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When morals and medicine conflict: Morning-after pill reignites issues

Balance must be found between ethics and continuity of care

The issue of whether a health care provider can refuse to provide treatments they find ethically objectionable is one that has been around for years, although recently it was again brought to the fore with the approval of the over-the-counter sale of the "morning-after" pill. But, as a recent article in the *New England Journal of Medicine*[1] pointed out, there are numerous situations that may involve ethical rights and obligations, such as administering terminal sedation to dying patients or providing abortions for failed contraception.

For the quality manager, this raises several issues. For one thing, the issue of respecting the ethical and moral beliefs of the clinician can impact staff satisfaction. In addition, while most facilities do recognize the right of clinicians to opt out of certain procedures, they may not all have formalized the policy or created a process through which these objections can be communicated. The other quality concern, of course, is ensuring continuity of care once the provider balks at a given procedure.

How often do such issues arise? "Anecdotally, it's not uncommon," says **Farr A. Curlin**, MD, assistant professor, section of general internal medicine and the MacLean Center for Clinical Medical Ethics, University of Chicago. "But it tends to group in

Key Points

- Staff members should have the option of refusing treatment they deem morally or ethically objectionable.
- Plan ahead for such situations, to ensure someone else will be available to fill in.
- Become active in committees that address these issues from a hospital-wide perspective.

practice specialties, such as sexual and reproductive health care, and end-of-life situations."

Each state has its own policy covering these situations, as do many hospitals, notes Curlin. "For example, under the state of Illinois 'Conscience Clause,' doctors are broadly shielded from any adverse repercussions of refusing to do what they say they can't in good conscience do. To do otherwise would be employment discrimination, which could result in a fine."

"Beaumont has a commitment to its staff," says **Carol Spinweber**, MS, RN, ACNP, nursing manager of the neurology/trauma ICU at Beaumont Hospital, Royal Oak (MI). "We want them to be involved in decision making, and we do not want to say 'You *have* to take care of this patient' — that would not do anyone any good."

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Staff members at Beaumont are told the hospital policy is that if they feel uncomfortable for any reason, they should come see their manager and allowances will be made.

Issues not always clear

While there may be general agreement about an approach, some issues are not "black and white," Curlin points out. "Patients should have access to needed medical care, but exactly what that is may not always be specified," he says. "It is not easily resolved beyond disclosure and candor and honesty, and not being coercive."

Resolution may also depend on the procedure, he adds. "Take abortion," he says. "Some people will not be able to refer patients for the procedure because to them it is unethical in such a grave way that they can't even refer them. This begs the question, 'What is needed medical care?'"

True emergencies, Curlin notes, are not a problem. "For example, Catholic Healthcare, which is strictly against abortions, does permit you to treat women patients in whatever way necessary to care for their lives," he points out. "One place where there might be a rub is when 'emergency' contraception is requested, which does not have much effect past 72 hours. A lot of people disagree about whether that is truly an emergency."

Seeking high quality

In issues like these, notes Spinweber, "when you're talking about quality, you're talking about continuity of care." When you say to staff that no matter the issue, if they are not comfortable you will provide for other care, "you must ask yourself, 'How, as a manager, do I provide continuity of care?'"

At Beaumont, once an objection is made, the provider in question is removed from the case. "Then, we identify people who are very comfortable with the treatment," Spinweber says. "So, for example, when we give our daily report, we may say, 'This is the patient and here are the issues that surround them; we'd like to match the family with someone who is able to help them through these issues.'"

There is no problem finding someone on short notice at Beaumont, says Spinweber. "We have a huge team that deals day in and day out with crises, and we have learned to take care of patients, families, and others," she says. "But it is

definitely an environment that has to be created. We do that by telling the staff it's OK to say no.

"In other work we've done that is as-yet unpublished, we found there are subpopulations of OB-GYNs who will not prescribe contraceptives," notes Curlin. "They make that explicit up front, and mechanisms are put in place where a clinic can be called, or the triage person is advised the doctor will not prescribe the drug, but if the patient elects to see someone else they can."

The Joint Commission says . . .

There are actually two Joint Commission standards that speak to these issues, notes **Paul Schyve**, MD, senior vice president of the agency. "The first is a standard we have in our 'Rights' chapter, which states the hospital follows ethical care," he says. One of the elements of performance, he continues, is that leaders ensure that care, treatment, and services are not negatively affected when the hospital grants a caregiver's request to be excused.

"My recollection is that many years ago we put the reference in," he says. "It came up because of ethical or religious reasons, but it is no longer restricted to that. Suppose a caregiver has a particular illness themselves that would make them susceptible to severe complications from infections if they cared for a particular patient? While that may be uncommon, we felt that if the key issue was how to make sure the patient is not harmed, why should we necessarily only talk about conditions where there are ethical questions?"

So, for example, if for religious reasons a provider does not prescribe certain kinds of contraceptive procedures and a patient is delivered at that place, "if the hospital decides to honor that wish they need to find someone else to do it, so the patient is not in the OR with [only] a nurse taking care of them," says Schyve.

The second standard requires there to be a mechanism that can be used by patients and staff to address ethical concerns and uncertainty. "Most hospitals have chosen to do that with an ethics committee, but some have used an ethics consultation service or a consultant," notes Schyve. "In any event, there needs to be some mechanism where the provider can go and say, 'I am opposed to or uncertain about doing certain procedures, and my conscience will not let me do them.'"

Plan ahead

In an ideal world, says Schyve, these situations "really shouldn't occur in the heat of battle." So, for example, "One of the things the individual provider and the hospital should have an understanding about when they are employed is what the hospital does and doesn't do, and what the individual feels they will and will not do." So, in that ideal world, such a person would never even be asked to do those things. "We can then schedule procedures so they are not in on those particular ones," he adds.

Ideally, patients also should be informed ahead of time what the hospital will and will not do. In terms of patient safety, he continues, this is good policy even when ethics or religion is not involved. "So, for example, suppose you are going to have a cardiac exam of the type that it commonly might lead to the patient immediately going to surgery," Schyve poses. "What if you've chosen to have it in a hospital [that didn't do cardiac surgery] and you didn't know ahead of time that if you needed surgery they might have to transfer you? Your not knowing that has placed you at potential risk."

Get involved

Schyve recommends that quality managers become involved in hospital activities that address such conflicts. "I would think a number of people should be involved, even as a team, to figure out how the organization will address this issue. Certainly, someone from the ethics committee or an ethics consultant, and it makes a lot of sense to have the quality and/or safety person involved," he says, "Because ultimately you are concerned not just about ethical considerations, but more importantly, quality and safety in caring for the patient."

More specifically, the quality manager ought to be involved, he adds, "because these are situations which, if not addressed ahead of time, will create a risk for the patient. Those are the No. 1 things you should be concerned about and proactively trying to prevent."

What specific processes can the quality manager put in place to protect the patient if one of these situations *does* pop up; how would they still protect the patient? "The first element to consider would be, how does the organization staff itself and respond to *any* kind of emergency?" says Schyve. "Suppose one of the staff members gets

really ill in the OR and needs to leave? What process do you have in place, and how does it apply to that situation?"

The second thing to consider, he says, is under what circumstances — if any — would a reluctant staff member be willing to do "X" in an emergency? "For example, it may be something not within their privileges," he explains. "It is something they might normally not be expected to do, but that they would do in a specific situation."

Reference

Curlin FA, Lawrence RE, Chin MH, and Lantos JD. Religion, conscience, and controversial clinical practices. *N Engl J Med* 2007; 356:593-600.

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Should quality data be collected by race, ethnicity?

Expert says it's important in analyzing disparities

At first glance, the thought of collecting and studying quality data by patient race and ethnicity might make one uncomfortable, but in fact, it's a powerful strategy for quality managers wishing to eliminate disparities in health care, asserts **Bruce Siegel**, MD, MPH, director, Urgent Matters National Program Office, George Washington University Medical Center, Washington, DC, and lead author of a study by The Commonwealth Fund entitled *Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care.*

The authors assert, in fact, that efforts to reduce disparities must be firmly tied to quality improvement efforts. However, as they observed while interviewing representatives from five public "safety net" hospitals, most clinical and QI leaders don't think of their initiatives from that perspective.

"I think they need to start doing that," Siegel says. "One thing we were struck by in our discussions with these hospitals is when you ask questions about disparities or equity, the first reaction is, 'We treat all of our patients the same; we believe in high quality for all.' But when we ask them, 'How do you know?' you don't get much of a response."

In other words, he continues, there's an assumption of equity with not a lot of data to support it. "That, in and of itself, tells me this is an area ripe for self-examination," Siegel asserts.

Why we should care?

Why does Siegel insist that equal care is an appropriate concern of quality professionals? "One of the six domains of quality in the [Institute of Medicine] publication *Crossing the Quality Chasm* is equity — every patient gets the care they deserve," he explains. "So a core domain of quality is equity. The second point is that more and more people are saying that disparities are evidence of some patients not getting high-quality care. After all, if every patient got the best care, *there would be no disparities*."

Part of the disparities issue, he continues, is that studies do find that hospitals treat different patients differently. "We saw a little bit of that in our study, which included communication measures," says Siegel. (The hospitals participating in the study used Hospital Quality Alliance [HQA] measures in collecting their data). "Part of what we find is that hospitals with a lot of minority patients do not provide optimal quality for *any* of their patients and have a real opportunity to improve across the board. So, it's a complicated picture on both sides of the story."

'Getting serious'

Siegel says he is starting to see more health care institutions collecting data by race and ethnicity. "We are now getting serious about collecting race data on patients; for example, it is now mandated by the state of New Jersey," he observes. "They are being trained how to do it in a uniform, standardized fashion."

Part of the impact of such data collection is that the hospital's quality staff will now be able to look at their data and see any disparity problems that exist, Siegel explains. "Also, they will start to know more about their patients in gen-

Key Points

- Most quality improvement leaders do not link disparities and QI initiatives and do not measure for disparities, according to study.
- Equity of care is one of the six domains of quality identified by the Institute of Medicine.
- At least one state now mandates collection of quality data according to race and ethnicity.

eral. They will gain a better idea of how many patients need language services, or have different cultural beliefs and perspectives." Another important part is learning exactly who your customers are.

Siegel recognizes this is not an altogether easy process, as he has learned through his involvement in a disparities collaborative (www.expectingsuccess.org), in which all hospitals have been trained how to collect such data. He says so far there are two headlines coming out of his experience.

"There is some anxiety about doing this; some facilities are concerned that there are legal issues — which there are *not*," he says. In addition, he notes, "Some people are nervous about asking people these questions." What the collaborative has found, however, is there has really not been a big pushback.

"People are used to being asked these questions in a lot of situations," he observes. "Health care has really lagged behind other parts of our society in looking at these issues." For example, he notes, President Bush's "No Child Left Behind" program has schools report data by race and ethnicity. "Banks report mortgage lending by race and ethnicity; these requirements have arisen from a perceived issue of disparity," Siegel notes. "Health care lags behind, even though we know from thousands of studies that disparities are a real issue for health care."

Improved collection needed

Another take-home message of his study, says Siegel, is that collection methodology needs to be improved. While the participating hospitals used all the HQA pneumonia and heart care measures that were in place at the time, and with which the hospitals should have been familiar, "it was hard for some of them; they were not really set up [to collect data this way]," he observes. Some facilities were able to run some ad hoc reports, while many turned to outside vendors to help them.

"I think looking at the HQA measures could be worthwhile because some disparities may show up," he offers. Another important area of focus, he notes, is the entire area of transitions: How well prepared are the patients to return to the community? For example, is the patient prepared enough that they will be compliant with their home care? The only way to determine that, Siegel says, is ultimately to look at statistics such as heart failure readmission rates.

Siegel has no doubt this is a trend that will grow. "We've heard rumblings that CMS is looking at examining data by race, ethnicity, and language," he says. "This could be very telling."

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Two-minute briefing may reduce wrong-site surgeries

Effective communication critical to improvement

Researchers at Johns Hopkins Hospital and the Johns Hopkins School of Medicine in Baltimore have determined that a simple two-minute briefing prior to surgery may have a significant impact on reducing wrong-site surgeries. Their work is described in a recent issue of the *Journal of the American College of Surgeons*.[1]

A group of 147 Johns Hopkins surgeons, anesthesiologists, and nurses was surveyed prior to and following the implementation of this new policy. After they were trained in the briefing, there was a 13.2% increase in those who thought the policy would be effective, and more than 90% thought it was important to patient safety.

The study also showed specific improvements in communications, based on six items in the survey. For example, to the item, "Surgery and anesthesia worked together as a well-coordinated team," 67.9% agreed pre-briefing, while 91.5% agreed post-briefing. And for the statement, "A

preoperative discussion increased my awareness of the surgical site and side being operated on," 52.4% agreed pre-briefing, while 64.4% agreed post-briefing.

"We know that in any high-risk industry that standardizing what you do improves performance, and we found those same rules apply to communication," asserts **Peter J. Pronovost**, MD, PhD, associate professor, departments of anesthesiology and critical care medicine and surgery, Johns Hopkins School of Medicine and department of health policy & management, Bloomberg School of Public Heath; medical director, Center for Innovations in Quality Patient Care; director, Division of Adult Critical Care; and a co-author of the article. "And, we know poor communications are the No. 1 cause of sentinel events. These briefings are a standardized way to cover all the necessary preoperative safety elements, and an opportunity for the entire care team to surface any hazards."

Pronovost goes on to note that they "have identified in most sentinel events that somebody knew something was wrong and did not speak up, or was not listened to. We do that all the time in health care; we do not listen to the nurses, techs, and so forth. The briefing gives you an additional number of eyes looking at the patient."

How the briefing works

The briefing, Pronovost explains, involves the entire care team — the surgeon, anesthesiologist, nurses, and, at Hopkins (and other academic centers), the residents. "It often happens with the patient already in the OR; they were also often asleep, as was the case in our hospital," he notes.

The briefing begins with everyone introducing themselves with their names (first name included) and their role (i.e., "I am Dr. John Smith, and I am the anesthesiologist."). "You want to break down the barriers to communication," Pronovost observes.

The second part of the briefing involves the "time out" recommended by The Joint Commission. "This involves stating what we are about to do, who the patient is, confirming we have the necessary consents, and all team members agreeing the consent matches what we are about to do," says Pronovost.

In the third part of the briefing, "We try to surface any hazards by asking if anyone has any concerns," notes Pronovost. "In addition we ask, 'If something *would* go wrong, what would it be, and how would we defend it?'"

Next, the team is asked if they have all the equipment they are going to need and whether they have people who know how to use that equipment. "When you look at sentinel events, equipment keeps occupying a higher and higher percentage as a cause," Pronovost observes. Finally, the team is explicitly asked about its efforts to reduce infections — i.e., did they get the necessary antibiotics?

Believe it or not, these briefings take all of two minutes. "There's a tension we see when you put too much detail in; it becomes a *meeting*," says Pronovost. "We found addressing a smaller number of key items makes you much more successful."

Apply principles broadly

While advocating these briefings for all facilities, Pronovost is not suggesting you follow the Hopkins model — in fact, he says, it's preferable if you design your own briefings.

"I think these principles should be broadly applied," he clarifies. "What I'm suggesting is, what we have to take away from this study are the concepts and principles. What we probably *shouldn't* do is broadly adopt the Hopkins method."

In other words, he continues, you should adopt the concept of standardizing your briefing, but adapt it to your culture. "You should develop the exact questions on your own; if you do not develop it locally, it will not work."

Pronovost saw a clear example in his own facility. "When we started, we tried to make a standard form for all our ORs," he recalls. "One of the questions was, 'Did the patient get beta-blockers?' One pediatric surgeon said to me, 'Why am *I* asking this question?'"

Key Points

- An effective briefing needn't last longer than about two minutes.
- The entire care team should be involved in the briefing.
- While certain key elements should always be used, hospitals and departments should customize the briefings as much as possible and try not to include too many details.

Your orthopedic service, he notes, may have very different needs than your cardiac service. "Orthopedics may, for example, wish to ask if artificial limbs have been sterilized in a particular way," he offers.

Still, says Pronovost, all briefings should have some basic elements. "You have to have the opportunity to identify yourself, you have to have the timeout components, and you need a way to identify and mitigate hazards," he advises. "The details could often vary, but the mean concepts are pretty much the same."

Reference

1. Makary MA, Mukherjee A, Sexton JB, Syin D, Goodrich E, Hartmann E, Rowen L, Behrens DC, Marohn M, Pronovost PJ. Operating room briefings and wrong-site surgery. *J Am Coll Surg* 2007 February; 204(2):236-243.

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Demonstration project continues gains in year two

Year three is looking even better

The Premier Hospital Quality Improvement Demonstration (HQID) project, a joint effort between Premier Inc., of Charlotte, NC, and the Centers for Medicare & Medicaid Services, continues to go from strength to strength.

The recently released second-year results of the hospital value-based purchasing demonstration project show an average improvement of 6.7% in the second year, leading to total gains of 11.8% for both years. Thus, the improvement rate in the second year actually topped that of the first year.

And things continue to get better. "We're seeing [the steady improvement] continued in the third year," says **Stephanie Alexander**, MBA, senior vice president of Premier. "It's not slowing down; I think it will be the same or better in year three."

The improvements resulted in incentive payments totaling about $8.7 million to 115 top-performing hospitals, according to CMS.

Key Points

- Adherence to several measures sees significant improvement from first quarter of project to most recent quarter.
- Payment for performance is only one of the keys to success; transparency, knowledge transfer also given much of the credit.
- Quality manager uses reliability science to help meet the challenge of improving year after year.

A breakdown of the numbers shows impressive gains in specific measures. "A good example is that in the first quarter of the project we were at 89.88% in the acute myocardial infarction [AMI] clinical focus group, and at the last quarter of the second year we were at 95.77%," reports Alexander. "For coronary artery bypass graft it went from 85.14% to 97.01%, and pneumonia went from 70% to 86.3%."

Hospitals participating in the Premier project submit data to Premier for validation and analysis. Premier then submits the data to CMS. The hospitals report process and outcome measures in five clinical areas — AMI, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement.

There are financial incentives for the top 20% of high-scoring hospitals in each of the five clinical areas. The top 10% of all hospitals receive a 2% incentive payment for patients in that clinical area. Hospitals in the second decile receive a 1% incentive payment. Hospitals in the top 50% of each clinical area also are recognized on the CMS web site.

Examining the numbers

This steady improvement becomes more impressive when weighed against the knowledge that as a facility improves, each additional percentage of improvement becomes that much more difficult. Alexander notes, however, that there were some mitigating circumstances in year one.

"In the first year there was a lot going on; some people may call it 'noise,'" she notes. "Hospitals had to get prepared and get their infrastructure up and running, and as you can imagine, they were now documenting. In the second year, all that infrastructure was set and

the hospitals could really focus on what matters."

Nevertheless, she adds, the numbers do tell a valuable story, "We took a subset of these measures [Hospital Compare, a publicly available web site established by CMS and the Hospital Quality Alliance], which are reported every quarter with a 12-month rolling average. When we compared the hospitals, every quarter we were getting better."

The entire nation is improving, she adds, but the 250 demonstration project participants were getting better at a statistically significant higher rate. "I would have thought that because the rest of the country [started] at a lower rate they'd be improving at a faster rate," she observes.

Why was this conventional wisdom turned on its ear? "I believe this is a combination of P4P and transparency; knowledge transfer is the silver bullet here," Alexander asserts.

Keeping the numbers high?

Just how difficult is it to maintain top-level performance? "I think it is difficult, because the nature of performance activities in health care is that if you take your eye off the ball you tend to deteriorate," says **Charles Riccobono**, MD, chief quality officer and chairman of the performance improvement department, Hackensack University Medical Center in New Jersey.

He should know: His facility, which provides care for 2,853 Medicare patients, was a top performer in all five areas for the second year in a row. The facility's total award across the five clinical areas will be about $744,000. "The key to our success is that we have used what we've learned about reliability science — a method of designing and building processes in such a way that they will be self-sustaining," says Riccobono. **(For more on reliability science, see "Reliability science: Ensure system success even when components fail," the cover story of our July 2004 issue.)** "But still, you have to continuously monitor and tweak your processes. You can get surprised; specific measures may change and you won't know why. You'll have to look at it, and you still may have to redesign your process."

Still, he says, the reliability approach (which he and his team try to build into everything they do) "has been very helpful in creating a process that is good from the beginning, and gets even better as we tweak it." Instead of a Band-Aid approach, he says, "We try to design process right from the beginning, then use things like [Failure Mode Effects Analysis] tools to predict how we might fail and try to prevent it. We look at process very seriously."

Riccobono adds that he and his team are learning along with many others. "We've worked on the Institute of Health Care Improvement's IMPACT project, where people shared a lot of information," he notes. "That's another great thing that has come out of this project — transparency, and hospitals communicating with each other."

Gap is closing

Another trend identified by Premier is that the range of variance among participating hospitals is closing, as those hospitals in the lower quality range continue to improve their quality scores and close the gap between themselves and the demonstration's top performers.

"We anticipated that in each year the variation would be reduced, and in fact in year two that has played out," says Alexander. "Premier's goal is to leave no one behind."

Premier was sufficiently pleased that it has formally announced a three-year extension of the project. (The project, launched in October 2003, originally was designed to be terminated after three years.) In actuality, year-three data have already been collected, but has not yet been reviewed and finalized by CMS.

And what of the future for P4P? "Last October, CMS did increase the financial risk of publicly reported data," notes Alexander, "but what they are working toward for this summer is to present to Congress their value-based purchasing plan, which they have been tasked to implement in 2009. They have prepared an issues paper and accepted written comments, and I believe a draft will be ready in April."

Riccobono says the incentive structure in the demonstration project will need to be amended going forward. "They will have to modify it because everybody is stacked at the top so tightly that with a small variance you plummet deciles," he notes. "I'm not sure that would be a sustainable process of incentivizing health care workers."

He also notes that while the positive numbers look good, they focus more on process than on outcomes. "[Premier] has probably done a lot more of looking at things from a global perspective than we have," he concedes. "We are waiting

to see what happens. It's clear everyone is improving; people are taking these things seriously and pay attention to improving processes, which we hope results in better outcomes."

That, however, is "a little up in the air," Riccobono asserts. "Some of the data would make you think it's related, but some other data do not necessarily support that," he says. "But you can see that people are taking evidence-based practice seriously, and implementing them by improving their processes and delivery of care."

The bottom line, he says, is that "it's not so about making money as it is the interest of people in improving their care and [the public's] perception of their care."

For complete information about the HQID project and to view a list of those hospitals ranking in the top 50% in each focus area, visit www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp#TopOfPage or contact:

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'Full disclosure' approach to errors may be costly

Could lead to increased exposure to lawsuits

A policy of full disclosure — that is, a situation in which physicians and hospitals are disclosing to patients all serious adverse events due to medical care — is recognized as the most ethical approach to communicating medical errors. But as new research shows, it can have some less than desirable consequences.

A new study by the Harvard School of Public Health, Brigham and Women's Hospital, and the Harvard Risk Management Foundation[1] indicates that under a universal full disclosure policy, "the total number of malpractice lawsuits is likely to rise as many patients will be 'prompted' to sue, and malpractice costs will consequently increase."[2] Some proponents of full disclosure, they note, had argued that such an approach might actually lead to fewer law suits.

Key Points

- Full disclosure may make patients aware of errors they did know had occurred.
- While initial reaction of patients is likely to be gratitude for honesty, additional reflection could lead to negative feelings.
- Study indicates a 95% chance that the number of lawsuits would increase under a full disclosure policy.

"The conventional wisdom is that disclosing injuries will dissuade patients who otherwise [might have] sued from doing so, because they would be less angry, and [see the staff as] more compassionate," notes **Michelle Mello**, JD, PhD, of the department of health policy & management, Harvard School of Public Health, and one of the authors. "It seems right, but there is a huge reservoir of unlitigated injury, and the possibility [full disclosure] might prompt even a small percentage who otherwise would not have sued might outweigh [those who are dissuaded from suing]."

In undertaking the study, she explains, "We were interested in applying the evidence we have on the epidemiology of medical injury and malpractice claims to see the effects of a world of full disclosure on the volume and cost of malpractice claims." A group of physicians reviewed a random sample of 1,452 closed malpractice claims from five liability insurers "to determine whether a medical injury had occurred and, if so, whether it was due to medical error."[3]

The researchers then "analyzed the prevalence, characteristics, litigation outcomes, and costs of claims that lacked evidence of error."[4]

Hypothesis proved

Mello says the hypothesis that a full disclosure approach would lead to greater litigation was proved. "The 'headline finding' was there would be a 95% chance under our model that the total number of claims would increase, and a 60% chance it would double," she reports. "In terms of cost, there was a 94% chance they would increase, and a 45% chance they would at least double."

Would something less than full disclosure then be a better financial strategy? "That seems to be the direction in which our model points," says

Mello. "But it's not what we advocate; we think disclosure is the right thing to do."

In terms of other quality considerations, such as patient satisfaction, Mello says that again the full disclosure approach may have mixed consequences. "It absolutely could have [an initial] positive impact on patient satisfaction," she says. "When people feel they are being dealt with honestly they are likely to react positively."

The problem, she says, is that a lot of patients would become aware of problems they otherwise would never have been aware of. "So ultimately it could have a negative effect on patient satisfaction."

Change your approach

On the bright side, Mello continues, "our model assumed the world we live in *now* in terms of how claims are dealt with, and what would happen when we move to full disclosure," she observes. "However, when you do move to full disclosure, you should also develop compensation programs [for patients affected by medical errors]." By offering compensation to patients in those situations that are warranted, she explains, "people who otherwise might bring lawsuits would have an alternative."

In any event, full disclosure is gradually becoming a reality, says Mello, adding that a few states have instituted full disclosure requirements. "As a regulatory requirement of The Joint Commission, it has been in place already," she notes. However, she adds, compliance with the requirement is incomplete. "Enforcement will probably harden at some point, but it takes a while for institutions to move staffs toward compliance with new approaches," she explains.

References

1. Studdert DM, Mello MM, Gawande AA, Brennan TA, Wang YC. Disclosure of medical injury to patients: an improbable risk management strategy. *Health Aff (Millwood)* 2007; 26:215-226.
2. Ibid.
3. Ibid.
4. Ibid.

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Study: EHRs valuable in identifying quality care

Diabetic patients sampled

A study in the January/February issue of the *Journal of the American Medical Informatics Association*[1] quantifies the difference between calculating quality measures for diabetes using claims data and data extracted from an electronic health record (EHR). The study was conducted by the Palo Alto Medical Foundation and Lumetra, California's QIO, as part of the Doctor's Office Quality project.

The researchers, led by **Paul Tang**, MD, MS, took a random sample of medical charts from Medicare beneficiaries with diabetes. Then, based on the sample of 125 charts, they identified diabetics two ways using the same predefined inclusion criteria — by administrative claims data and by coded clinical data in an EHR.

Only 75% of Medicare beneficiaries with diabetes were identified using administrative data, while coded information in the EHR revealed 97% of the diabetics with a specificity of 99.6%. Differences in the detection of quality measures for HbA1c testing, blood pressure, urine testing, and eye exams also were found to be statistically significant.

"New development of standardized quality measures should shift from claims-based measures to clinically based measures that can be derived from coded information in an EHR," conclude the authors. "Without adding burden to the care process, clinical data entered by clinicians into an EHR system at the point of care should be mined to generate new knowledge, measure performance, and reward those who deliver the best care with the best outcomes."[2]

References

1. Tang PC, Ralston M, Arrigotti MF, Qureshi L and Graham J. Comparison of methodologies for calculating quality measures based on administrative data versus clinical data from an electronic health record system: Implications for performance measures. *J Am Med Inform Assoc.* 2007;14:10-15.
2. Ibid.

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light what is possible when organizational attention to quality is deliberate and intentional every day." ▼

HealthGrades names 'Top 50' hospitals

Golden, CO-based HealthGrades Inc. has identified "America's Best 50 Hospitals" based on the analysis of about 90 million hospitalization records from nearly 5,000 hospitals over the years 1999-2005. The list, says HealthGrades, not only includes a number of well-known facilities, but also some facilities that are lesser-known nationally. (A full copy of the analysis is available at www.healthgrades.com.)

In order to place in the top 50, a hospital must have patient outcomes that are in the top 5% in the nation the most consecutive times over the past five years. HealthGrades uses objective outcomes data from the federal government, and the mortality and complication rates that reflect how patients fared at the nation's non-federal hospitals.

HealthGrades' annual assessment of mortality and complication rates analyzes 26 procedures and diagnoses and then risk-adjusts the data.

"For a hospital's patient outcomes to be in the top 5% in the nation one year is truly an achievement," said HealthGrades' chief medical officer, Samantha Collier. "To achieve this level of high quality year over year for five consecutive years is astounding. These hospitals high-

NCQA to require quality data for accreditation

All health plans seeking accreditation from the National Committee for Quality Assurance (NCQA) would be required to report on the quality of care delivered to patients under proposed requirements issued on Feb. 15, 2007. Under the new program, NCQA will evaluate PPOs on the same set of standards, clinical measures, and patient experience ratings on which NCQA has evaluated HMOs and POS plans.

"Today's confusing alphabet soup of plan types and names often distracts from what people really need to know," said Margaret E. O'Kane, NCQA president. "It doesn't matter what a plan calls itself; what matters to patients is how well they perform."

Under the proposed standards, PPOs seeking NCQA accreditation would be required to report clinical quality results using NCQA's Health Plan Employer Data and Information Set (HEDIS). Plans also would be required to report results from the Consumer Assessment of Healthcare Providers and Systems (CAPHS), which evaluates patients' experience with care and service.

To further tie accreditation to improved health, NCQA also proposes to increase its emphasis on HEDIS and CAHPS in its health plan accreditation programs. Currently, HEDIS and CAHPS scores represent about one-third of the score a health plan needs to become accredited. Beginning in 2008, that proportion would rise sharply to 50%.

Following a 30-day public comment period, NCQA plans to release final standards July 2007, to take effect on July 1, 2008. ▼

COMING IN FUTURE MONTHS

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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.

The agency 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. ▼

On-line NPI information available through WEDI

Health care providers can receive free on-line information about the National Provider Identifier (NPI) in the form of on-demand audio and video web casts.

The service is being offered by the Workgroup for Electronic Data Interchange (WEDI) and the Blue Cross and Blue Shield Association to help educate providers on how to obtain and implement their NPI by the May 23, 2007, deadline, according to a WEDI statement.

Only about 60% of providers had obtained their NPI by the beginning of 2007, the Centers for Medicare and Medicaid Services estimates. All entities covered by HIPAA, including providers, health plans, and clearinghouses that process health care transactions using HIPAA format, must implement the 10-digit NPI code by the May 23 deadline.

Two 60-minute webcast audio or video sessions are available: one for large practices or institutional providers, and a second version tailored for individual providers or small group practices. The webcasts, which include PowerPoint materials, cover these topics:

- Who Needs an NPI?
- The Application Process
- Obtaining and Sharing NPIs
- NPI and Paper Claim Submitters
- Provider Practice Considerations and Impacts
- Resources and General Questions

In addition to offering the webcasts, WEDI's NPI Outreach Initiative will respond on an ongoing basis to questions submitted via the Q&A feature of the webcast sessions. ■