

Healthcare Benchmarks and Quality Improvement

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Response is mixed on CMS value-based purchasing paper

Some question whether all ramifications have been considered

If the reaction to the options paper released by the Centers for Medicare & Medicaid Services (CMS) on value-based purchasing does anything, it points out clearly just how difficult — if not impossible — it will be to create a plan that makes everyone happy. The good news is there is still a lot of talking and responding to be done before the final plan is in place.

The options paper, (www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf) published April 12, was developed in response to the Deficit Reduction Act of 2005, which authorized CMS to develop an approach to value-based purchasing (VBP) for hospitals for fiscal year 2009. It includes chapters on:

- performance assessment model;
- translation of performance score into incentive payment;
- options regarding structuring incentive payments;
- VBP measures;
- transitioning from the current payment system to VBP;
- redesigning data infrastructure to support VBP;
- public reporting.

One of the more interesting reactions to the paper is that for once, government may actually be acting *too* quickly.

"This whole concept got integrated into public law before pay

Key Points

- While jury may still be out on P4P, for CMS it's clearly full speed ahead.
- Hospital association asks for more predictability in budgetary considerations.
- Issues arise over who will assist hospitals with data validation.

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for performance [P4P] had been thoroughly tested so, consequently, Congress jumped on the bandwagon before we had good data that showed its goals could actually be achieved," notes **Patrice L. Spath**, consultant with Brown-Spath Associates in Forest Grove, OR. "Now, CMS has to move ahead; they can't go back and say there is no value to it, or it has not achieved its intended goals. The hospital industry is stuck with it unless Congress goes back and changes the law."

Is P4P necessary?

One of Spath's main questions is whether, in fact, P4P is necessary to spur performance improvement. "Studies have shown, for example, that public reporting improves performance

and has really advanced QI in hospitals. So the question for me is: Is that enough by itself to enable us to achieve the quality goals we have set?" Spath poses.

AHA weighs in

In a letter to CMS, the American Hospital Association (AHA) made a number of comments. For example, it urged CMS to move cautiously to avoid any "unintended consequences that may adversely affect hospitals and the patients they serve." In addition, it voiced concern that some aspects of the program "do not ensure the transparency and predictability that hospitals need for budgeting purposes." Finally, it encouraged CMS to design a program "that ensures all hospitals, including those with a small number of reporting cases, have a fair opportunity to earn the financial incentives."

"We do a lot of work on sharing hospital data publicly as part of the Hospital Quality Alliance," notes **Nancy Foster**, AHA's vice president for quality and patient safety policy. "That sends a strong signal about what's important and where the opportunities [for improvement] are. Adding a payment link throws even more weight behind these things. We have found that pushing measures strongly has caused some organizations to respond by proactively ensuring that every potential patient that may be eligible for a certain treatment gets that treatment — but if you don't craft the measure carefully, you sometimes end up pushing [the wrong treatment for the patient]."

For example, she notes, there is a requirement for certain pneumonia patients in the ED to receive antibiotics within four hours. "This suggests to some hospitals that they may need to act before they know if the pneumonia the patient has is bacterial," says Foster. "What's important is striking that right balance, choosing measures wisely and making sure they do what they are intended to do."

Affects on budgeting

In terms of budgeting, she continues, "at the beginning of the year, you should have a reasonable way to expect what income you will have so you know what you are able to afford in terms of providing services. For example, will you be able to continue to run your [free] clinic if you are also taking a penalty on some of these quality measures?"

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Editorial Questions

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

But there are two sides to this issue, says Spath. “AHA says you need to tell us the target ahead of time, but if I’m a consumer, the target should be 100%,” she says. “However, if you’re a financial person and need to budget based on expected revenue, you do need some expectations.”

Spath says she agrees with the need for validation and predictability, “but when you tie it to money, it creates a whole different issue. Now, with Joint Commission or CMS measures, if you do not get the results back for six months, it’s no big deal. But here, if the results from last year are what next year’s payment is based on, you can’t fix [revenue] in the first six months. Still, the consumer would say if you’re always working to do the right thing, it shouldn’t matter what the lag time is.”

When it comes to smaller hospitals, says Foster, “the devil is really in the details.” The options paper, she notes, suggests there will be a pool of dollars created by withholding what might have been paid under the DRG system. “There are places in the paper where if you had fewer than 10 cases, a given measure might not work for you,” she notes.

“My issue is, should a patient expect the same level of quality in a rural facility as in a large urban one, and the answer really should be yes,” says Spath. “If you have an MI you should be put on a beta-blocker; shouldn’t that happen regardless of where you go? The trick is incorporating all payment incentives of score and structure, but the bottom line is the patient should get the same standard of care.”

How will data be handled?

The American Health Quality Association (AHQA) also has some issues with the options paper, says **David G. Schulke**, executive vice president. “It seems to capture what Congress was looking for,” he concedes. “But in the paper, CMS says it’s important for QIOs [quality improvement organizations] to continue to provide technical assistance to hospitals on quality improvement; but it will eliminate our support to hospitals in correctly submitting data.”

QIOs, he says, view that as connected with the help they provide to hospitals in terms of self-measurement. “A key part of that is assessing your own performance,” he says, “and that’s what CMS perceives — the link to validating hospital public reporting data.”

Hospitals, he notes, create files for people to

view on Hospital Compare, and receive a financial reward for doing it accurately. “The QIOs’ job today is to assist hospitals with ensuring that the data they submit are accurate, and when problems are spotted by auditors, helping hospitals figure out what they did wrong and how not to do it again,” says Schulke.

When hospital provider data are to be publicly reported, a small sample is validated by a clinical data abstraction center, or CDAC. “The CDAC, which is funded out of the QIO program, validates the data and sends them back to the hospital,” Schulke explains. “Then the QIO teaches the hospital how to eliminate any errors that were found.”

There is “quite a bit of interaction” between the hospitals and the QIOs, he continues. “But CMS proposes to treat these two functions in very different ways. It says we should continue to assist hospitals in improving, but remove our support in correctly submitting data.” For QIOs, he insists, these are seamless activities. “CMS, however, says it will give this function to a smaller number of contractors — and not necessarily QIOs.”

Using two different contractors, says Schulke, “probably introduces some inefficiencies.” Beyond this one issue, he says, “what CMS is trying to do with value-based purchasing is good.”

For Spath, this new stance of CMS raises an important question. “Who will go in and do validations?” she poses. “The more people who do the validation studies, the more unreliable the validation process becomes — and since it is tied to payment, the validity of the data becomes even more important.”

Spath says there must be some logic behind the decision. “Hospitals might have somebody new to interface with; the question is, if CMS is already paying for this function and QIOs are doing it, why have they chosen not to use this pre-existing framework? They may not be all that pleased with what some QIOs are doing. My bet is it will still be done by QIOs, but only those who have had a consistent track record.”

Spath notes that CMS also is talking about having a repository for reporting adverse events. “This will be a contract that may be let to QIOs,” she offers.

Looking ahead

Spath says that for quality managers, the options paper reinforces the inevitability of P4P.

“It means this is the way it will be, and therefore, it will be very important to have good quality data that are accurate and timely,” she says. “You need to do your own internal validation studies; you need to look at ways to capture the data electronically as much as possible. In fact, you almost have to have a little process improvement project for each of these measures to see how you can make improvements. Measures are the right thing to do, but you’ve got to control your processes in your own organization.”

Where do we go from here? “CMS has taken input and written comments, with an open session to be held on June 12,” Foster notes. “It will be incorporating changes based on those comments into a final proposal, which we believe will go forward to Congress in the middle of the summer.”

At the same time, she says, the Medicare Payment Advisory Commission is working on its own proposal. “All of that then gets sent to Congress for further deliberation,” she explains.

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‘Value exchanges’ next step in HHS QI initiative

Goal is person- and population-centered health

The Department of Health and Human Services (HHS) has unveiled a new phase of its Value-Driven Health Care Initiative, an undertaking with several components all designed to support QI through public reporting of cost and quality data.

The voluntary plan calls for the development of “value exchanges,” which HHS describes as “nationally chartered, local collaboratives that

would become part of a nationwide system using nationally recognized standards to measure and improve quality of care at the community level.”

These value exchanges are considered “advanced” versions of the community leader collaboratives selected and chartered by HHS. While the final form (and who it will comprise) has not yet been determined, HHS anticipates that pre-existing collaboratives will be at the core. In order to receive a value exchange charter, says HHS, candidates must be independent, nonprofit, local organizations that are:

- recognized as a community leader;
- actively engaged with critical local stakeholders;
- financially sustainable;
- facilitating the collection of provider-level measurements across the Institute of Medicine’s six aims;
- using or promoting performance measures for public reporting of cost and quality, rewarding better care, quality improvement, and interoperable health IT;
- fostering collaboration and information sharing;
- supporting knowledge transfer;
- conducting ongoing evaluation and improvement efforts;
- using national performance measures effectively.

“We haven’t designated [any value exchanges] yet,” says Nancy Wilson, MD, MPH, senior advisor to the director of the Agency for Healthcare Research and Quality (AHRQ). AHRQ will administer and maintain the national learning network, which will provide expert faculty, tools, resources, and web-based communications to members of the exchanges to facilitate expansion and sharing of QI techniques.

Wilson notes that the Federal Register has just published a notification of a 60-day period for public comment. “Then we will post RFPs [Requests for Proposals] to apply — hopefully, by Sept. 1,” she says.

Explaining the vision

As for the vision behind the value exchanges, “I would say the goal is really enhancing person- and population-centered health by improving quality health care services and reducing costs,” says Wilson, adding that “thinking about the person and the population is a bit different than

Key Points

- New structure will be available for public reporting of cost and quality data.
- Learning network will provide resources for education, information sharing.
- All stakeholders must work cooperatively to optimize patient value, quality.

has been done historically; we have not always tried to operationalize QI work around that notion.”

The other piece of the goal, she continues, is for employers, health plans, providers, consumer groups, and all stakeholders to work together to improve health care value for patients. “Historically, providers and hospitals have been leaders in QI,” she says. “What we are suggesting is that we can make some breakthrough improvements by engaging all stakeholders in the community.”

This effort, she explains, operates on some underlying assumptions. “We really think that greater transparency of this information will improve consumer selection of providers and management of health, and will also accelerate QI by providers — if they think in terms of comparative performance information,” Wilson asserts. “And, having more information in the marketplace is really going to allow insurance plans to design benefits and payments [around more efficient use of health care services]. Personally, for example, it would be great if plans provided some sort of discount or benefit that incentivized folks to do prevention.”

Many stakeholders involved

Following this model, the value exchange is, in essence, a multi-stakeholder coalition, Wilson explains. “These are the folks at the table; their authority is by consensus — and it is voluntary. We are encouraging local stakeholders to sit down together, agree on a common goal, commit energy and resources to that goal or goals and measure how well they perform.”

Hospital quality managers, she continues, “have a critically important role to play. They are the folks who have the tools for QI, and in general it is the providers who need to come up with the recommendations for what makes sense for the redesign of health care. After all, they understand how to improve the system of care.”

What’s important for hospitals to recognize, she says, is that there is a great need and value for the hospital community to look beyond its borders and work for patient value across care settings. “Yesterday I attended a breakout session where a hospitalist was giving a presentation about palliative care and the importance of working across settings so that patients at the end of life who truly wanted to be in the hospital were in the hospital but those who preferred other support systems would have those as well,” Wilson shares. “There are multiple examples of how we can improve value for patients.”

One of the problems in the past, she notes, had been focusing only on improving quality and lowering costs for a particular stakeholder. “That does not always pan out,” says Wilson. “We have to think more as a county, for example, and find the win-win for the hospital, the patient, and so forth.”

The common goal that unites employers and plans with providers and consumer groups, Wilson says, is value for the patient. “That’s really critically important,” she observes. “Historically, employers and plans have been perceived by providers as simply emphasizing cost, and provider groups have been perceived as working to improve quality without considering cost. We do not have the luxury of having stakeholder groups going off in parallel — we need everyone at the table. We are very clearly stating that quality is local, QI is local, and success requires local stakeholders committed and working together.”

[For more information, visit the HHS transparency web site: www.hhs.gov/transparency, or contact Nancy Wilson at (301) 427-1310.] ■

Study shows best practices do improve outcomes

Randomized study shows where improvement needed

One of the most challenging issues for quality managers is demonstrating that best QI practices can actually improve outcomes. Demonstrating such success requires a good deal of time and resources. In light of this challenge, the results of a new study published in *JAMA* should be good news, indeed.

Key Points

- Improvement seen not only among inpatients, but also in six-month outcomes.
- Core measures, linkage of performance to reimbursement are important factors in improvement.
- Eliminate errors by creating systems in which your staff can't fail.

The article, based on data from the Global Registry of Acute Coronary Events (GRACE) study, which has collected data from 44,372 patients treated at 113 hospitals in 14 countries, shows a correlation between a period during which hospitals increased use of certain drugs, tests, and procedures that have been proved to help reduce the immediate and long-term impact of acute heart problems, and a significant drop in the rate of heart failure and death. People who suffer a heart attack or severe chest pain today are much less likely to die or to experience long-lasting effects than their counterparts even a few years ago, according to the study.¹

All of the patients studied had suffered either an ST-elevated myocardial infarction (STEMI) or had acute coronary syndrome (ACS), which includes non-STEMI heart attack and unstable angina. Between 1999 and 2006, the use of drugs such as aspirin, statins, glycoprotein IIb/IIIa inhibitors, clopidogrel and heparin, and ACE inhibitors increased markedly. At the same time, the use of angiography and angioplasty as an emergency or secondary treatment to reopen blockages increased by more than 30% in STEMI patients and about 20% in ACS patients.

"I think the most significant finding was the magnitude of improvement in both inpatient and six-month outcomes that reflect the global effort to provide more rapid reperfusion for ST-elevation MI and a steady migration to using acute angioplasty as an approved method to open occluded arteries, and the remarkable impact on inpatient heart failure and stroke that was maintained after six months by getting patients on evidence-based therapies after leaving the hospital," says **Kim Eagle**, MD, FACC, a co-author of the paper and co-chair of the publication committee for GRACE, and director of the University of Michigan Cardiovascular Center in Ann Arbor.

A 'remarkable transformation'

Eagle notes these findings mirror a recent progression toward greater use of evidence-based practices. "Professional societies began creating guidelines 30 years ago, and 20 years ago we started having important randomized trials that suggested improved outcomes, but as recently as 15 years ago, studies said doctors were not using their own guidelines," he notes. "In the last 10

years we've seen a multi-faceted effort at trying to make sure these key therapies are available to every patient we treat."

Today, he continues, "we are being asked to show this through core measures, and, in some cases, it affects the way reimbursements are parceled out. This reflects quite a remarkable transformation that we're in."

While he was careful about calling this paper one of the first studies to show that following best practices leads to better outcomes, Eagle offered that: "This is one of the largest studies [of its kind] in the world. This is observational, taking the average patient who presented to one of 115 hospitals [with one of these conditions] and a six-month follow-up. It suggests if we do a good job at the point of discharge, we will do better downstream as well, and that is very gratifying."

Eagle says the study also underscores that in the early treatment of ACS "the evidence that reperfusion with balloon whenever available is beneficial is compelling. And this study shows that in real-world experience, the benefit may even exceed what we saw in the trials. Second, we cannot underestimate the additional benefit on other outcomes, such as heart failure and stroke."

Making failure impossible

Despite the encouraging results, there were also disappointments. For example, the percentage of patients receiving reperfusion therapy has not increased significantly over time. Eagle also notes that only 85% of STEMI patients and 83% of ACS patients in the study received a statin in 2006, when virtually all such patients should receive the cholesterol-lowering drug.

"I'm convinced all cardiovascular caregivers want to give the best care, but the ideal solution is to create systems where we can't fail; build into your systems reminders of those

things you always want do," says Eagle. "If we get more systematic, it's amazing what we can do."

So, for example, at the point of discharge the University of Michigan has created a system where every quality measure is gone over and explained. "For example, if the patient is not on blood pressure medicine, we have documented why they are not," Eagle explains.

Tracking the patient's experience is also important, he continues. "For example, if a patient's heart rate is 50 when they are admitted, they would not get a beta-blocker; but when they are discharged and it is 80, they are now eligible. However, this could potentially get omitted unless there is a system of review."

There could be simple human errors, such as forgetting to tell a patient they need to stay on aspirin or not writing a prescription because it can be purchased over the counter. "Those kinds of simple little omissions can have a big impact when you are treating a large population," Eagle notes.

The program at the University of Michigan starts with standardized orders, key early strategies, and at the point of discharge, a document called a contract that both the nurse and the patient sign. "It basically goes over key lifestyle goals, key pharmacological drug goals, and tries to ensure a clear follow-up plan that includes the patient knowing what to do if they get recurrent symptoms," Eagle explains.

When the chart is coded, the discharge coders also review the notes and if they pick something up, the doctor is immediately notified and can call the patient to correct the information.

"So, we have three levels of correction," says Eagle. "We've shown when we use this layered redundancy we substantially improve quality indicators to almost 100% of patients, and we have a significant impact on six-month recurrent MI and death."

The three keys to success, he continues, are clear quality goals, a simple way to track performance, and a feedback loop to make sure they are adhered to. "We send a quality measures report card to our doctors and nurses every month," he reports. "The future of quality is to guarantee, rather than say we are trying."

A few years ago, he notes, "We stopped asking the question, 'How can we get better?' We started asking, 'How can we make sure we never miss?'"

[For more information, contact Kim Eagle, MD,

FACC, Director, University of Michigan Cardiovascular Center, Ann Arbor, MI. Phone: (734) 936-5275.]

Reference

1. Foyx KAA, Steg PG, Eagle KA, Goodman SG, et al. Decline in Rates of Death and Heart Failure in Acute Coronary Syndromes, 1999-2006. *JAMA* 2007; 297:1,892-1,900. ■

WHO unveils patient strategies to redesign care

Joint Commission bodies coordinate effort

The World Health Organization (WHO) has published nine strategies aimed at assisting member states in the redesign care process to prevent human errors in patient care. The strategies, developed by WHO's Collaborating Centre for Patient Safety Solutions, include:

- **Look-alike, sound-alike medication names:** The recommendations focus on using protocols to reduce risks and ensuring prescription legibility or the use of preprinted orders or electronic prescribing.
- **Patient identification:** The recommendations emphasize methods for verifying patient identity, including patient involvement; standardization of identification methods across hospitals in a system; patient participation; and use of protocols for distinguishing the identity of patients with the same name.
- **Communication during patient hand-overs:** The recommendations include using protocols for communicating critical information; providing opportunities for practitioners to ask and resolve questions during the hand-over; and involving patients and families in the process.
- **Performance of correct procedure at correct body site:** The recommendations include a pre-operative verification process; marking of the operative site by the practitioner who will do the procedure; and having the team involved in the procedure take a "time out" immediately before starting the procedure to confirm patient identity, procedure, and operative site.
- **Control of concentrated electrolyte solutions:** The recommendations address standardization of the dosing, units of measure, and terminology; and prevention of mix-ups of spe-

cific concentrated electrolyte solutions.

- **Assuring medication accuracy at transitions in care:** The recommendations address creating the most complete and accurate list of all medications the patient is currently taking; comparison of the list against the admission, transfer and/or discharge orders; and communication of the list to the next provider of care whenever the patient is transferred or discharged.

- **Avoiding catheter and tubing misconnections:** The recommendations address the need for meticulous attention to detail when administering medications and feedings (i.e., the right route of administration), and when connecting devices to patients (i.e., using the right connection/tubing).

- **Single use of injection devices:** The recommendations address the need for prohibitions on the reuse of needles at health care facilities, periodic training of practitioners and other health care workers regarding infection control principles, education of patients and families regarding transmission of blood borne pathogens, and safe needle disposal practices.

Sharing knowledge

While many of the topics and strategies are familiar to quality managers and patient safety officers in the United States, several of the strategies were influenced by international experts participating in the process, says **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission. It is The Joint Commission and The Joint Commission International that were named as the Collaborating Centre, or, as Angood puts it, a “Center of Excellence.”

“We have developed these ‘solutions’ with the help of a couple of different groups we use as external advisors for vetting — including an international steering committee,” he explains. In addition, Angood says, there are three

regional advisory groups — Europe, Asia Pacific, the Middle East — and there will eventually be five. “In addition, there are three other expert panels — for communication, medication safety, and patient/family involvement,” he notes.

WHO’s Alliance for Patient Safety, he adds, has been active for more than two years, and includes a number of different topic areas. “Since the start-up, our recommendations have been based on review data from our own sentinel event database and National Patient Safety Goals program, and other international safety organizations,” Angood explains. “We presented a variety of topics to our steering committee and eventually focused on those nine topics.”

The draft solutions were vetted through the advisory groups and expert panels, followed by an extensive Internet-based survey (field review). “The recommendations were revised based on all that input, and re-presented to the steering committee for approval, and then released,” says Angood.

All of the recommendations are designed with a similar template — that is, the same topic areas are found within each solution — and “are basically meant to highlight and profile issues and general strategies that could be used to address the problems,” says Angood. “We have stopped short of specific implementation protocols because it would have been really complex to simultaneously disseminate information and try to evaluate if there had been any impact.”

(The complete patient safety solutions can be found at: www.jointcommissioninternational.org/solutions.)

What was learned

Angood says that while The Joint Commission saw many of its standards validated through the process, there was also new and valuable knowledge gained. “Patient safety problems are fairly uniform around the globe, and we found that our National Patient Safety Goals program and standards are pretty solid overall, but there are differences and other areas within these topics that other countries have addressed differently,” he says.

For example, notes Angood, the UK has done a good deal of work focusing on avoiding catheter and medical tubing missed connections. “African countries have taught us a lot about

Key Points

- Recommendations based on sentinel event data, National Patient Safety Goals, international safety organizations.
- Implementation protocols will be focus of next phase of initiative.
- International input offers new approaches to catheter connections, single injection devices.

injection safety and the use of single injection devices."

As a result of these new insights, "we've learned from these and they will be incorporated into our solutions," says Angood. "Our attitude, after all, was to learn as much as we could and be as all-encompassing in the development of solutions as we could. We did *not* promote America-based strategies."

Quality managers, he says, will find The Joint Commission web site on these findings a valuable resource, "not only the preamble but the nine strategies and 'Access to Patient Safety Goals.' It could help improve their own patient safety strategies," Angood offers.

As for the future, Angood says the center is in the process of getting an implementation test pilot project off the ground. "We will take five of these solution topics, with the goal of organizing far more specific protocolized approaches to solutions, and implement those into at least seven different countries through technical lead agencies," he reports. "We will then implement them into at least 10 health care facilities in these countries, and we will evaluate sentinel event activity, do root cause analyses, collect patient safety indicator data, culture of safety information, and economic data. We will learn from all of this what works and what doesn't."

[For more information, contact Peter Angood, MD, Vice President and Chief Patient Safety Officer, The Joint Commission. Phone: (630) 792-5000.] ■

PA partnership publishes IT recommendations

Public-private coalition unveils four-phase plan

The Pennsylvania e-Health Initiative (PAeHI), a public-private coalition, has unveiled a set of health information technology recommendations designed to improve the quality of Pennsylvania's health care and reduce costs, while giving patients improved access to their own health care information.

In a statement that accompanied the release of the report — "Connecting Pennsylvanians for Better Health: Recommendations from the Pennsylvania eHealth Initiative" — the coalition outlined two major goals: "evolving electronic patient health

records to a uniform format for all health care providers, and outlining in detail how the Commonwealth can assist in the development of local approaches to create an integrated statewide health information network." The entire report can be found on-line at www.paehi.org/Documents/PAeHI%20Better%20Health%20Report%204-25-2007.pdf.

"Essentially, [electronic transmission] is a way health care information can be accessible to providers so that they can be better enabled to provide care than they are through a paper chart," says **Martin Ciccocioppo**, MHA, MBA, PAeHI board chairman and vice president, research with The Hospital & Healthsystem Association of Pennsylvania. "In the inpatient setting, you do not have the problem of different departments wanting to hold the paper chart, since everyone will have access to a common electronic record."

In addition, he notes, there are now a wide variety of reporting requirements providers need for reviewing quality, and having electronic data available makes it easier for hospitals to report on outcomes and for providers to follow up on situations that need immediate attention, such as the recall of individual medications. "You can easily go into the system, put in a query, and identify in seconds what was taken by whom in the last few hours or days," he says.

Some of the immediate actions planned by PAeHI include:

- development of a marketing and education plan for "Connecting Pennsylvanians for Better Health;"
- creation of a consumer brochure providing information about "Connecting Pennsylvanians for Better Health" and health information exchange;
- development of resource guides and tools for local health information exchanges;
- formation of a task force to study existing Pennsylvania state laws (e.g., privacy, security, medical records) and making recommendations on needed changes to encourage the widespread adoption of electronic health records (EHRs);
- coordination with the Commonwealth to develop a request for proposal process for local health information exchange funding.

The ultimate goal, Ciccocioppo says, "is to make a complete personal health record available to individual patients so they can take better care of themselves."

Common goals

The coalition got its start three years ago when several different organizations realized they had common goals when it came to promoting a health information exchange within the state, recalls **Donald F. Wilson**, MD, chairman of the PAeHI communication and education committee and medical director of Quality Insights of Pennsylvania, the state's QIO. "We had some discussions with the Pennsylvania Medical Society," he says. "We were starting our new contract with CMS and part of that contract was to promote health information exchange within our state. In my discussions with them, I found it was part of their strategic plan, too."

Very shortly thereafter, he says, they decided to bring in The Hospital & Healthsystem Association of Pennsylvania "And together we became the founding members.

"Basically, after [our discussions and after] the president announced his executive order (in 2004) to have all U.S. citizens have a personal health record in 10 years, we had an invitational meeting for healthcare stakeholders — 40 organiza-

Key Points

- Long-term goal is a statewide regional health information system.
- Partners assert that electronic health information exchange will promote safety and efficiency.
- Eventually, all citizens in the state will have complete personal health records available electronically.

tions in all — in the winter of 2005," adds Ciccocioppo. "We considered whether there was a need to have a statewide coordinated effort to educate providers and policy makers; as a group we determined very quickly that there was, and by September 2005 we had our bylaws and were incorporated."

One step at a time

The long-term goal of the coalition is to create a statewide regional health information exchange, or RHIO. "We want to have connectiv-

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ity across the state," says Wilson. "And everybody wants to jump to that, but we've seen what happened in other areas, and we're going to start with smaller steps."

Just what are those steps? "We see ourselves, for one thing, as being educators — for both providers and consumers — on the importance of having an exchange implemented across the system, then, to work with and foster efforts that are sprouting up locally within health care systems," Wilson says.

There are several systems, such as Geisinger Health System, that already have impressive electronic health information exchanges under way, he notes. "What we see ourselves as is a neutral convener for these folks to come together, so they are not doing anything as an isolated entity," he explains. "Then, as they start developing their plans, eventually they will be able to 'talk' with each other." In addition, he says, he is looking at the development of statewide standards "to hopefully meld with what will probably happen nationally."

Why is it so important to achieve what PAeHI has laid out? "For one thing, just to have the ability to get physicians to implement EHRs is critically important for patient safety as well as efficiency — like avoiding duplicate tests," says Wilson. "Basically, most of the Medicare folks we deal with see as many as 10 doctors a year and none of them know what the rest are doing. That's why it's important to have that connectivity."

Ciccocioppo says that the progress to date is impressive. "To this point, participation has been completely voluntary," he notes. "What we've been able to accomplish over two years is pretty remarkable; we not only have the three lead organizations, but there are now over 160 organizations participating."

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Donald F. Wilson, MD, Medical Director, Quality Insights of Pennsylvania. Phone: (877) 346-6180, ext. 7802.] ■

NEWS BRIEFS

AHRQ: Good news, bad news on gender discrepancies:

Although there are signs of improvement in some conditions, differences in the quality of health care provided to men and women continue to persist, according to the latest News and Numbers from the Agency for Healthcare Research and Quality (AHRQ).

The good news is that:

- In 2004, about as many women with Medicare (85%) received recommended care in the hospital after a heart attack as male Medicare patients (86%). As recently as 2002, only 79% of female Medicare patients received the recommended treatment after a heart attack, compared to 81% of male Medicare patients. Heart disease is the leading cause of death among both women and men.

- Women were more likely than men to have a usual source of ongoing health care in 2004 (90% compared with 83%). Across all income level groups and for most racial and ethnic groups, women reported having a usual source of ongoing care more often than men. A usual source of care is associated with lower costs and improved health outcomes.

However, there is bad news:

- Women were more likely than men to be hospitalized for high blood pressure in 2003 — 56 vs. 38 per 100,000 population. Hospitalization for high blood pressure can usually be avoided if patients have good quality primary care.

COMING IN FUTURE MONTHS

■ 'Wakeup call' from Joint Commission survey spurs hospital to change processes

■ Cross training will enhance respiratory care in the wake of a disaster

■ Why do many organizations measure the wrong quality criteria?

■ AHRQ issues landmark handbook on use of patient registries

• Women age 50 and older were less likely than men to receive recommended colorectal cancer screening — 50% percent compared with 54% percent in 2003.

• There are disparities among women by race and ethnicity. For example, although only half of all white women are screened for colorectal cancer at age 50 or older, among Hispanic and black women the rates are even lower — 38% and 44%, respectively.

• Only 71% percent of American Indian-Alaska Native, 76% of black, and about 78% of Hispanic women start prenatal care in the first three months of pregnancy, compared with 86% of white women.

These data were derived from the “2006 National Healthcare Quality Report” and the “2006 National Healthcare Disparities Report,” which measure the quality of health care across America in four areas — effectiveness of health care, patient safety, timeliness of care, and patient centeredness. ▼

Phone-based therapy eases depression

When people receive brief telephone-based psychotherapy soon after starting on antidepressant medication, strong positive effects may continue 18 months after their first session. So concludes a group health study in the April *Journal of Consulting and Clinical Psychology*, which followed close to 400 patients.

Long-term positive effects of initially adding

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phone-based therapy included improvements in patients' symptoms of depression and satisfaction with their care. At 18 months, 77% of those who got phone-based therapy (but only 63% of those receiving regular care) reported their depression was “much” or “very much” improved. Those who received phone-based therapy were slightly better at taking their antidepressant medication as recommended, but that did not account for most of their improvement. And effects were stronger for patients with moderate to severe depression than for those with mild depression.

As is usual in clinical practice, the patients' primary care doctors diagnosed their depression and prescribed their antidepressants. Half of the patients also received eight sessions of telephone psychotherapy during the first six months, then two to four “booster” sessions in the second six months as well as medication follow-up and support from master's-level therapists.

The patients and therapists never met face to face, only over the phone. Therapists followed a structured protocol for psychotherapy. They encouraged the patients to identify and counter their negative thoughts (cognitive behavioral therapy), pursue activities they had enjoyed in the past (behavioral activation), and develop a plan to care for themselves.

Few of the patients who received phone-based therapy — even fewer than those who did not receive it — sought in-person therapy. ■