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CMS unveils proposed list of 'no-payment' conditions

Observers say greatest impact will be on coding and documentation

As the Centers for Medicare & Medicaid Services (CMS) began unveiling the details of is value-based purchasing plan (see the cover story in the July 2007 issue of *HBQI*), knowledgeable observers were waiting for the "other shoe" to drop. Well, now it has.

In a proposed rule, published in the May 3 *Federal Register,* CMS suggested eliminating hospital reimbursement for a group of preventable complications. (Under Section 5001(c) of Public Law 109-171 [the Deficit Reduction Act of 2005], the secretary of the Department of Health and Human Services must select by Oct. 1, 2007, at least two hospital-associated medical conditions for which hospitals will not be paid.)

In the proposed rule, CMS identified 13 conditions that may be included on the non-payment list:

- catheter-associated urinary tract infections;
- pressure ulcers;
- serious preventable event — object left in surgery;
- serious preventable event — air embolism;
- serious preventable event — blood incompatibility;
- *Staphylococcus aureus* septicemia;
- ventilator-associated pneumonia;
- vascular catheter-associated infections;

Key Points

- CMS identifies 13 different conditions that may eventually be included.
- Quality managers take on even greater importance in light of new proposal.
- Accurate, timely documentation will be a key to optimizing reimbursement.

• *Clostridium difficile*-associated disease;
• MRSA;
• surgical site infections;
• serious preventable event — wrong surgery/wrong patient/wrong body part;
• falls.

The first six conditions are being considered by CMS for "initial" implementation, which is set to begin Oct. 1, 2008; the other seven conditions may be future candidates, but CMS says additional development and research is needed before a final decision is made. According to CMS, all six conditions identified as eligible for initial implementation are either high volume, high cost, or both; largely preventable by following established guidelines; and identifiable using ICD-9 codes.

Observers, by and large, do not object to the principle behind this decision; they recognize that many hospital-associated infections (HAIs), for example, are preventable. They are, however, concerned with how difficult it might be to demonstrate that certain conditions existed upon admission — and to clearly document the finding so as to ensure reimbursement.

Indeed, this move could have a significant impact on hospital revenues. For example, at the first annual serious event report by the Indiana Patient Safety Center, presented April 11, the following were the most frequently reported events:
• stage three or four pressure ulcers (23% or 29%, respectively, of reports);
• retained foreign object (21% to 27.3%);
• wrong site surgery (9% to 11.7%);
• death or serious disability from medication error (6% to 7.8%).

A 'watershed' in thinking

"This is a fascinating issue and a complicated problem," says **David B. Nash**, MD, MBA, chairman of the department of health policy, Jefferson Medical College in Philadelphia. "Here's what we know, and what we don't know: Clearly, sepsis is a hospital acquired infection and the result of a failed process. Run-of-the-mill [urinary tract infections] without sequallae clearly could be a failed process, and especially with certain patients who may be predisposed to it. An infected Foley [catheter] is a failed process, but you can get [infections] other ways.

"We have research evidence today that, in general terms, the majority of hospital-acquired infections are not the result of severity of illness on admission, but are the result of multiple failed processes," he continues. "This marks a watershed in our current thinking about HAIs."

In the past, Nash explains, such infections were viewed as a toxic byproduct of day-to-day work in the hospital — "smoke up the smokestack," if you will. "But there are hospitals with zero central line-associated blood infection rates," he notes. "If they can achieve 0%, that's proof it is process, process, process. In other words, we can have a 'smokeless factory.'"

But by withholding reimbursement in certain cases, while rewarding hospitals financially in other cases, isn't CMS "giving with one hand and taking with the other?"

"That is correct," says Nash. "But it is the avowed intent of the Department of Health and Human Services that this be budget-neutral."

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Editorial Questions

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(Here's more bad news: Pay for performance may not be as great an incentive as first thought. See story, p. 88.)

"It's still a form of P4P — or, if you will, no pay for no performance," asserts **Patrice L. Spath,** of Brown-Spath & Associates in Forest Grove, OR. "I view the whole transparency issue as a form of P4P — hospitals fear losing market share if consumers see their performance is not as good as someone else's."

Worried about coding

Attendees at a recent industry meeting in Nashville, TN, were more concerned about coding problems associated with the proposal than the actual issue of prevention, notes Spath. "It seemed the issue they were most concerned about was coding, because of how hard it is to know if something is present on admission," she notes. "If it is not documented at the time but is documented later on, it will look like something that the hospital caused."

For example, she notes, if a patient comes to a hospital from a nursing home with an infection, but does not become symptomatic until three days later, "it looks like we're responsible."

Which, from the clinician side, does raise the question of whether all of these infections are truly preventable, says Spath. "It's a difficult barrier to overcome," she asserts.

Deborah K. Hale, CCS, president of Administrative Consultant Service LLC, a Shawnee, OK-based company that assists hospitals with clinical documentation improvement and quality issues, agrees. "One of the biggest issues is making sure the patient had the condition when they came in, and it's not an easy thing to do — there is usually very poor documentation," she notes. "When a patient is admitted for pneumonia, for example, there is very little documented about early skin breakdown, so it will look like it was not present on admission and count against the hospital."

In addition, Spath says, several years ago The Joint Commission quality standards "Said 'measure your performance, and do not do anything [else] until you reach a trigger threshold.' It's very much ingrained in the health care profession that a certain amount of people will get infections, and it's difficult to overcome that mindset."

But overcome it they must if they are going to optimize reimbursement, say observers — especially as the coding challenge deepens. "It's more than likely that hospitals will experience a financial impact," says Hale.

She notes that 80% of all Medicare discharges now have a CC (comorbidity and complication) condition secondary diagnosis that has been statistically shown to increase length of stay at least one day in at least 75% of patients. "With a CC, that currently means a substantial increase in the hospital's reimbursement because of a secondary diagnosis," says Hale. That will continue to be true, she notes, but the definition of a CC likely will be more limited.

Looking at the proposal, and at the move to a severity-adjusted DRG, Hale makes the following comparisons:

- While there are currently 3,326 codes on the CC list, the revised CC list will have only 2,583;
- Under the current CC list, 77.66% of patients have at least one CC; under the revised list, that figure would drop to 40.34%;
- Under the current CC list, 22.34% have no CC; under the revised list, 59.66% would have no CC;
- Under the current CC list, the average charge for patients with one or more CCs is $24,538; under the revised list it would be $31,451;
- Under the current CC list, the average charge for patients with no CC is $14,795; under the revised list it would be $16,215.

This move to a severity-adjusted DRG methodology, adds Hale, "is part of the whole value-based purchasing program." Hale agrees that CMS seems to be giving with one hand while taking with another. "That's really accurate — if you could have prevented [the condition]," she says. "Basically they're saying, 'We will not pay you for things you caused.'"

The burden, she emphasizes, comes all the way back to the hospital. "It's all about documentation being accurate on admission, and doing the preventive care that is needed," she says. "CMS said in the proposed rule they believed hospitals would make a much greater effort to evaluate these patients more closely on admission to determine whether or not there is evidence [of infection upon admission]."

Great role for quality manager?

Hale and Nash believe this new reality will increase the importance of the quality manager. "This moves the work of the quality manager front and center," Nash asserts. "There is an immediate new economic implication; every CEO now has a deep and abiding interest in measur-

ing and improving quality, so the quality manager is more important than ever."

"This certainly will put more importance on what quality managers do because the hospital has potential to lose money," adds Hale. "The key will be that the quality manager or case manager will need to make sure those patients who have these conditions are adequately documented as they present on admission. If they are, there will be no payment penalty. If the condition develops during the course of their hospital stay, there will be."

"If anything has the potential to affect the financial side with quality of care, that naturally raises the importance of quality and patient safety," says Spath, but she notes that the focus should not be on the quality manager alone. "I use the phrase, 'It takes a team,'" says Spath. "It can't just be the quality manager who owns the responsibility — just like it's not just the quality manager alone who is responsible for compliance with CMS measures or Joint Commission standards." While quality managers often are the facilitators of the team that gets together to work on improvement, notes Spath, "It can't be solely owned by them."

The same goes for accurate coding, she continues. "While they may be expanding the DRGs, it really does not matter what the external pressures are; good documentation takes a team," says Spath. "They could add more codes, or take some away, but there are some basic fundamentals of good documentation, as well as evidence-based practices to limit the likelihood of these things occurring."

People had better pay close attention to this issue, she warns, because the CMS proposal is likely just the first of many. "If Medicare starts to do this, other insurers will start to as well," she predicts.

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Study casts new doubt on effectiveness of P4P

Study in JAMA *compares two groups of hospitals*

Does a pay-for-performance (P4P) approach to quality improvement really work? A new study in the June 6 issue of *JAMA* raises some serious questions as to whether it provides a superior incentive for hospitals to improve their performance.[1]

For the purposes of the study, the authors chose to compare two groups of hospitals: one that participated in the highly touted Demonstration Project by the Centers for Medicare & Medicaid Services (CMS) — the largest pay-for-performance pilot project to date in the United States; and one group that did not.

"Prior studies had come out, and using Premier [CMS' partner in the project] data had shown that care had improved since the beginning of the pilot," notes **Eric D. Peterson**, MD, MPH, director of cardiovascular research at the Duke Clinical Research Institute in Durham, NC, and one of the article's authors. "It had been contented that the data showed the program alone was highly successful, but obviously other things had been going on at the same time. So it was not clear how much of the improvement was a direct result of the pilot project."

Peterson says the *JAMA* study adopted "a more classic control design" to see whether hospitals that had enrolled in a national voluntary quality initiative — Crusade 400 — but did not participate in the CMS project improved at a similar rate (All of the hospitals studied were part of Crusade 400; only a small percentage also participated in the CMS project.) The Crusade 400 collaborative collected clinical information on patients admitted with acute coronary syndrome (ACS) and participants received quarterly feedback, plus a series of other QI tools.

The study included an analysis of data for 105,383 patients with acute non-ST-segment elevation myocardial infarction. Patients were treated between July 2003 and June 2006 at 54 hospitals in the CMS program and at 446 control hospitals. The main outcome measures were the differences in the use of ACC/AHA Class I guideline-recommended therapies and in-hospital mortality between pay for performance and control hospitals.

The researchers found that composite measure

Key Points

- CMS participants also targeted measures that were not financially rewarded.
- Both groups showed improved outcomes — at similar rates.
- Higher incentives might make P4P even more attractive.

scores for CMS processes showed significant improvement at both pay-for-performance and control hospitals. There was no significant difference in the rate of improvement in the composite score between the two hospital groups. Two of the six CMS measures, aspirin prescription at discharge and smoking cessation counseling, had slightly higher rates of improvement at pay-for-performance hospitals than control hospitals. For composite measures of heart attack treatments not subject to incentives, rates of improvement were not significantly different. There was a slight reduction in the mortality rates over time at both pay-for-performance and control hospitals, although the difference in the rate of the reductions between the groups was not statistically significant.

Posing key questions

Peterson said that he and his fellow researchers sought the answers to three key questions:

- Would the hospitals that participated in the CMS pilot project show greater improvement in the CMS performance measures?
- Would participants in the pilot project only worry about the measures that were to be rewarded, and perhaps pay less attention than they should to other important measures?
- What would the actual impact be on patient outcomes?

"All of the hospitals improved over time," notes Peterson. "We could not find an incremental benefit of the P4P relative to those who were not in it, so this was kind of a negative finding."

The "good news," he continues, is that the researchers did not find any harm arising from the P4P project. "Those hospitals did just as well in the adoption of newer therapies that were not part of the CMS 'package,'" Peterson reports. "We also found out overall that as hospitals got better with their care, the outcomes got better — and at a similar rate [among the two groups of hospitals]."

Peterson's overall conclusion: "We did not find that P4P had a large incremental impact on care or outcomes."

This is not good news for the proponents of P4P, to be sure. "I think, at least in its current iteration, P4P may not be the ultimate panacea for quality improvement," Peterson asserts. "Hospitals that are committed to doing quality improvement generally improve with or without this financial incentive."

All hospitals, Peterson contends, are truly interested in QI and in receiving feedback on their progress. "My general recommendation would be for the government to create incentives for all hospitals to be engaged in quality improvement and get feedback on their progress, but whether a financial incentive should be tied to it is unclear," he says. "At least in its current iteration in terms of the amount or the ways of paying for hospitals and health systems to improve, it does not seem to be changing hospital or physician behaviors."

A larger financial incentive, he concedes, "could have a larger effect. Or, you could use funds simply to pay for participation in the program."

Reference

1. Glickman SW, Ou F-S, DeLong ER, Roe MT, Lytle BL, Mulgund J, Rumsfeld JS, Gibler WB, Ohman EM, Schulman KA, Peterson ED. Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction. *JAMA*. 2007; 297:2,373-2,380.

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Health systems form 'Safest Hospital Alliance'

All member hospitals will follow the same template

Three health care systems — Wellmont Health System, based in Kingsport, TN; Novant Health, based in Winston-Salem, NC; and Adventist Health System, based in Winter Park, FL — have come together to seek a solution to improving patient safety. Their collaborative, called the Safest Hospital Alliance, was founded by **Richard Salluzzo**, MD, president and CEO of

Wellmont. Together, the systems say they serve about 1.5% of all the hospital patients in the United States.

The alliance, led by each system's chief medical officer, will create metrics, benchmarks, and templates, and identify best practices in an effort to define how a truly "safe" hospital should function and provide treatment to its patients. Over a two-year period it will focus on one to three core hospital-wide processes, seeking to close the gap between current performance and "perfection" by 80% percent. The group's preliminary estimates indicate that implementing the safest hospital template could reduce health care costs by 20% to 30%. The alliance has been given a head start by Wellmont Holston Valley Medical Center in Kingsport, TN, which has been implementing a preliminary template for about six months. **(See story, p. 91.)**

The alliance proposes to implement 172 safety measures at participating hospitals, each of which has about three to five critical steps that, if followed, should eliminate the error. For instance, in order to reduce the number of falls in hospitals, the plan requires nurses to assess each patient's risk of falling upon entry to the hospital; if they have a high risk, the nurse orders a bed alarm, checks on the patient hourly, places a sign on the door, and puts a star on the patient's chart.

Key Points

- 172 safety measures to be implemented, with 80% improvement sought in two years.
- Safety threats will be "called out" immediately, and root cause analyses conducted.
- Sponsors hope template will be transferable to any health system.

No perfect model

What was the impetus behind the alliance? "There were two things," says **Anthony Oliva**, DO, chief medical officer of Wellmont. "One was that when we looked at trying to go after safety, the basic premise we worked under was that there is really not anything out there to model what we need to do; there's really no template out there to get to a level of reliability."

The second driver, he says, involved metrics. "If you go to the Agency for Healthcare Research and Quality [AHRQ] they will very clearly tell you their metrics are based on empiric performance — on 27 indicators; that's the benchmark," says Oliva. "If that's the case, it's not a very good benchmark because what you really have are average 'bad' performances. Now, we could do this as a single hospital, but would the data be reliable and statistically significant? If we do it with a couple of other systems and get the volume of denominators up to a certain point, we might be able to create something statistically significant and drive numbers to a new level and keep them there."

The final question, then, would be whether the template is transferable. "In other words, can we get enough statistical value out of our numbers to say we can move to a new place?" Oliva poses. "These should be the numbers to look for — pushing to four, five, or six sigma levels in certain areas."

What made the alliance attractive to Novant? "We had a relationship with them through our CEO," says **Stephen Wallenhaupt**, MD, executive vice president and chief medical officer. "They had chatted and visited, and Rich [Saluzzo] said he'd like us to work together on something they were doing involved with patient safety."

The source of the model

How did Wellmont determine the basic model for the initiative? "We've been working with a group called Value Capture, which was developed and put together by [former Treasury Secretary] Paul O'Neill," says Oliva. "He had previously been with Alcoa and adopted the Toyota production system model. They were driving employee injuries to zero."

When O'Neill left government, says Oliva, "He decided he wanted to move from industry to health care. So the challenge became, how do you use the Toyota system to drive moving health care organizations toward zero defects on a real-time problem-solving basis?"

In addition, as Wallenhaupt notes, "A lot of people are working diligently across the country, and there are quite a few external organizations that have developed lists of safety measures they consider important. Tony Oliva asked for a comprehensive health safety plan, and they have collated all the safety measures from groups like the National Quality Forum, the Institute for Healthcare Improvement [IHI], The Joint Commission, and

Model piloted at Wellmont facility

Penny Romeo, RN, CPHQ, quality coordinator for Wellmont Holston Valley Medical Center in Kingsport, TN, may have as good an idea as anyone about the prospects for the Safest Hospital Alliance — after all, for the last six months she has been installing the model at her facility.

The structure involves groups of leaders called safety mentors and quality facilitators, as well as transactional assistants, or TA's, all of whom Romeo oversees. "You can't separate safety from quality," she explains.

When safety problems are noted they are 'called out,' the TA's responsibility is to see the condition is made safe for the patient immediately. The safety mentors, all RNs, conduct a root cause analysis. They identify problems that cross several department lines — "macro" performance improvement initiatives, if you will. "They get bundled over to the quality facilitators," Romeo says. At present there are six safety monitors, two (non-clinical) transactional assistants and four nurse facilitators.

How are the problems first identified? The safety mentors and TAs, Romeo explains, are involved with all the areas of the hospital, clinical and non-clinical. "We all do 'work-arounds' every day," notes Romeo. "The first issue is to identify this as a problem."

"Say, for example, Tylenol cannot be found in Mrs. Jones' drawer," suggests **Anthony Oliva**, DO, chief medical officer of Wellmont Health System. "Instead of just working around the problem, we call it out, and see if someone can determine the root cause. We have someone get the Tylenol, but then we ask why it wasn't there and how we could prevent that in the future. Nurses, the pharmacy, the techs, and so forth, work in an immediate time frame."

"These problems are prioritized by the quality facilitators," adds Romeo. "After they begin to solve the problems by getting to the root cause, they then go to the manager and the front-line workers to come up with a solution."

The facilitators, she notes, are discouraged from coming up with the solution themselves because they do not know the process. "They help implement the solution, and then monitor the results," she says.

This model will be used at all the hospitals in the alliance. "I have learned so much," says Romeo. "We are just constantly looking to see where we are on the learning curve. We started by setting competencies for the safety staff, followed by training — both one on one and in the classroom."

The safety staff has "uncovered things that we at the management end would not have known about had they not been here," Romeo says. One simple example involved order entry. "We found out about a simple thing like the unit secretary putting in an order for a swallowing study, but the order not going to the appropriate place," she shares. "It was called out as a problem by the speech therapist; the order was going to radiology and then to the therapist. We fixed our computer system, so now the order goes directly to the therapist."

Currently, she says, all the safety mentors and leaders and transactional assistants from each Wellmont hospital spend time at Holston every week to train together "to make sure we are standardizing our approach," says Romeo. Oliva is coordinating with the other systems.

That sharing will be facilitated by the installment of a web-based program that will allow all staff at every hospital to get information in real-time. "We will share problems across the system as they occur; every manager will know what problems in their area have already been resolved and/or are still problems," Romeo explains. "Everyone in the organization needs to learn how to recognize a problem and solve it."

There are two reasons Romeo is convinced this approach will be successful. "For one thing, it's real-time, so you are not just looking at things retrospectively," she says. "Then, as problems are resolved, staff members who called them out see we really helped fix these things, and that makes a real difference in how they feel about safety."

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AHRQ [the Agency for Healthcare Research and Quality] in an organized manner that made sense."

Rolling the model out

For about 18 months now, says Oliva, Wellmont has been working on creating the "safest unit" at Holston Valley. "Now, we are ready to roll it out and drive our rapid cycle improvement model hospital-wide," he asserts.

In terms of the other alliance members, he says, a "big education mode" was to be implemented beginning in July. "It will have three pieces," he explains. "First, we will create some structure. We

have reached out to NQF and adopted their 30 safe practices as best practices; we are using AHRQ's 27 patient safety indicators as key metrics. We are implementing all the IHI initiatives, and working with The Joint Commission to make sure to implement the National Patient Safety Goals."

At this point, the other systems have started to begin to set what Oliva calls "their base core," getting metrics in place. "In other words, they will begin the same process we have gone through," he explains.

"We are now in the phase of analyzing the [combined] list of measures to be sure the definitions are consistent, and in most cases we have processes under way to improve them," says Wallenhaupt. They are also working on a "scorecard" — a template for evaluating performance — "to make sure we are all on the same page," he adds.

Wallenhaupt says he already has brought a team to Holston. "Our first pilot group sat side by side with them to see how they do it," he says.

Sharing experiences

In order for the 56 facilities to share experiences going forward, Oliva says Wellmont has installed software to capture all the data gathered by the alliance. "We will have a joint committee led mostly by the CMOs and chief quality people," he notes. "We will also be trying to centralize a lot of the data collection process here, so we can put out the same dashboards, and so everyone will get the same data."

Third, he says, they are developing an advisory board of industry leaders "to help give us direction on where we should be going."

How will they measure success? "In a couple of ways," says Oliva. "We will look at whether we have made true improvements in real metrics. In other words, what are the real outcome indicators, rather than process indicators."

One of the key questions, he says, is whether the alliance can truly get some outcome measures. "AHRQ, and perhaps some others, are starting to look at the number of failures per process," he notes. "We want to see if we can get to a reliability level; can we get to one to two errors per 100,000 times? People need to start thinking about zero."

Oliva says there are key things hospitals do every day that they must do perfectly, or they will create bad outcomes. "It's like the wheels coming down on an airplane before it lands; that has become a very highly reliable thing," he explains. "What we need is to be performing on a very high reliability level in areas like door-to-balloon time for chest pain and MI. Initial processes like getting an EKG done and alerting the lab have to work perfectly every time to function at a most reliable level. If a patient comes in with chest pain and gets an EKG in five minutes, there is no failure."

As the alliance progresses, says Oliva, he'd like to bring in other systems — perhaps by the end of this year. His long-term goals are anything but modest. "Hopefully, at some point down the road we'd like to create a template where The Joint Commission could say, 'Here's an accreditation piece on patient safety,'" he shares. "Can we do that? That's the question."

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Telehealth helps hospital cut readmissions by 75%

New approach to heart failure saves money

Fuqua Heart Center of Atlanta (GA) at Piedmont Hospital has used telehealth technology to significantly reduce the rate of hospital readmissions for heart failure patients. Data collected by the facility show that hospital readmission 30 days after discharge for heart failure patients in the program was 75% lower than for patients not in the program (a 1.45% readmission rate vs. a 5.85% readmission rate.)

"Heart failure is a very expensive population, and they tend to come to the hospital a lot," notes **Jennie Mattia**, RN, CCRN, CPHQ, manager, cardiovascular quality and heart failure disease management for the Fuqua Heart Center. "The majority of hospitals lose money for every heart failure admission, so institutionally you should be looking at what your margin is," she says. It's not that it will necessarily make a tremendous

impact on the bottom line, she adds, "but streamlining your process and paying close attention to care on the outside can prevent readmissions — which we did."

Long time commitment

Piedmont, notes Mattia, has a long history of commitment to care of chronic conditions. "In the mid-90s we really started looking at disease states, aligning their care in the hospital, and at ways to funnel patients to appropriate outpatient resources," she says. "Because it is such a financial burden, you want to be able to handle heart care as efficiently and cost-effectively as possible."

They began with two advanced practice nurses going to the homes of patients who had been identified as high risk, and who had been cited by their primary care physicians as good candidates for outpatient management. "This was effective; we took the gains from that and then asked how we could increase intensity of service and geographical reach," says Mattia, noting that by using the nurses for home visits they could see perhaps two patients a day per nurse.

"That led us to explore telehealth in 2001-2002," says Mattia, who notes that the initial venture was PC-based, using Internet access and a video camera. "We took the PC out, showed patients how to use it, and hooked up the video cam in our office," she recalls. The nurses would ask the patient, for example, to point down to their feet to see if they were swollen. "Then, we could call the doctor and tell them what was happening," she adds.

Limitations noted

However, Mattia points out, this approach also had limitations. "If the patient was not computer literate, it would not work," she says. "So we had to triage who would and who would not get the service."

By mid-1993, says Mattia, it became very clear the PC-based program was not working well enough. "We had five computers; they were cumbersome, and most patients who needed help couldn't work with the computers because they were either not skilled enough or not well enough," she recalls.

Mattia and her staff started to investigate a more user-friendly approach, and came across a company called WebVMC in nearby Conyers, GA. "Their product is a tiny box that sits on a table; you plug in a blood pressure monitor, a scale, a phone line, and a power plug," she explains. "It uses a touch screen, so you do not have to be computer literate to use it." All of the data go to a secure server. "We can access the information from wherever we are with Internet access," says Mattia.

One of the hallmarks of this program, she continues, is that the patient has to do something in order for the program to work. "We have to teach them how to effectively self-manage their condition, and it is their tool, and their responsibility to get us the information," she explains.

If the nurse has not heard from the patient in a couple of days they will give them a call. "We might say something like, 'You are consistently not weighing yourself on Monday; what are you doing on the weekend you do not want us to know about?'" Mattia explains. "We don't let them go stagnant for very long."

Assessing the value

Mattia is certain of the program's value, although she has not formally calculated its return on investment. "We didn't have to; this is part of the hospital's commitment to disease management," she explains.

Nevertheless, she adds, "it's not tremendously expensive in the scheme of things, and the cost is certainly reasonable for the product we are getting." She says there is an ongoing monitoring fee based on patient utilization, and the hospital provides it to the patients free of charge.

Still, she insists, the program is "absolutely" beneficial from the hospital's perspective in terms of geographic reach alone. "It allows more efficient use of nurses' time," Mattia explains.

Piedmont has ordered a total of 70 monitors, having brought 45 on board initially (about a year ago) and then adding others later in the year. "We were almost instantly able to impact the number

Key Points

- Most hospitals lose money for every heart failure admission, so issue is critically important.
- Program teaches patients how to effectively self-manage their condition.
- Reach expanded from 40 patients to 100 after initial success.

of patients we were able to interact with, so instead of a population of 40 people we could actively manage we were able to go to 100 — monitor them remotely, and know they were OK," she says. "We know who the problem people are, and we can prioritize their care."

It also has helped workload efficiency, Mattia notes. "We refer these people who are inpatients for outpatient disease management by protocol," she says. "We have been able to impact ED visits as well as hospital admissions because, for example, they can get the same IV on an outpatient basis."

This approach, she adds, is also "A tremendous patient satisfier — the patients do not want to go to the hospital, and we are able get better management on an outpatient basis."

Through the program, the hospital also is able to get the patients on optimal therapy much faster than it would if they were using a standard approach, Mattia asserts. "Typically a patient is discharged from the hospital, has a follow-up visit with their cardiologist in two weeks, then comes back in a month, and sees very slow, incremental changes," she notes. "This way, we are able, for example, to monitor their response to the meds we give and scientifically and quickly adjust them to the appropriate levels the patient needs."

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Mass General makes its survey findings public

Openness helps ensure performance improvement

Why would a major, high-visibility facility like Boston's Massachusetts General Hospital (MGH) willingly share the findings of its final accreditation report from The Joint Commission — especially when the findings were not entirely positive? The answer, according to its quality leadership, is at once simple, but the process is complex.

"You're not going to improve on this stuff unless you are honest and get the word out about it," asserts **Greg Meyer**, MD, MSC, medical director and vice president of quality and safety for the Massachusetts General Physicians' Organization.

The staff learned in late 2006 in a memo from MGH's CEO **Peter Slavin** that "we did not do as well as we should have, and that there were a number of areas we just had to get to work on," notes Meyer. "When you have 20,000 employees, you know that e-mail is going out in the public domain."

And go out it did, in the form of coverage by the *Boston Globe.* Slavin's memo was cited in the paper as saying The Joint Commission found employees weren't washing their hands enough, weren't completely filling out medical records, and weren't correctly following medication reconciliation policies.

Faced with a choice

At that point, says Meyer, the hospital was faced with a decision. "The *Globe* had an immature approach to reporting on quality and safety," he notes. "We could have crawled under a rock, or we could have said, 'Why should we let a reporter tell our story?'"

MGH chose the second option. "This was an important story to our patients," Meyer explains. "If it wasn't told right it could have led to confusion, but we knew the truth ought to get out there because we needed to improve the situation."

And that's exactly what they did. Today, anyone who wishes to know the full story can go to the MGH web site, www.massgeneral.org, and click on the link on the left-hand side of the home page that says, "Massachusetts General Hospital Joint Commission Findings."

Once there, the reader will see a letter from Slavin, then an MGH summary of The Joint Commission findings. In each case, it enumerates what was found, why it was important, what

Key Points

- Hospital takes two-pronged approach, dealing with transparency while pursuing performance improvement.
- In addition to a copy of The Joint Commission survey, facility answers key questions and provides regular updates on web site.
- Policy of openness helps generate staff buy-in for PI initiatives.

MGH is doing about it, and what progress they have made to date.

Oh, yes: For those who wish to wade through it, the Joint Commission's final report is also there in its entirety at the bottom of the page. "Frankly, we did not just want to put out the report, because it is so arcane many people would not have understood it," Meyer explains. "Our summary, by the way, does not pull any punches; it has all the data, and we will be updating it."

Parallel tracks

MGH is proceeding on two parallel tracks, explains Meyer. Not only is it pursuing its policy of public transparency, but it is working hard to address the issues raised by The Joint Commission.

"We thought it was important because, first of all, The Joint Commission is doing a better job than it ever has on a number of fronts," says Meyer, who used to be on the board. "They are measuring things that are really important to improving patient care; the unannounced survey is a better process, and things like the National Patient Safety Goals put really important challenges out there."

Since MGH is such a large facility, the process was quite involved. "We had the equivalent of 30 or so surveyor days, and the notion that all of us would get everything right in a short inspection is unrealistic," says Meyer. "To their credit, the Joint Commission released their initial findings, and then we had the adjudication process, where we had a chance to tell them what we think they got wrong. With that said, we knew as soon as the survey was done that we did OK — that we were even good — but not good enough."

The next step, then, was to interact with The Joint Commission to get to the truth. "This takes time; they required more data; there were additional chart reviews, and so on," says Meyer. "The final report is a reasonable reflection of the truth."

At the same time, Meyer knew there were some things "we just had to get to work on 'today.'" The dilemma was how can a small group of people sitting in a room fix things in an institution with 20,000 employees?

The answer is that they can't. "Everyone needs to get involved," says Meyer. That's where the policy of transparency proved invaluable. "I think it made all the difference," Meyer asserts. "The employees saw that this was serious, but that we were willing to work together and take our bumps. They also saw the commitment of leadership to put in the systems that were needed, and to align things so processes would get better."

The bottom line, he says, is that MGH is giving The Joint Commission, its patients, and the public "What they ought to have — better, safer care." As for the tedious process, Meyer admits, "a lot of my colleagues across the country might say they would not want to go through what we've gone through, but if it decreases hospital acquired-infections, then it's worth it."

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NEWS BRIEFS

Journal focuses on surgical QI, measurement

The *Journal of the American College of Surgeons (JACS)* devoted its June 2007 issue to a quality measurement program called the American

COMING IN FUTURE MONTHS

- How those 'top' hospitals continue to stay on top year after year
- One simple test can make a big difference in stroke care
- How caring for the spiritual needs of patients can make a big difference in quality
- Quality measurement program reduces complications, helps surgeons better assess risks

College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). ACS NSQIP tracks the outcomes of various surgical procedures and provides data to help hospitals improve patient safety and quality of surgical care.

A number of the 20 articles show how ACS NSQIP has helped reduce complications among surgical patients and enabled surgeons to better assess a patient's risks before he or she has an operation. For example:

• Three hospitals reduced postoperative complications by using ACS NSQIP.

• Prediction models help patients avoid complications after an operation: A group of five studies report on how ACS NSQIP data was used to develop risk assessment models to help predict which patients were susceptible to postoperative complications. The studies correlate the condition of the patient before and after an operation to determine the conditions associated with complications.

Currently, ACS NSQIP is used in 155 private hospitals. ACS NSQIP also includes reporting for the Centers for Medicare & Medicaid Services' Surgical Care Improvement Program. ▼

AONE taps 68 hospitals to improve patient care

The American Organization of Nurse Executives (AONE) has selected 68 hospitals to participate in a two-year project to improve patient care. The project will disseminate tools to help hospitals redesign care delivery processes based on lessons learned from Transforming Care at the Bedside, a Robert Wood Johnson Foundation initiative. For more information, visit the AONE web site at www.aone.org. ▼

Working conditions for ICU nurses linked to infections

Hospitals that have better working conditions for nurses are safer for elderly intensive care unit (ICU) patients, according to a recent report by Columbia University School of Nursing researchers who measured rates of hospital-associated infections. A review of outcomes data for more than 15,000 patients in 51 U.S. hospital ICUs showed that those with high nurse staffing levels (the average was 17 registered nurse hours per patient day) had a lower incidence of infections. Higher levels of overtime hours were associated with increased rates of infection and skin ulcers. On average, nurses worked overtime 5.6% of the time. These findings, reported in the June issue of *Medical Care* support the notion that a systematic approach aimed at improving nurse working conditions will improve patient safety. ■