Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

AHC Media LLC

IN THIS ISSUE

MAY 2007

VOL. 14, NO. 5 • (pages 49-60)

New study shines light on poor transfer communications

Focused attention on discharge summaries can help reduce problems

Quality improvement professionals have long known of the difficulties involved in discharge communications between hospital-based physicians and primary care physicians, but in the words of one observer, "This is the first time the problem has been quantified."

"This" is a new article in the *Journal of the American Medical Association* (*JAMA*), entitled "Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians."[1]

Extracting data from observational studies, the researchers found that:

• Direct communication between hospital physicians and primary care physicians occurred infrequently (3%-20%);

• The availability of a discharge summary and the first post-discharge visit was low (12%-34%) and remained poor at four weeks, affecting the quality of care in approximately 25% of follow-up visits and contributing to primary care physician dissatisfaction;

• Discharge summaries often lacked important information such as diagnosis test results (missing from 33%-63%), treatment or hospital course (7%-22%), discharge medications (2%-40%), tests

Key Points

- Direct communication between hospital physicians and primary care physicians occurs infrequently.
- The Joint Commission's deadline for transmission of discharge forms may be too generous.
- Discharge forms should be disseminated within one week, and they should be *complete*.

results pending at discharge (65%), patient or family counseling (90%-92%), and follow-up plans (2%-43%).

"As a hospitalist, I and my colleagues have had a lot of anecdotal experience about the communications around hospital discharge being poor," notes **Sunil Kripalani**, MD, MSc, assistant professor in the department of medicine, Emory University School of Medicine and assistant director of the hospitalist program at Grady Memorial Hospital, both in Atlanta, and lead author of the paper. "I am also trained in primary care, and, as such, I know these doctors feel they often don't have enough information about the patient. But [this problem] has never been emphasized formally, so we decided to flesh out the specifics of the problem and see what can be done about it."

Kripalani and his colleagues did just that; they not only put the problem squarely into focus, but they also laid out a template for a new discharge form they think will help eliminate many of the quality issues they detailed in the paper.

"We know that this is a huge issue, and it occurs with specialists as well as with hospitalists," adds **Bev Cunningham**, MS, RN, associate administrator, clinical performance improvement, Medical City Dallas Hospital.

"For example, if your pulmonologist gets a referral, especially if you are a referral center, your docs should take a very good look at making sure their communications with the primary physician are handled well."

Discharge communications, she continues, raise a number of important issues. "One is safety; the patient can definitely get 'lost,'" she asserts. "Second is The Joint Commission standard of handoff, which does include the physician. The third is results: If you want people to refer patients back to you, you want to have the right processes in place, because it can affect volume."

A matter of time?

While The Joint Commission does have standards pertaining to this issue, Kripalani says quality professionals should look beyond those standards to achieve optimal performance.

"I think one of our main findings was the 'disconnect' between the information that needs to be communicated promptly at hospital discharge and what the current Joint Commission requirements say," he asserts. "The majority of times the primary care physician does not have detailed information from the hospital when he begins follow-up care.

One of the reasons is that the current performance standards hold discharge summaries under the umbrella of all other hospital records, so there is a 30-day time period for completing discharge summary, and the physician is not considered delinquent until a certain percentage of their records has been incomplete for 30 days. In other words, the physician may have several chart summaries not completed within one month before he is really considered an outlier."

That is just not sufficient for patient follow-up, Kripalani continues. "Patients often receive follow-up care within a week of discharge; I saw

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $549. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $92 each. (GST registration number R128870672.)

Editor: **Steve Lewis**, (770) 442-9805, (steve@wordmaninc.com).
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

AHC Media LLC

Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

one study where the median was six days," he observes.

"This is so true," echoes Cunningham. "If someone comes here for a severe infection, or to see a big-time oncologist, what happens two days later when they are 100 miles away and their primary care doctor does not have a clue [about what happened]? It goes back to patient safety, which is why it is part of The Joint Commission standards and National Patient Safety Goals."

It's also why, she continues, a conscientious facility would not be satisfied with a 30-day wait, regardless of The Joint Commission's standards. "If you have a patient, regardless of the standard, why would we wait 30 days for that?" she poses.

But the first communication need not be written, she adds. "It could be a 'howdy' call, in which you give them a summary, and then document it," she offers. "It's like the immediate post-op note that you have to write in the record and then have to dictate."

At her facility, she says, "My hospitalist group is not employed [by the hospital], but the president of the group is entrepreneurial; he knows if his communication is good, his referrals will match. And I *want* him to have referrals, because I want full beds."

Cunningham provides her hospitalists with a nurse practitioner, who makes the "howdy calls," and then documents the calls. "In a smaller facility, it could be some sort of advanced practice nurse, or even a physician's assistant," she suggests.

Other ways to speed the process, Cunningham notes, include faxing the discharge form. "The other consideration here is with the EMR [electronic medical record]; as more and more hospitals move to this technology, it becomes easier to transition information from the patient's record to the physician electronically," she notes.

In any event, says Kripalani, time is of the essence. "There's a patient safety argument that can easily be made that information flow has to be prompt and complete — occurring within a week of discharge," he asserts. "Another line of thought is that perhaps the performance standard should be revisited."

Thus, to Kripalani's thinking, speed is not the only important element in discharge communication; the information that is received quickly should also be complete — ergo, the recommendations for a more detailed discharge form.

Elements of discharge summary

The researchers recommend, for example, that discharge summaries should include the following elements:

- primary and secondary diagnoses;
- pertinent medical history and physical findings;
- dates of hospitalization, treatment provided, and brief hospital course;
- results of procedures and abnormal laboratory test results;
- recommendations of any subspecialty consultants;
- information given to patient and family;
- the patient's condition or functional status at discharge;
- reconciled discharge medication regimen, with reasons for any changes and indications for newly prescribed medications;
- details of follow-up arrangements made;
- specific follow-up needs, including appointments or procedures to be scheduled, and tests pending at discharge;
- name and contact information of the responsible hospital physician.

"One important consideration from the process standpoint would be to systematize prompt completion of discharge summaries the day the patient is discharged," says Kripalani.

"Like most performance improvement initiatives, it should involve a multidiscipline approach; for example, in a hospital that relies on care managers to oversee the discharge process, you may make it their responsibility to ensure the form is completed. Other facilities may be configured around billing software, which could prompt the physician to enter the form when the charge is billed. There are a variety of ways completion could be anchored to something already in place in the individual hospital."

He adds that quality managers could play an important role by completing part of the form themselves, as well as by monitoring how consistently the new form is being used.

Tracking results

In tracking results, Kripalani thinks the successful use of the forms is worth measuring, but it's not everything. "Simply completing forms in a timely

manner would be an improvement, but it wouldn't be optimal," he argues. "An optimal process would also include ensuring the primary care provider has received the form in a timely manner. The reason I mention that is, today, patients are sometimes admitted without having a designated primary care provider. In that context, it's expected that 15%-20% of the PCPs following these patients still may not receive the hospital information, perhaps because they were not the PCP at the time the patient left the hospital or they were but their contact information was not available." In the study, he notes, 15% of primary care physicians reported *never* receiving a discharge form.

A simple way to track performance, Kripalani continues, would be on a subset of the discharge documents. "Include a postcard for the PCP to return upon receipt of the information," he suggests. "That's a simple way of auditing; you could even have a date on it." A more hi-tech counterpart, he notes, would be e-mail.

Another way to measure performance/results, says Cunningham, would be a survey, which could be part of your documentation. As for anticipated results, she says. "I would hope it would impact readmissions, satisfaction of PCPs, and I would hope it would also impact patient satisfaction.

"We do our [patient satisfaction] work with Gallup; we're currently fixing it so that we can drill down to the physician level."

As more and more national organizations look at pay for performance and at physician and nurse satisfaction, she says, "There might be a question such as, 'If you are the patient of a hospitalist, did you feel your primary care provider had the necessary communications to take care of you?' Or, 'Did you have the information you needed to take care of yourself when you went home?'

"Another might be, 'Did you feel your hospitalist and primary care provider worked as a team after your discharge?'"

References

1. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, and Baker DW. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA* Feb. 28, 2007; 297, 8: 831-841.

For more information contact:
Bev Cunningham, *MS, RN, Associate Administrator, Clinical Performance Improvement, Medical City Dallas Hospital. Phone: (972) 566-6824. Fax: (972) 566-7533.*

Sunil Kripalani*, MD, MSc, Assistant Professor, Department of Medicine, Emory University School of Medicine, Atlanta, GA. Phone: (404) 449-1242.* ■

Joint Commission report shows quality gains

Compliance lags in surgical time-outs

A new report from The Joint Commission, of Oakbrook Terrace, IL, indicates that hospitals in the United States have achieved significant improvements in quality of care in the past four years for patients suffering from three conditions: Heart attack, heart failure, and pneumonia. However, the report, entitled "Improving America's Hospitals: A Report on Quality and Safety" also showed room for improvement in areas such as surgical time-outs.

According to The Joint Commission, this report will now be issued annually. The current report covers 2002 through 2005 and details the performance of accredited hospitals against standardized national performance measures and the Joint Commission's National Patient Safety Goals. **(To view hospital-specific performance on the measures, go to the individual hospital's Quality Report on Quality Check at www.qualitycheck.org.)**

During a March 20, 2007, press conference unveiling the report, **Dennis S. O'Leary**, MD, president of The Joint Commission, said, "The magnitude of improvement in the safety and quality of care provided ranged from 1.1% to 42.8% over the four-year period between 2002 and 2005, with performance improving the fastest on measures where the initial performance level was lowest."

The biggest improvement was in providing patients admitted to the hospital with pneumonia with smoking cessation advice. The national rate of sharing this type of information rose from 37% in 2002 to 80% by 2005. Another area of improvement was the overall use of specific care interventions for patients admitted with heart attacks and the in-patient mortality rates.

"Room for improvement exists for most of the quality measures," O'Leary said. "For example,

Key Points

- Greatest improvement occurred in providing smoking cessation advice to patients admitted to the hospital with pneumonia.
- Pneumococcol vaccinations, discharge instructions for heart failure patients need improvement.
- Low compliance with timeout standards remains a nagging problem.

hospitals are currently achieving 90% performance or higher for about half of the measures tracked since 2002. Hospitals are performing at less than 65% for two of these measures — providing pneumococcol vaccination to patients admitted with pneumonia, and providing discharge instructions to patients admitted with heart failure."

Change varied by states. For examples, O'Leary said, "the statewide averages for providing discharge instructions to patients admitted with heart failure range from 33.5% to 89%. On the measure of providing pneumococcol vaccination to patients admitted with pneumonia, performance ranges from 48% to 84% across the states."

Results showed some hospitals performed better than others in treating specific conditions and more than 90% of hospitals showed 90% performance on only one measure.

Where was compliance lowest? For National Patient Safety Goal requirements that surgical teams take a time-out before surgery to confirm the patient's identity, that the procedure is the correct one, and that potentially confusing abbreviations are not used in ordering the necessary medications.

"Although National Patient Safety Goal compliance is trended over time for the various requirements," O'Leary said, "the report urges caution in interpreting these trends because Joint Commission surveyors have become increasingly sophisticated in assessing compliance with some of the requirements."

Good news, bad news

This hard data, O'Leary continued, "moves us ever closer to creating truly informed health care consumers. The good news is that we have made significant progress in improving quality of care for these conditions. However, the data also indicate there are significant opportunities for improvement."

The progress that has been made, he continued, "is quite real — but so are the opportunities to improve safety and quality of care."

"This report is a very important addition to the total body of information, and is the product of valid, reliable, evidence-based measures that have a broad consensus of support in the field," adds **Carolyn M. Clancy**, MD, director, Agency for Healthcare Research and Quality (AHRQ). "It tracks very closely the findings of our own agency's National Healthcare Quality Report, which we present every year to Congress."

Even the "bad" news, adds **Richard J. Umbdenstock**, FACHE, president of the American Hospital Association, is "good news for us in that it points out where we can and should focus our improvement efforts."

What's behind the improvement? "Much of it is due to public reporting and the availability of information on hospitals," Clancy asserts.

"This is not a time to be complacent," she adds. "The health care system continues to have significant gaps in quality that need to be addressed; for example, except for vaccinations, the improvement rate for preventive services was less than 2%. We've read what hospitals have done in smoking cessation; we can do the same elsewhere in health care."

Issues such as broad disparities in care by race and ethnicity also must be addressed, she points out.

Improving time-outs

Indeed, a good portion of the conference was devoted to potential solutions to nagging problems, such as low compliance with time-out standards. In response to a question from *HBQI,* O'Leary admitted to "some significant frustration" over what the data showed.

"[Time-outs are] the embodiment of trying to prevent wrongs, and we did issue a universal protocol two years ago that was endorsed by some 50 medical societies and nursing groups," he said.

Whatever the level of non-compliance is, O'Leary asserted, "It is too much." Part of the problem, he added, lies in the very nature of surgeons. "No surgeon has ever had a wrong-site surgery," he noted sarcastically. "My surgical colleagues tend to be strong-minded in their beliefs about things and some are less inclined to take

[time-outs] seriously."

O'Leary said The Joint Commission convened a summit on wrong-site surgeries a couple of years ago and not only reaffirmed the universal protocol, "But it was suggested we become even more prescriptive. That process is moving forward, and there is a good chance we will be tightening [the requirements]."

There are two key issues at the heart of the problem, O'Leary added. "One is care process design. This can be solved in part by integrating the usual steps in the OR," he said. "The other is attitude and behavior, which will require increased attention to peer pressure and leadership."

Looking ahead

In response to other queries from the media, O'Leary indicated where The Joint Commission was headed in terms of performance measures. "We will see the measure set on surgical infections," he predicted. "We will also bring in line pediatric asthma. In the pipeline are critical care and ICU measures. Further back are issues like the nursing-sensitive measures set, which is in final field testing."

When asked at what point The Joint Commission will start measuring outcomes, O'Leary responded: "I know a lot of people believe that outcomes measures are the Holy Grail, but there are a number of *process* measures that have been scientifically established to be good proxies for eventual outcomes. I'm not saying we should *not* have outcomes measures, but a good profile includes both."

Another media question addressed the issue of multiple reports being issued by different bodies. Might a single report eventually be produced?

"The major achievement we've reached is a national collaborative to focus on emerging numbers through a common process, so that at least we are talking about the same sets of measures and providers are able to focus on those that are deemed ready to be used and documented," Umbdenstock says. "You will continue to see a variety of organizations take that data and work to make it available — maybe in different formats and through different perspectives."

"For those who get 'down in the weeds,' there *are* some subtle differences," added O'Leary.

For more information contact:
***Carolyn M. Clancy**, MD, Director, Agency for Healthcare Research and Quality, 540 Gaither Road, Suite 2000, Rockville, MD 20850. Phone: (301) 427-1364.*

***Dennis S. O'Leary**, MD, President, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000.*

***Richard J. Umbdenstock**, FACHE, President, American Hospital Association, One North Franklin, Chicago, IL 60606. Phone: (312) 422-3000.* ■

Interventions improve care, not necessarily outcomes

Health Disparities Collaborative helps care centers

A study published in the March 1 issue of the *New England Journal of Medicine*[1] found that interventions for chronic conditions in the Health Disparities Collaboratives led to improvements in processes of care, but the authors could not document improvement in clinical outcomes.

The Health Disparities Collaborative was designed to improve care in community health centers in which many minority and uninsured patients receive care.

The process improvements achieved included:

- A 21% increase in foot examinations for patients with diabetes.
- A 14% increase in the use of anti-inflammatory medication for patients with asthma.
- A 16% increase in the level of HbA1C screening for those with diabetes.

However, the researchers found no improvement in intermediate outcomes, including:

- Control of blood sugar for people with diabetes.
- Control of blood pressure to normal levels for patients with hypertension.
- No reduction in urgent care, emergency department visits, or hospitalization for people with asthma.

Explaining the results

There are logical explanations for some of the results, notes **David M. Stevens,** MD, senior medical officer for quality improvement at the Center for Patient Safety & Quality Improvement, Agency for Healthcare Research and Quality (AHRQ), Rockville, MD, who initiated the Health Disparities Collaboratives while working with

the Health Resources and Services Administration (HRSA), which administers the program.

So, for example, in terms of lack of process improvement in hypertension, he notes, "There is limited access to meds, as many of those patients are not insured. This translates as well in the ambulatory care facilities that hospitals run; 30%-40% of patients who are not insured may not have access to the treatments you prescribed."

Nevertheless, it is evident from the results that the collaboratives are doing something right. "We wanted to break new ground; our main message was that *this* would be different. Our measures were very patient-centered, and we decided to start building from the beginning," Stevens says.

"We had a common language and framework – the 'Care Model' of what care should look like," he says. That model can apply to hospitals as well as to health centers, he adds. "You know what all the key elements are, what you are trying to give the patients, and what outcomes you want," he explains. "The model talks about teams, decision support, and other things that help you get there; it's a common language around improvement, a standard way of doing things, which was very important." **(For more on the Care Model, visit the web site of Improving Chronic Illness Care at www.improvingchroniccare.org.)**

HRSA, Stevens notes, concluded an interagency agreement with AHRQ to study the work of the collaboratives. "When we started this, we only had two measures; we wanted to err on the side on parsimony," he recalls. Steven adds that while the subjects of the study were health centers and not hospitals, "Many principles are the same."

One other important factor for successful improvement in health centers that is certainly applicable to hospitals, Stevens continues, is a strong quality improvement team that is fully integrated into the organization— not, he emphasizes, "viewed as a marginal 'science fair project.'" **(An important tool aimed at hospitals that Stevens says is helpful is available at www.ahrq.gov/qual/teamstepps.)**

Key Points

- Treatment of asthma, diabetes patients shows significant process improvements.
- Limited access to meds for the uninsured helps explain some of the disappointing results.
- Mutually agreed-upon treatment plans an important component of the Care Model.

Looking at outcomes

One of the reasons outcomes were not seen to improve, Stevens suggests, "is that it takes longer than a year." If a quality manager is looking to measure outcomes, he says, "Maybe what you want to do is set up some process measures of your own, so you track not only what is tested and done, but also the structural changes you want.

For example, if you put together a team, you may want to measure whether the team has gone from identifying its aims to small tests, and to implementation. Also, you may want to see if you get some immediate successes, while not expecting to see normal blood pressures right away, and so forth."

One of the key elements in the Care Model, he continues, is patient self-management, but he cautions quality managers against thinking in terms of the word "compliance."

"That word may not be that helpful," he offers. "If you have two different patients, you will have two different sets of goals. You should work with the patient and their family to get a mutually agreed-upon goal and look for ways to support them."

The patient, he continues, also must think about what things will help achieve his goals, and what some of the potential barriers are. "Then, you can help them overcome those barriers, and problem solve. This is *very* powerful," says Stevens.

This type of approach could be very helpful in the hospital setting, says Stevens, "both on discharge, and also in helping to limit unnecessary ED visits or primary care visits — and of course, by following mutually agreed-upon treatment plans. If we can figure out ways to use our resources to help patients do that and take advantage of new technology like e-mails and the web, I think in the future this model will be very helpful."

Reference

1. Lando BE, Hicks LS, O'Malley AJ, Lieu TA, Keegan T. McNeil BJ, and Guadagnoli E. Improving the Management of Chronic Disease at Community Health Centers. *NEJM*

March 1, 2007; 356:921-934

For more information, contact:
***David M. Stevens**, MD, Senior Medical Officer for Quality Improvement, Center for Patient Safety & Quality Improvement, Agency for Healthcare Research and Quality (AHRQ), 540 Gaither Road, Rockville, MD 20850. Phone: (301) 427-1311.* ■

Key Points

- Registration to the ISO-9001 Quality System Standard helps QIO stand out.
- IPRO leaders say they have to walk the 'quality walk' if they are to serve hospitals.
- Organization stresses effective employee communications, training, and rewards and recognition.

IPRO, New York QIO, wins prestigious quality award

Based on Malcolm Baldrige National Quality Award

What makes an outstanding QIO? It appears that IPRO, the New York Quality Improvement Organization (QIO), knows the answer, as it has just garnered the prestigious Empire State Advantage's (ESA) Empire State Silver Certification. According to IPRO, it is the only award program in the state that is based on the Malcolm Baldrige National Quality Award criteria.

The Empire State Silver certification is awarded to organizations that have effective management systems and work processes, are achieving good results, and have developed methods to significantly improve over time.

According to **George Hansen**, executive director of Empire State Advantage, the folks at IPRO "aim to be a national leader in assessing and improving health care services, and they are well along the way to achieving that vision. They work closely with their customers to define and improve the services that they deliver, and they are registered to the ISO-9001 Quality System Standard.

"IPRO has a very positive work environment with effective employee communications, training, and rewards and recognition, and they enjoy employee turnover rates well below those typical for their industry. IPRO leaders monitor performance regularly using a 'balanced scorecard' approach. All of this has helped IPRO to improve customer satisfaction, employee satisfaction, and revenue growth over recent years."

Certification important

The ISO-9001 certification is an important one, notes **Tierre A. Jeanne-Porter**, JD, CPHQ, vice president, planning & quality, for IPRO. "It means you use business management practices that are deemed to be best practices for efficiency and effectiveness," she explains. "We have an internal auditing program, we have controls in place for document and record management, and we have procedures in place to correct problems as soon as we identify them — and even to take steps to prevent them before they occur."

Being knowledgeable about best practices and effective processes puts IPRO in a good position to perform some of the services it provides for hospitals. "In general, QIOs teach hospitals about the best practices they've learned in observing top performing hospitals," says **Tom Hartman**, an IPRO vice president involved in quality. "We recommend internal processes, paper and electronic tools, and assist hospitals in making the most efficient and effective improvements possible."

Hospitals apparently appreciate that knowledge and sophistication, based on IPRO's customer satisfaction surveys. "Our rate from last year was 98%," reports Jeanne-Porter. "Compared with a national benchmark for hospitals or health care facilities of 73%."

IPRO conducts "robust activity gathering information" on customer and employee satisfaction, adds **Spencer Vibbert**, vice president of communications and corporate development. "So we can improve every year."

That's a message IPRO continually seeks to communicate, says Jeanne-Porter. "Our customers have the assurance we have strong internal controls in place that allow us to have consistent and uniform approaches to work, and we take immediate action if issues are ever identified," she says. "This advertises to the world that we continually try to be better.

"Since we regularly talk to providers about improving quality, we felt we should be able to walk our own talk," she continues. "That's why

we pursued ISO-9001 and challenged ourselves about going after the state award."

"We feel we do a really good job," adds Hartman. "We've developed a reputation over a period of 20 years for being objective, knowledgeable, and an honest broker among the various interest groups and constituencies and cultures."

IPRO, he continues, is trusted by both the physicians' community and hospitals. "Where there were difficulties in communication between the hospitals and the physicians, we've facilitated a better way of communicating," Hartman notes. "We provide the same services for communication between hospitals and nursing homes or home health agencies."

For more information, contact:
***Tom Hartman**, Vice President, **Tierre A. Jeanne-Porter**, JD, CPHQ, Vice President, Planning & Quality, **Spencer Vibbert**, Vice President of Communications and Corporate Development, IPRO. Phone: (516) 326-7767.* ■

Collaborative aimed at hospital communication

Important means of reducing care disparities

A new program from the Department of Health and Human Services (HHS) called "Effective Communication in Hospitals" is designed to aid hospitals in meeting the communication needs of individuals who do not speak English as their primary language, or who are deaf or hard of hearing.

The program will have both national and state-based components; the state-based initiative involves collaboration between HHS' Office for Civil Rights (OCR) and state hospital associations. At present, hospital associations in Kentucky, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island, Utah, and Washington are slated to participate.

According to HHS, state-based efforts will be tackling such issues as:

• Developing a process for assessing the communication needs of patients and their families;

• Identifying tools and strategies for developing training, best practices, educational materials, technical assistance activities, and other resources;

• Responding appropriately and efficiently to the communication needs of individuals who are limited English proficient or deaf or hard of hearing;

• Sharing the results of efforts to assist other hospitals and state associations facing similar communication issues;

• Identifying potential resources and creative approaches to cover costs.

Key Points

- All of the hospitals in Kentucky will participate in, benefit from the collaborative.
- Having a program in place for improved communications a major step in providing quality care to targeted populations.
- Pilot program will use symbols to communicate information about injuries, patients' needs.

One of the 'chosen'

One of the participating organizations, the Kentucky Hospital Association (KHA), was actually enlisted by the OCR, explains **Pam Mullaney**, KHA's director of membership services.

"The OCR and AHA [American Hospital Association] brought it to us," she recalls, explains that there are 10 OCR offices in the country, with Kentucky falling within the jurisdiction of Atlanta's office.

Kentucky is unique in a number of ways, Mullaney continues. First, all 126 hospitals in the state belong to the KHA, which, she says, is unique. "Most states have more than one organization that represents its hospitals," she asserts. This means that in Kentucky, every hospital will be exposed to the program. KHA, adds Mullaney, "represents and facilitates collaborative efforts among Kentucky hospitals and is the source for strategic information about the constantly changing health care environment."

In addition, says Mullaney, "Because more than half our hospitals have fewer than 100 beds, we are considered a rural state. Urban hospitals probably are going to have programs in place already."

The program is important, she says, because "Patient care starts with communication; it's No. 1. Once you have a program in place that can assist these populations, you are on your way to

delivering quality care."

So many of these people don't know how to find their way through the health care system, she explains. "In a lot of other countries, health care is provided by the government; they do not understand that we provide care for the indigent. They also do not understand, however, that this care should not start in the ED, but with a primary care doctor."

Starting pilot project

The KHA will begin its effort with a pilot program, says Mullaney, and it may even "go after" some grant dollars.

"Our idea currently is to come up with something like they've done in Illinois," she says. This involves the use of an oversized laminated board that employs dry erase markers, covered with many different symbols.

"So, if a person [who did not know English or who could not speak] came in and had a broken arm, they could point to it," Mullaney explains.

The board, she says, will have "maybe 100 different pictures, as well as the letters of the alphabet to spell out words." This will be done for the top five languages used in the state: Spanish, Somali, Russian, Arabic, and Vietnamese.

If KHA gets its grant dollars, it will investigate the different language line companies that could provide interpreters. "If a Vietnamese patient comes in, for example, you can call the phone line using two phones — one for the patient and one for the physician — and they can converse back and forth using an interpreter," she explains.

KHA will do due diligence on the top companies. "Since our endorsement could mean all the hospitals in the state would use this vendor, we could get a discounted rate," she suggests.

The OCR is doing a lot of population analysis for KHA "so we'll have a lot more arrows in our quiver when we go to grant writing," says Mullaney, adding that this collaborative "is all about patient care and patient safety," as opposed to a government-mandated activity.

"The nice thing about working with OCR," she continues, "is that they are not claiming to come to us with the answers. They recognized that we know your hospitals and our state, and they want to listen to us for guidance as to what would be of value in each hospital in each setting."

Still, she notes, one program will not be a cure-all. "I think this is a monumental problem, and we will not be able solve it with this one collaborative effort," she concedes. "But it *is* a step in the right direction; we'll try to give our hospitals a mechanism [for addressing the problem], and then spread the word from there."

For more information, contact:
***Pam Mullaney**, Director, Membership Services, Kentucky Hospital Association, 2501 Nelson Miller Parkway, Louisville, KY 40253. Phone: (502) 992-4363. Fax (502) 814-0363. E-mail: pmullaney@kyha.com.* ■

Leapfrog hospital survey gets tougher

This year, the Leapfrog Hospital Quality and Safety Survey will include the types of questions asked by other national initiatives such as The Joint Commission, the Centers for Medicare & Medicaid, and the Institute for Healthcare Improvement's 100,000 Lives campaign, says to the Washington, DC-based organization.

New survey questions will include the following:

- What will your hospital do if they make a big mistake?
- How well does my hospital treat my condition?
- How open with the public is your hospital?

A new "Transparency Indicator" will show which hospitals are doing a good job at publicly reporting their quality and safety track records by giving credit for the other public reporting initiatives in which they participate. In addition, the survey will provide a more complete picture of how well a hospital performs one of seven high-risk procedures and how adequately they can treat low-birth-weight babies.

The first round of survey results will be posted at www.leapfroggroup.org/cp in early June. Leapfrog will use these results to determine the list of Leapfrog Top Hospitals 2007. ▼

New Haven gets $3 million EHR grant for software

The Center for Community Health Leadership, an initiative sponsored by Raleigh, NC-based Misys Healthcare Systems, has selected Greater New Haven, CT, for a grant of health care software valued at $3 million. New Haven will be the first community to receive grants of electronic health record (EHR) software to establish a community-wide network of connected medical organizations.

The grants, in the form of EHR software, are available to health care professionals in New Haven and surrounding towns interested in participating in the initiative. The Hospital of Saint Raphael, a large teaching hospital in New Haven, played a major role championing the application process for the grant and will be an active leader advancing this initiative in the New Haven area.

The Center for Community Health Leadership says it selected New Haven as the center's first grant recipient because of the area's reputation for health care excellence, the strong commitment to data sharing exhibited by the physicians and nurses in the area, and their interest in electronically connecting all settings of care – hospital, physician offices, home care agencies and long-term care.

The center was launched in June 2006. The grant program accepted applications through the end of 2006 from interested communities across the country, as well as regional health care organizations including hospitals, physician offices, and home care agencies.

In addition to pledging a donation of up to $10 million in health care IT software to grant recipients, Intel and other partners will further assist grant recipients in the successful installation, training, and operation of health care technologies. Additional communities will be named as grant recipients by the Center for Community Health Leadership later in the year.

For additional information on the grant program from the Center for Community Health Leadership, please visit www.misyscenter.com. ▼

California launches hospital report card site

A new web site, www.CalHospitalCompare.org, enables Californians to compare the performance of more than 200 hospitals statewide on a variety of quality measures from maternity services to cardiac treatment.

The free service allows consumers to search for hospitals by location, name, or by medical condition. Hospitals are rated on 50 performance indicators, including patient satisfaction measures and specific conditions, such as heart disease, maternity, and pneumonia.

CalHospitalCompare is the result of a two-year collaboration by The California Hospital Assessment and Reporting Taskforce, whose members include hospitals, health plans, doctors and nurses, consumer groups, employers, and the California HealthCare Foundation (CHCF). The data collection and analysis was performed by the University of California at San Francisco's Institute for Health Policy Studies.

Beyond consumers, CalHospitalCompare is also intended to benefit health care organizations. The report card is intended to provide health plans with relevant information to make decisions about which hospitals to include in their networks and offers hospitals reliable data to help improve the quality of care at their facilities. Physicians, nurses, and other health care professionals can use the data to make referral decisions.

CalHospitalCompare will be updated regularly with new measures. Future enhancements will

COMING IN FUTURE MONTHS

- 'Value exchanges' support quality improvement through public reporting of cost and quality data
- Hospital considers releasing its Joint Commission survey report
- Award program recognizes nurses for going 'above and beyond'
- CMHS unveils proposal for hospital value-based purchasing

include a Spanish-language version and an expanding set of performance measures; specifically, pediatric and intensive care measures will be added later this year. ▼

Cost biggest barrier to health IT adoption

Hospitals continue to accelerate their use of health information technology, with 68% reporting that electronic health records had been fully or partially implemented as of fall 2006, according to the American Hospital Association's second annual survey of hospital health IT use.

About one-half of hospitals shared electronic patient data with others in both 2005 (53%) and 2006 (49%). Their most common partners included private-practice physician offices, laboratories, payers, and other hospitals.

Cost is the biggest barrier to greater adoption of health IT, with urban hospitals, teaching hospitals, and larger hospitals more likely to afford the investment, the survey found.

Forty-six percent of community hospitals reported moderate or high use of health IT, compared to 37% in 2005. Health IT use was determined by the number of clinical IT functions — such as medication order-entry, test results review, or clinical alerts — a hospital had implemented.

The AHA points out that while recent Department of Health and Human Services rules have lessened obstacles posed by the physician self-referral and anti-kickback laws, hospitals have been concerned that, under Internal Revenue Services rules, helping physicians access and use health IT could impact hospitals' tax-exempt status.

The latest indication from the IRS, according to the AHA, is that the new HHS rules would not jeopardize hospitals' tax-exempt status. ■

HHS starts medical response tool site

The U.S. Department of Health and Human Services has developed a new downloadable on-line diagnostic and treatment toolkit designed to help health care providers and primarily physicians provide medical care during a radiation incident. The toolkit, available at the Radiation Event Medical Management (REMM) web site (http://remm.nlm.gov), includes procedures for diagnosing and managing radiation contamination as well as guidance for using radiation medical countermeasures, and other information. Users also can register for automatic e-mail updates. Future plans include formatting the material for personal digital assistants. ■