that higher numbers of submitted reports supported a greater focus on patient safety," says Mick.

Also, because nurses historically had submitted reports only when an error had occurred, a change in thinking was required to understand that nurses should report interventions that prevented an error.

"Nurses identify and correct errors as part of their daily practice. But these fixes are not often reported so that systems issues can be identified and addressed," says Mick. "Close-call reporting provides nurses with the opportunity to document their important role on the front line of patient safety."

Each week the numbers of submitted reports are tallied, with scores e-mailed to team representatives. Scoreboards are posted on nursing units

Plan to attend medical error disclosure audio conference

Intense feelings of anxiety and humiliation, not to mention fears of being sued or professionally censured, are extremely common. Not surprisingly, the appearance of defensive and self-protective strategies that urge concealment are common as well. Nevertheless, recent reports showing declines in malpractice claims and costs when disclosure and apology are implemented, are changing the ways health care organizations manage the aftermath of medical errors.

These issues will be addressed in our upcoming live audio conference: **When the Worst Happens: Techniques to Manage Medical Error Disclosures**, on March 13, 2007, from 2:30 pm to 3:45 pm, EST.

Our presenter, **John Banja**, PhD, is a medical ethicist at Emory University who is nationally regarded in the area of medical errors and their disclosure. His book, "Medical Errors and Medical Narcissism," was published by Jones and Bartlett in 2005.

A fee of just $299 ($349 for the live conference and CD combo) allows you to invite as many listeners from your facility as you can accommodate around your conference phone.

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and are included in the on-line weekly nursing newsletter to recognize the teams and division that submitted the most reports.

In addition, a weekly summary of the types of reports submitted and action plans for items that require follow-up are e-mailed to teams. "This verifies that nursing time used to enter reports is a worthwhile investment of time and effort," says Mick. Since the Good Catch pilot was launched in December 2005, more than 10,000 reports have been submitted from participating units.

Good Catch themes have included: medication dispensation and labeling, transcription, communication, equipment, policy issues, clinical procedure issues, and fall prevention. "Reported concerns are addressed with the assistance of quality improvement, and are reported back to the units," says Mick.

One concern involved nurses continually changing one of the intravenous tubings due to a leaking port. "The manufacturer was contacted and a quality review of the manufacturing process identified a problem with one of the welds," says Mick. "They revised the process and are now producing tubing that doesn't leak. The company also sent a thank you letter to the nurses for reporting the problem."

Another potential error was identified on an order set that listed medication names with blanks for the physician to fill in dose per unit of measure. All medications were to be ordered in milligrams, except for one in the middle of the page. "When filling out the order set, a physician calculated and ordered all of the medication doses in milligrams," says Mick. "The potential error was caught by the nurse and pharmacist and was prevented." The medication that requires a varied dosage/unit is now highlighted on the order set.

At Spectrum Health in Grand Rapids, MI, a Good Catch program catches potential errors before they reach the patient. "The system is proactive in identifying system flaws and supporting a non-punitive culture of safety," says **Sylvia Baird**, manger of patient safety.

The program began in 2004, with staff asked to report near misses on index cards with fish pictured, called Good Catch cards. The data was entered in an Excel database used to identify trends or patterns that could be potentially unsafe for patients.

As a result of staff reports related to scheduling and the paper medication administration record,

system changes were made in the way procedures were scheduled and the development of the electronic medical record for medication administration.

At the same time, though, incident reports were being filled out separately. "People started saying, how do we put the two of them together? This was difficult to do, since both the incident reporting process and the Good Catch program were submitted by paper, and sent to two different areas of the hospital," says Baird.

In 2005, the hospital's incident reporting system switched to an electronic system, but the Good Catch program was still paper-based. In November 2006, Good Catches were converted to the electronic system and made part of the organization's incident reporting process. Staff can go onto the web page, choose whether they want to report an incident or near miss, and electronically enter the data.

We are very excited about being on the same page. We are using the same headings and descriptions when either an incident report or Good Catch is completed," says Baird.

Because of the standardization, reports can be requested that include both Good Catch data and incident report information, such as identifying reported duplicate medication orders. "We then can use that information to identify where process flaws may occur, and then make system improvements," says Baird.

When a staff member reports a Good Catch, these steps occur:

• The staff member answers the questions "What is the issue?" "What contributed to it?" And "What recommendations do you have?"

• The nurse manager is alerted by e-mail that the report was filled out "so they can be reviewing that within 24 hours of being reported vs. waiting for the manual process of reviewing the data," says Baird. "If it relates only to their area, they can implement changes on their unit immediately."

To encourage staff to report near misses, there is a recognition program called "What a Catch!" with near misses reviewed to see which ones had a significant impact in preventing harm. At an annual banquet, one individual is recognized and given a plaque for their role in system changes that were made to promote patient safety.

A recent example involved a staff members reporting that patients in the adult critical care unit were experiencing low blood sugars. Upon further investigation, the low blood sugars were correlated with patients that were receiving a new type of insulin during the evening and then having their nutritional intake being held for procedures the following day. The staff person collaborated with pharmacy and developed a process to flag this potential medication safety issue.

Now that the data are easier to collect and collate, quality professionals can go in and query the database looking for a specific word or phrase, such as "duplicate orders" or "scheduling issues."

"Before, even though we had an Excel database, there was no connectivity to them both," says Baird. "Now the quality professional can analyze, trend, and track the information, and use those critical thinking skills to go and hone in on the system issues involved."

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THE QUALITY - CO$T CONNECTION

Uncover opportunities using comparative data

Understand what the date are telling you

By Patrice Spath, RHIT
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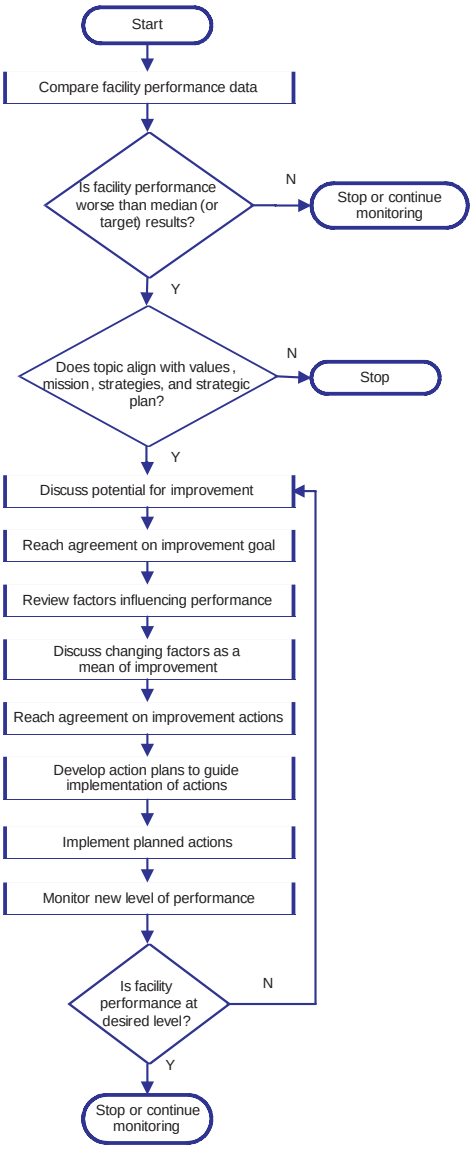
Forest Grove, OR

With the increasing number of health care performance measurement initiatives being carried out across the country, comparative data are easy to obtain nowadays. These data can be powerful motivators for organizational change by highlighting opportunities for improvement and thereby assisting in setting strategic improvement goals. To reap benefits from comparative performance data, quality managers must identify ways to integrate this information with the organization's improvement efforts.

First, it must be determined what performance factors senior leaders are most interested in. Some organizations are chiefly concerned with comparative data that are routinely made available to the public. Although these measures may be applicable to only a small percentage of the organization's patient population, concerns about how consumers may react to these data can be the primary drivers of internal improvement activities. Ideally, the quality goals of the organization also should be taken into consideration as these goals may affect patient populations or factors not routinely evaluated in publicly available performance data. If senior leaders are interested in analyzing less widely available comparative performance data, quality managers can be challenged to find suitable comparisons.

A new on-line resource from the Commonwealth

Figure 1: The Journey of Discovery and Performance Improvement



Source: Patrice Spath, Brown-Spath & Associates, Forest Grove, OR.

CE *questions*

9. Which is true regarding The Joint Commission and non-compliant areas?
A. Only unit staff will be asked about recurring non-compliant areas.
B. Surveyors don't consider past recommendations during patient tracers.
C. Leaders are not expected to be involved in sustaining improvements.
D. Tracer methodology will assess whether previous problems are still occurring.

10. What will be a result of the new Centers for Medicare and Medicaid Services requirements for "present on admission" designations?
A. Hospitals will no longer need to report secondary diagnoses that patients present with upon admission.
B. Providers will be held more accountable for complications that occur after a patient is admitted to the hospital.
C. The "present on admission" indicator cannot include conditions present at admission but diagnosed later.
D. Quality data on discharged patients will become less accurate.

11. What did a recent survey find about pay-for-performance (P4P?
A. Most quality directors did not support a P4P program in any form
B. Many felt P4P was an impediment to quality improvement.
C. Most said it resulted in fewer quality improvement resources.
D. Many said P4P was an opportunity to stimulate quality improvement.

12. Which of the following strategies did M.D. Anderson Cancer Center use to increase the number of safety reports submitted to the Close Call Reporting System?
A. Changing terminology regarding nurses' identification of possible errors from "near miss" or "close call" to "good catch."
B. Using an end-of-shift safety report to help nurses identify patient safety concerns that ocurred during the shift.
C. Promoting incentives.
D. All of the above.

Answer Key: 9. D; 10. B; 11. D; 12. 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Fund, *Performance Snapshots*, can make it easier to locate comparative data for various performance issues. The resource includes measures for more than 80 topics along with suggestions for improving health care practices. You can download customized collections of topics and charts for internal reporting purposes.

Once the performance measurement priorities of the organization have been clarified and comparative data obtained, the task of analyzing and responding to the results begins. The journey of discovery and performance improvement is illustrated in Figure 1 **(see p. 42)**.

The journey begins with the quality council (or other leadership group) reviewing the data and determining the hospital's comparative standing. If the hospital performs outside the ideal performance range (significantly above or below the average) further investigation is warranted. However, for many comparative measurement results the hospital's observed performance rate will most likely fall between the upper and lower values of the expected performance. Just because your facility's performance falls within the average or expected range does not mean that quality is perfect. Tests of statistical significance and other data analysis techniques are merely tools that can help point to potential problem areas. Don't rely solely on these tools to identify improvement opportunities.

Your facility's performance may be consistent with that of other organizations and yet improvements are still desirable. Why? Because people in your organization have established *stretch* goals. Average or slightly better than average performance is not the stopping point in an organization with *stretch* goals — people aspire to achieve optimal performance. Quality goals, reflective of a commitment to performance excellence, may be established as part of your organization's strategic planning process. Medical staff departments may select certain conditions or procedures for which they have higher than average performance expectations. Nursing and other clinical departments can launch improvement projects that are intended to achieve lofty goals, such as a restraint-free environment. For any number of reasons, it may be necessary to look beyond statistical significance and special-cause process variation and decide if your organization is realizing internally defined expectations.

A common concern about comparative performance data is the validity of peer groups. It is virtually impossible to create peer groups that are identical in all ways: clinically, demographically, and therapeutically. There are literally hundreds of variables that may impact clinical outcomes and performance measurement results. Risk adjustment of patient populations as well as population stratification can help enhance the validity of the comparisons, but peer groups will never be perfect.

You may be unable to manipulate the peer group comparisons through production of customized reports or other means. For example, say your hospital has higher than expected mortality rates for patients undergoing cardiac surgery. Why? Because your facility has a first-class cardiac program and high-risk patients are more likely to be admitted to your facility. But don't be too quick to attribute the cause of significant variations. An in-depth analysis should be done to determine what factors are most likely affecting

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 or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

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performance rates at your facility.

It is unlikely that perfect peer group comparisons will ever be possible. Either unique facility and/or patient characteristics will not be adequately accounted for. However, perfection is the enemy of improvement; understand what the data are (and are not) telling you. Don't expect comparison data to be flawless before you can investigate variations.

Should performance vary significantly from comparison facilities or if performance does not meet the organization's internal goals or expectations, questions naturally arise about why performance is what it is. These "why" questions are answered by investigating all the factors that might be impacting performance. For instance, if the facility's surgical wound infection rate is higher than that reported by other facilities, clinicians must identify the contributing factors and agree on what needs to be done to reduce infection rates. Effectively answering the why questions is the critical first step toward implementing appropriate changes in policies, procedures, or processes that will positively impact the quality of services.

Once agreement is reached on the tactics needed to improve performance, detailed action plans are developed. These action plans also should identify the specific steps to be taken to transform the action from an idea to reality. The action plans should also identify the time frame within which the steps will be completed and the individuals responsible for completion. Once approved, implementation of the action plans begins. Once implemented, performance is monitored to determine the level of improvement achieved.

As depicted in Figure 1 **(see p. 42)**, after a reasonable amount of time has elapsed performance is re-evaluated to determine if the desired level has been reached. If it hasn't, the improvement cycle begins again, with clinicians seeking new insights into mechanisms for change. If performance is acceptable, the organization can turn its attention to other areas needing improvement.

Comparative performance data can provide powerful motivation for organizational change by highlighting opportunities for improvement and assisting in setting improvement goals. The availability of this information is driving collaborative projects at the national, regional and local levels. Quality managers must champion a systematic approach to evaluating performance in key clinical and administrative functions. Without such an approach, organizations risk missed improvement opportunities or misapplication of data.

(To learn more about *Performance Snapshots* visit the Commonwealth Fund's web site www.cmwf.org/snapshots). ■