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New 2008 NPSGs target early intervention, medication safety

Organizations still struggling with existing goals

Just three new National Patient Safety Goals (NPSGs) were added by The Joint Commission this year, but the requirements — both new and old — pose some challenges for organizations and quality professionals.

"The overall feedback that we have been hearing from the field in the last couple of years during review of potential goal topics has been that it's difficult to keep up with the pace of too many new goals and requirements," says **Peter B. Angood**, MD, The Joint Commission's vice president and chief patient safety officer. "So last year and again this year, we have by design made only a few changes and suggestions."

While some organizations have incorporated the NPSGs very well, many others continue to struggle, says Angood. **(See related story on non-compliance with existing goals, p. 120.)**

"An interesting change this year is how much more detailed the language is for how the goals are to be met and monitored," says **Frederick P. Meyerhoefer**, MD, a consultant based in Canton, OH. "This will present a challenge to almost all hospitals, but particularly to smaller hospitals with fewer resources that are already stretched to the limit. Because of the complexity of developing the processes to meet the goals, no hospital can avoid starting the compliance process immediately."

Here are the three new goals with compliance suggestions for each:

• **Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.**

The goal's rationale is that anticoagulation is a high-risk treatment that often leads to adverse drug events (ADEs) due to the complexity of dosing these medications, monitoring their effects, and ensuring patient compliance with outpatient therapy.

"What we have heard from several areas is that patients who require anticoagulation therapy have several risks involved with their care. The Sentinel Event Advisory Group felt that this was an important topic," says Angood.

If therapeutic ranges are either undermet or overmet, patients are at increased risk for complications. "Because of the potential magnitude of these complications, all patients on anticoagulant therapy, both inpatients and outpatients, need to be followed and monitored closely. That is the intent of this goal," says Angood. The requirements are consistent with existing

guidelines from professional organizations on the management of anticoagulation therapy, he notes.

To reduce harm related to use of anticoagulation, The Joint Commission has established very specific actions to be taken, says **Patrice Spath**, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

"The first step is for hospitals to create a task group to address each of these steps and analyze current processes related to the goal," she says. This may involve the development of a process flow chart showing the current way things are done, and a chart that describes how the process needs to change to meet the intent of the NPSG.

The goal will be easier to accomplish for inpatients than for those receiving outpatient therapy, says **Kathleen Catalano**, RN, JD, director of health care transformation for Plano, TX-based Perot Systems. Facilities already monitor inpatients on anticoagulation medications, but this goal also requires patient compliance with outpatient therapy, she explains.

"How will this be accomplished? This may be the hardest NPSG to accommodate yet," says Catalano. "Standardized practices are necessary, but that's easier said than done. Now the onus is on the health care facility to basically attain buy-in from patients — humans with their own ideas about compliance with doctor's orders."

The focus on patients receiving anticoagulant therapy is an attempt to prevent problems by instituting awareness and closer monitoring, says **Patti Muller-Smith**, RN, EdD, CPHQ, a Shawnee, OK-based consultant who works with hospitals on performance improvement and regulatory compliance.

"Although some of the treatments with anticoagulants have been in use for a long time, they are, in fact, high-risk treatments because of the complexity of dosing and patient responses," she says. This will require additional education of all staff, and a method of identifying patients on therapy so they can be monitored more closely.

The goal points to the need for nurses to perform assessments of each patient on each shift, according to Muller-Smith. "I don't think that nursing assistive personnel are adequately trained to make some of the judgments that are required," she says. "Documentation should be sufficient to support the identified patient response to treatment and prevention of any injury, especially falls."

Baptist Hospital of Miami has been addressing safety measures regarding anticoagulation therapy for many years, says **Faith D. Solkoff**, RN, BSN, MPA, assistant vice president. "We have seen improvements in our patients' care and outcomes," she says. "We are currently addressing other measures across our system, such as consolidating teaching and follow-up into a post-care clinic."

• Comply with current hand hygiene guidelines from the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC).

The CDC guidelines have been well recognized for some time and will continue to be the guidelines most commonly used by organizations, says Angood. "In our work internationally, we have

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come to appreciate that the WHO guidelines are commonly used. And so we wanted to make sure that those institutions have the opportunity to use the WHO guidelines if they so choose," he explains.

The guidelines are fairly similar to the CDC guidelines, and in fact, many of the experts who authored the CDC guidelines also participated in writing the WHO guidelines, notes Angood.

"There really is no difference in the guidelines. The verbiage and recommendation strength rating scale look identical to the CDC's," says **Doe Kley**, RN, BS, CIC, infection control coordinator at McKay-Dee Hospital in Ogden, UT. For this reason, facilities using the CDC guidelines will probably continue to do so, says Catalano. "Others that do not have a policy and practice in place will adopt one or the other," she says.

Whichever guideline is used, there is no question that evaluating compliance is difficult. "Direct observation remains the best approach for evaluating compliance," says Angood. "We recognize that monitoring the volume of different solutions is another method, but it should be substantiated by direct observation."

At McKay-Dee, each unit has a designated staff member who acts as the "official observer" for their area. This individual is required to complete a hand hygiene compliance form once a month, so that Kley can calculate and graph the results.

Most of the time, the observer watches the comings and goings at a given patient's room or work area for the observation period, and documents who came and went and whether hand hygiene was practiced — for example, if the health care provider washes three out of four opportunities, a score of 75% is given.

"They try to do their observations secretly — if staff know they are being watched, you just don't get 'real' data," says Kley. "It typically doesn't take more than 30 minutes to complete the observations."

• Improve recognition and response to changes in a patient's condition: The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

Early response for critical events such as cardiopulmonary and respiratory arrests or changes in patient vital signs may reduce cardiopulmonary arrests and patient mortality. "Many facilities have already established rapid response teams, and that is probably the answer to this goal," says Catalano. "Facilities that have not yet breached this approach will need to do so in the near future."

Though many institutions already have implemented rapid response teams, Angood says, "we also recognize that the medical literature and research on that topic continues to remain somewhat ambiguous and not fully strong in support of the use of rapid response teams."

The purpose of this goal is more basic — organizations must have a process in place to identify when a patient's condition is changing and recognize that there are opportunities for those situations to be managed by notifying other providers.

"However an organization chooses to identify those patients, and however they choose to respond to those deteriorating patients, is up to the organization, at this stage," says Angood. "I think a significant number have not addressed the implementation of any type of program to identify and respond to deteriorating patients."

At Baptist Hospital, a Code Rescue program was implemented in February 2005, which has significantly reduced Code Blues outside the critical care unit. "We are seeing improvements in survival rates, too," reports Solkoff.

Rescue events in medical/surgical areas were increased to almost 40 per 1,000 admissions, whereas the Institute for Healthcare Improvement's best practice benchmark is 25 per 1,000 admissions, says **Jill M. Szymanski**, RN, MS, CHE, CPHQ, quality manager at the hospital. "At the same time, we have reduced the frequency of resuscitation events from over two per 1,000 admissions to less than one and a half per 1,000 admissions," says Szymanski. "Now, over 25% of our resuscitated patients survive at Baptist Hospital, while the national average is 15%."

Depending on available resources, implementing a rapid response team might pose a problem to some organizations, says Muller-Smith.

The Joint Commission indicates several elements to comply with this goal:

1. Selection of a method.
2. Criteria for calling additional assistance.
3. Education of staff, patients, and families concerning requesting additional assistance.
4. Formal education regarding the process.
5. Ongoing monitoring of the method's effectiveness.
6. Pre- and post-statistics on cardiac and pulmonary arrests and mortality.

"Many of these practices may already be in place but will require review and monitoring to demonstrate that the method is working," says Muller-Smith. She suggests monitoring the num-

ber of times the team is called, and comparing the pre and post implementation numbers of cardiac or respiratory arrests.

"The rapid response team is an effort to reduce the number of Code Blue episodes that occur, by getting the team in before an actual arrest occurs," Muller-Smith says. "The number of codes called pre- and post-implementation and mortality rates are good indicators of success."

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New safety goals will be phased in over a year

It may be difficult to meet milestones

For its 2008 National Patient Safety Goals, The Joint Commission has prescribed a one-year phase-in period with defined milestones for compliance at three, six, and nine months. "Some of these goals are complicated by the nature of their topic. We recognize that there will need to be a process and system redesign to successfully meet the goals," says **Peter B. Angood**, MD, The Joint Commission's vice president and chief patient safety officer.

However, it will be a challenge for many organizations to meet the milestones, predicts **Michelle H. Pelling**, MBA, RN, president of ProPell Group, a Newberg, OR-based consulting firm specializing in regulatory compliance.

"Some organizations have not implemented the existing National Patient Safety Goals within the required time frames, tending to put off tackling new requirements, no doubt feeling overwhelmed by NPSGs in general," she says. "They may not have had formalized processes for implementation planning."

The phase-in period is a sign that The Joint Commission has recognized this problem, says Pelling. Here are time frames that your organization will have to meet:

- By April 1, 2008, your organization's leadership must have assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG requirements.
- By July 1, 2008, an implementation work plan must be in place that identifies adequate resources, assigned accountabilities, and a timeline for full implementation. This will require an assessment of current processes, interdisciplinary discussions, collaborative review and analysis of potential problems that process changes may create, and tactical planning.

Most organizations will be able to achieve the April 1 deadline, but the July 1 deadline will be a much bigger challenge, says Pelling. "Many organizations may not have the resources or staff experienced in developing an implementation plan with these elements," she says.

- By Oct. 1, 2008, pilot testing must be initiated in at least one clinical unit. Plans must be tested, results measured, and the potential effects of full implementation evaluated. "This again requires organizational skills, time, and staff resources," says Pelling. "It may be a very different way of approaching these goals for some organizations. They will need to scramble to get the staff the skills and resources they need to meet the milestones."

The Joint Commission is introducing two new goals that reflect international consensus on focus areas that can potentially enhance patient safety and save lives, says **Judy B. Courtmanche,** president and CEO of Courtemanche & Associates, a consulting

firm specializing in regulatory compliance and outcomes management, based in Charlotte, NC.

"The World Health Organization, [Institute for Healthcare Improvement], [Agency for Healthcare Research and Quality], and others agree that these goals are worthy of our consideration," says Courtemanche.

However, organizations are struggling to meet the National Patient Safety Goals already in effect, Courtemanche affirms. "We monitor regulatory compliance and have seen organizational noncompliance with several NPSGs continue to increase over the past two years," she says.

In 2006, The Joint Commission found noncompliance at 59% for NPSG Goal 2 for improved communication, 38% for NPSG 8 on medication reconciliation, 28% for universal protocol, and 18% for NPSG 3 on medication safety.

"When organizations are not able to meet current expectations, raising the bar doesn't necessarily make patient care safer," says Courtemanche. "Instead, it creates competing priorities and divided focus as organizations attempt to meet new requirements without fully meeting prior expectations."

As NPSGs have been introduced, organizations have had to re-evaluate current practices and redesign their health care systems to meet the requirements. Often, designing their approach was the easy part, while implementation, reinforcement, and support of the new process lacked ongoing resources. "In our work with organizations, we find that enforcing the new expectations is difficult in most organizations, as accountability structures may not support practice change," says Courtemanche.

Take these steps for noncompliance:

• **Determine how far along you are in implementation, using data gathered by the quality department or other departments.** "If problem areas still exist, it's time to reconvene a task group to determine how best to resolve these problems," says **Patrice L. Spath**, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates.

• **Enforce practice changes.** For example, staff may be aware of the requirement to label all medications on the sterile field, but it may not be getting done. "People are being told to do this, but what happens when they don't? If there is no oversight and accountability, physicians and staff can easily slip back into their old habits," says Spath.

• **Celebrate achievements.** Whatever progress your hospital is making toward achieving full compliance with the NPSGs should be celebrated. Provide physicians and staff with data that show the level of compliance. "Keeping compliance information front and center helps to maintain the momentum and sustain gains," says Spath.

• **Build in accountability with the new process.** By setting performance expectations, it becomes clear to the organization and the individual what needs to occur and what to do when it isn't happening. "Lay the groundwork by focusing first on the defining the process, developing the documents and structures that set expectations, and support those that enforce them," says Courtemanche.

For example, if governance documents do not focus on patient safety, accountability is hard to enforce. On the other hand, if medical staff bylaws, rules, regulations, policies, and job descriptions contain language supporting performance for patient safety initiatives, the medical staff have the foundation for self-governance and discipline accountability. "The same is true for other disciplines in the organization," says Courtemanche.

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Most physicians still don't disclose errors

More training needed to standardize this practice

Although nearly every physician surveyed in a recent study said they would disclose a hypothetical error, fewer than half have actually done so, says a new study from the University of Iowa.[1]

"Our goal was to learn more about clinicians' attitudes, but also what they actually have and have not done," says the study's lead author **Lauris Kaldjian**, MD, PhD, associate professor of internal medicine in the University of Iowa's college of medicine and director of the college's program in biomedical ethics and medical humanities. "We were interested in what factors or beliefs might be motivating physicians who are more likely to disclose errors to their patients."

The researchers reviewed survey responses from

538 faculty physicians, resident physicians, and medical students from academic medical centers in the Midwest, Mid-Atlantic and Northeast regions of the United States. Respondents were asked about their attitudes toward disclosing medical errors, whether they would disclose an error from a hypothetical medical situation, and whether they had ever disclosed a real-life medical error.

Ninety-seven percent of the faculty and resident physicians indicated that they would disclose the hypothetical medical error that resulted in minor medical harm (resulting in prolonged treatment or discomfort) to a patient, and 93% responded that they would disclose the error if it caused major harm (disability or death) to a patient.

However, only 41% of faculty and resident physicians reported actually having disclosed a minor medical error, and only 5% responded as having disclosed a major error. In addition, 19% reported having made a minor medical error and not disclosing it, and 4% reported having made a major error with no disclosure.

If you take the results at face value, this would imply that over half of the physicians had never made a medical error, which is highly unlikely, says Kaldjian.

The study's findings also reveal that malpractice fears are not the only reason physicians are reluctant to disclose errors. Physicians are also worried about negative patient reactions, professional discipline, loss of reputation, and blame from colleagues.

For more standardization of error disclosure, the researchers recommend the following:

- Encourage physicians to communicate clearly with patients and families about errors.
- Take deliberate steps to reduce the professional repercussions that may be associated with disclosure.
- Include administrative support for professionals who may feel isolated and vulnerable as they attempt to navigate the psychological demands of the disclosure process and its aftermath.

More training is needed

Only 18% of 3,100 physicians in the United States and Canada had received education or training in disclosure of errors, while 86% expressed interest in such education or training, according to another study.[1] Here are key findings:

- About half of the physicians surveyed reported that involvement in medical errors increased their job-related stress.
- One in three physicians involved only with near-misses also reported that their lives were negatively affected. This indicates that physician distress after errors is not limited to the occurrence of serious errors. However, the greater the severity of the error, the more likely it was that the physician would be affected.

Only 10% of physicians surveyed agreed that health care organizations adequately supported them in coping with error-related stress.

The researchers recommend that hospitals offer more types of error-related support to physicians, both during and after work hours.

"The fact that so few physicians have had formal training in disclosure has important implications, both for quality professionals and for the profession at large," says **Thomas H. Gallagher**, MD, one of the study's authors and associate professor of medicine at University of Washington.

Based on the study's findings, there is good reason to believe the issues of lack of disclosure and lack of training are linked. "Having the training to do disclosures well is likely to at least partially diminish the distress health care workers feel after errors," says Gallagher.

Move toward standardization

Recently, the National Quality Forum (NQF) added standards of disclosure of unanticipated outcomes to its list of safe practices. The standard calls for aggressive education of providers — basic background education as well as just-in-time coaching immediately prior to disclosure.

Basic education typically consists of one- or two-hour sessions that sensitize health care workers to the challenges related to disclosure, says Gallagher. Cases are used to emphasize how difficult it can be to decide how much information to share with patients following errors, describe the basic steps involved in disclosure, and discuss the importance of getting help from the appropriate institutional resources before carrying out a disclosure.

Just-in-time coaching is usually provided by a risk manager or medical director, and consists of training immediately before an error is disclosed. This covers what information will be disclosed, who will do the disclosure, anticipates likely questions from the patient and formulates responses, and often includes some rehearsal, says Gallagher.

"The standard also recognizes the importance of supporting health care workers following errors," says Gallagher.

The NQF standard is important, because it calls

(Continued on p. 127)

PATIENT SATISFACTION PLANNER™

Unsatisfactory stay sparks Planetree care model

Nurturing environment valued

One woman's vision of a new type of hospital — sparked after the lack of personalized care she experienced during treatment for a serious illness — resulted in the creation of the Planetree organization, which has become became a leader in pioneering patient-centered care.

Named for the tree that Hippocrates sat under as he taught students in ancient Greece, the organization stresses the value of providing a nurturing environment, in addition to medical expertise and technology, and of listening to what the patient has to say about his or her condition.

The woman behind Planetree — **Angelica Thieriot** — began her efforts in that direction after concluding that the hospital at which she was treated provided good medical care, but didn't address any of her other needs as a human being, explains **Gillian Cappiello,** CHAM, a consultation services specialist for Planetree, which is based in Derby, CT.

Caregivers would talk over her, take her to have tests without telling her what they were doing, and come in and out of her room without familiarizing themselves with her or her chart, Cappiello says. The hospitalizations of Thieriot's father-in-law and son allowed her to experience these communication and education issues from a family member's perspective, she adds.

In the Planetree model that Thieriot's vision helped create, every employee is considered a caregiver — not just the nurse or the therapist, but also the housekeeper and the person talking to the patient about the bill, Cappiello points out.

Much of the focus is on creating a healing environment for patients, families, and visitors — and also for employees, she says. "A lot of what we talk about is care for the caregiver."

There are many applications for access services professionals, notes Cappiello, who previously served as senior director of access services and chief privacy officer at Swedish Covenant Hospital in Chicago.

"From the access side, it's focusing on how you can make your environment more welcoming for the patient," she says. "The human interaction piece is huge, and the physical environment comes into that as well."

Warm colors, comfortable furniture, and soft lighting contribute to a soothing environment, Cappiello points out, as do features that are reminiscent of nature, such as aquariums. She recommends having furniture arranged in conversational groups rather than a row of chairs, she advises.

Removing clutter and reducing noise levels also helps provide a more pleasant experience for patients, Cappiello adds.

Waiting and reception areas should be barrier-free, she says. "If there's a desk, it should be low, so it doesn't create a barrier between [employee and patient]. Always have somebody there smiling.

"Communication is key," Cappiello says. "Keep patients informed if there are delays." If there is wait time, she suggests, use conveniences such as roaming pagers to give patients more flexibility.

Making wait time more enjoyable

During the wait, she adds, "offer something other than two-year-old magazines." Provide choices for the patient, she adds: "'Do I want to wait here? Do I want to get a cup of coffee?' Have those things easily accessible."

Make the hospital stay more like a hotel stay, Cappiello says, by determining some of the patient's preferences: What newspaper do they want delivered? What is their preference for food service?

Instead of serving meals when it's convenient for hospital staff, she advises, do it when the patient is ready to eat.

CarePages, a program in place at Swedish Covenant Hospital and at several hundred other hospitals throughout the country, is a perfect example of the kind of customer service initiative that Planetree endorses, Cappiello notes.

The program allows patients or family members to send updates on the patient's condition over the Internet and receive messages in return, she says. "Families can post photos or write that Uncle Joe had surgery today and is doing fine. It

provides a virtual gathering place, a secure web page that is managed by the patient or a family member or friend."

Another way to make the hospital experience easier, says Cappiello, is to provide — starting with preadmission testing — a binder for collecting information regarding the entire process, from testing to follow-up care.

"Have sections for diagnosis, medications, diet, physical exercise or physical limitations, and cards for physicians," she adds. "It's very applicable for people who have a disease that requires [ongoing treatment]."

Having a resource center in a place — possibly in the preadmission area — where it is convenient for patients to go to get information is another way to help them be partners in their own care, Cappiello says.

There are now about 125 hospitals that are Planetree affiliates, Cappiello says, ranging from small rural facilities to large, complex health systems. "The program is not a cookie cutter," she adds. "Every model is going to look a little different."

The Planetree organization gleans ideas and best practices from all the hospitals with which it is affiliated, Cappiello says. "Even with new affiliates, we find things they are doing that are creative and help [other facilities] look at what they might do in a similar fashion."

There is an annual fee for being affiliated with Planetree, she says, and it covers a certain amount of consulting hours — depending on the specific contract — and other resources.

"If a hospital is interested, the chief executive officer would come out and do a presentation for the board of directors and other decision makers," Cappiello says. "Once the facility is signed on, staff like myself would come onsite and do a presentation for all employees, talking about specifics — like a best practice presentation."

An organizational assessment is done — including focus groups with employees and patients — that helps identify the hospital's strengths and where there are opportunities to improve the experience of the patient, she adds. "One of the biggest things hospitals use is patient satisfaction scores and [measurements] of employee satisfaction and staff retention. Typically, Planetree hospitals have much less turnover than the national averages."

Other areas of interest, Cappiello says, are issues of patient safety, such as processes for handling medication errors.

In addition to acute-care hospitals, Planetree encompasses other kinds of facilities, such as long-term care homes and health resource libraries, she notes. The idea behind the libraries — which may be independent or connected with hospitals — is to give patients the opportunity to take some responsibility for their own care by finding out about their medical conditions, Cappiello adds.

Resource for 'cyberchondriacs'

This is a better alternative, she points out, than the popular practice of consulting Internet sites for medical advice and the "cyberchondriacs" that sometimes fosters. "There is so much bad information out there," Cappiello says, that it is helpful to have a librarian and staff to assist with the research.

Access departments often oversee hospital transport, she notes, which offers an opportunity to enhance the person's initial impression of the facility. Some hospitals, Cappiello adds, pipe music into the parking area and take patients to the front door in golf carts.

Ideally, she says, a hospital "ambassador" is waiting to greet them.

Wayfinding is another area in which the Planetree philosophy can be employed, Cappiello says. "If there are multiple entrances, how do you make sure that patients have the easiest and most relaxing way to get where they're going?

"Signage is horrible in most hospitals," she notes. To make finding the way easier for patients, many Planetree hospitals use visual clues, Cappiello adds. "There might be a water fountain in the corner, or a piece of artwork, and the signage is directed to those things, which transcend language."

[Editor's note: More information on the Planetree organization is available at www.planetree.org or by calling (203) 732-1369.] ■

Health program saves $1.70 for every dollar

Inpatient admissions down, member satisfaction up

A health management plan for members with chronic conditions has generated a 1.7-to-1 return on investment and glowing responses to member satisfaction surveys for Health Alliance Plan (HAP).

Health Alliance Plan began the HAP HealthTrack program in August 2004 with a program for members with heart failure and expanded it to include other chronic conditions after the heart failure component showed a decrease in hospitalization and an increase in recommended care. For instance, from 2003 to 2005, the number of inpatient admissions among HAP members with congestive heart failure declined by 65%. Use of ACE inhibitors among members with heart failure increased from 38% prior to the program's implementation to 78% in 2005. The percentage of members with LDL cholesterol levels below 100 mg/dt increased from 61% in 2003 to 70% in 2005.

"In addition to the financial gains and improvement in member health, this program has enhanced member satisfaction. This year, we've had about close to a 70% return rate on our surveys. We have evaluated the first 117 surveys returned and 100% of members who talked to a case manager reported being satisfied or very satisfied," says **Richard Precord**, MSW, director of clinical care management for the Detroit-based health plan.

Members at high risk for hospitalization or complications from the disease work with an RN case manager, and, if indicated, a behavioral specialist or pharmacist, who helps them learn to self-manage their conditions.

"We have developed a member-centric chronic care registry rather than a disease-specific registry. We approach our members holistically, rather than from the standpoint of a disease," Precord says.

The case managers are cross-trained to work with members with all of the conditions in the program and attend regular in-services on the various conditions. They can call on a certified diabetic educator if needed when they work with members with diabetes.

"We have a high prevalence of comorbidities. For instance, many of our members with heart failure also have diabetes. There aren't very many members who have just one condition. We look at all the members' needs and work with them on all conditions," Precord says.

Members are identified for the program by a variety of methods. The health plan automatically analyzes medical claims, pharmacy claims, and laboratory claims and values every month to identify members with chronic conditions. The computerized system also looks for gaps in care that may indicate that a member's disease is not being well-managed. For instance, the program flags members with diabetes who have not had regular hemoglobin A1c tests as well as those whose test results are outside the normal range.

The enrollment packet sent to new members includes information about the program along with the insurer's web site and a telephone number to call for more information. If the data show that new members are not managing their chronic disease well or have not had the recommended tests and procedures, they are referred to the program for appropriate intervention.

"Our data system also identifies members who were admitted to the hospital with a chronic disease or who have had a coronary event and been hospitalized as soon as they are discharged so that a case manager can call them. We also get referrals from physicians and other providers," Precord says.

The names of members who are identified with chronic illnesses and gaps are forwarded to an enrollment center where the staff make outbound calls to members to discuss the program and schedule them for a telephone appointment with a case manager.

"There are health risk indicators for each condition that prompts a telephone call," Precord says. For instance, a member who has a high LDL cholesterol level or someone who has made a visit to the emergency room is referred to case management.

The case managers have the member's health profile, medication, labs, and utilization data at their fingertips when they call the members. The case manager completes an extensive assessment over the telephone and, based on the assessment and other information, the case manager identifies goals and works with members to set priorities, Precord says.

"In the past, the case managers would get a member's name and number and then call the doctor's office to obtain clinical information. We have put together a methodology we use to prioritize members. They are risk stratified before the nurse calls them and the relevant clinical data are readily available to the nurse. It's a much more efficient way of doing things," he says.

Case managers frequently contact members over the first three months, then taper off the calls when the members begin to better manager their condition. Members work with the same case managers on managing their conditions.

"Many of these members are trying to manage multiple conditions, which can be very overwhelming. The case managers work with them on getting the conditions under control and eliminating barriers to appropriate care," he says.

HAP's case managers go through training on

motivational interviewing and behavioral changes so they can more effectively engage members and facilitate healthy behavioral changes.

"Helping members manage chronic diseases is not as simple as just calling them and telling them what to do. Case managers need to find out what motivates people to change," he says.

Since there is a high prevelance of depression among people with chronic conditions, the disease management case managers may co-manage members with the behavioral health team when appropriate.

Promoting self-management

HAP's program promotes self-management of chronic diseases. During the early weeks members are in the program, case managers work with them to develop action plans and to set health goals.

The case managers call on HAP's clinical pharmacists for a consultation if a member isn't taking their medication or has questions about the medication.

For instance, the case manager can refer a member to the pharmacist if the member with asthma is using his rescue medicine too much or if a diabetic has questions about getting his LDL cholesterol under control.

The clinical pharmacists talk with the members and educate them on how and when to take their medication. They may contact the members' physicians to discuss medication or dosage changes.

Members with chronic obstructive pulmonary disease, heart failure, and diabetes who are at high risk for hospitalization are eligible for HAP's telemonitoring program.

Members in the program receive a small appliance that plugs into the telephone line. The appliance beeps every morning to remind members that they need to answer a series of questions. For instance, members with heart failure are asked to weigh themselves and answer a series of questions that assess their symptom knowledge and behavior patterns.

The system automatically flags members whose answers indicate health problems.

"The system helps us identify people early when they have difficulties and gives us the opportunity to intervene. The member may be scheduled for the next phone call from a case manager next week but if there are signs of a deteriorating condition today, the case manager can take action to help them get needed care or avoid a potential visit to the emergency room or a hospitalization," he says.

Case managers in the program work hand-in-hand with physicians to help the members learn to manage their condition.

"We emphasize to the members that we are helping them follow the treatment plan from their physician," Precord says.

The health plan sends provider bulletins and newsletters to physicians to let them know that the program is available to support their plan of care.

When a member is identified for case management, HAP sends a letter to the physician with details about the member's condition and the goals the member and case manager have set.

The plan sends physicians regular updates as the members work toward meeting the goals. "If something urgent arises, the nurses alert the members' physicians by telephone and work with them to get the condition under control," he says. ■

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 (AHQ).

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. ■

(Continued from p. 122)

on hospitals to apply standard performance improvement tools to the disclosure process, says Gallagher. He recommends tracking the following data: the percentage of staff trained, the percentage of eligible events disclosed, the presence of institutional policies and procedures on disclosure, and patient and physician satisfaction with disclosures.

At Portland-based Oregon Health and Science University, health care providers are encouraged to disclose errors, and the importance of this communication is emphasized with residents and faculty, says **Christine Samuelson Slusarenko**, MS, RN, director of medical affairs/quality management/employee health.

"Every case that I recall that has been reviewed, whether in determining whether or not a root cause analysis will be done or in less formal case reviews, had errors disclosed at the time they happened," Slusarenko says. "Delays, if any, occur because of delays in recognition of the error or disputes as to whether any error in fact happened."

She credits this consistency to a disclosure policy that has been agreed upon by the medical staff, effective education about the policy, and a commitment to strive for a blame-free culture in error reporting.

Particular complexity in family communication, unusual difficulty in patient or family communication with a provider, a patient or family's clear misunderstanding of a medical process or procedure, or anticipation of a volatile encounter are all times when a physician might require assistance, says Slusarenko. "Our patient advocate and chief medical officer are highly skilled in assisting physicians in disclosure, should they request assistance," she says.

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Do standardized order sets really improve care?

Tool is a "necessary evil"

Like all technology, standardized order sets have both pros and cons, says **Larry Abramson**, DO, MPH, quality director at POH Medical Center in Pontiac, MI. "There is good and there is bad," he says. "My thoughts on order sets are that they are a necessary evil at this point."

At POH Medical Center, order sets are used for many conditions and surgical procedures such as hip arthroplasty, knee arthroplasty, hysterectomies, and gastrointestinal surgeries. "Incorporating best practice, educating and training staff, and efficiently and effectively implementing and adjusting these sets remains a constant challenge," says Abramson.

It might take many years for evidence-based medicine to become part of routine clinical practice, but the use of standardized order sets can speed that process, says Abramson. "If it is done correctly and health care providers are involved in the development, then you have a better chance for the evidence-based practice to become reality," he says.

If you view standardized orders as the equivalent of a checklist, and apply critical thinking to the use of the order set, then they can definitely bring you closer to evidence-based practice. "But the caveat is you have to keep them current. Otherwise, they can come out of date rapidly and give you a problem," Abramson says. Order sets must allow customization to the individual patient, he adds.

Another potential problem is that order sets are frequently designed for only physicians' use. "There are a whole lot of individuals beyond the physicians that are providing care, however. Having their participation in development of

order sets is essential, so that everyone is on the same page," he says. Involve nurses, pharmacists, physical and occupational therapists, patient educators, radiology technicians, registered dieticians, and other members of the care team.

When collecting data for core measure requirements, order sets can make it easier to show that a test was ordered. But to show that the test was actually done, you must go back into the record and collect the data manually or use electronic abstraction in the case of an electronic medical record.

For example, for the data element on whether the proper intervention was ordered to prevent deep venous thrombosis, the question, "Was it ordered?" is answered by the order set, but the answer to the question "Was it done?" is found in the nursing record. "So in terms of data collection, finding the order is a lot easier. But you still have to go back into the record to find out if it was actually executed," says Abramson.

The way an order set is written can leave you in noncompliance with core measure requirements such as stopping antibiotics within 24 hours. "So you may have to do some wordsmithing," says Abramson.

External agencies frequently change data definitions, which makes meeting evidence-based guidelines more difficult in terms of public reporting, explains Abramson. For example, an antibiotic may be approved as an acceptable drug to use as prophylaxis for bowel surgery, but not before a certain date. So the drug is incorporated into a hospital's evidence-based guidelines, but if it's used before that date, the provider will appear noncompliant. "They can't change the data dictionaries fast enough for some emerging guidelines. So that, indeed, causes a bit of a problem on the reporting side," says Abramson.

There is a tendency to think of order sets as merely a kind of word processor, but they are a lot more complex than that, says Abramson. "For example, changes on an order set have to flow through the pharmacy workgroup and nursing service to ensure that those changes are reflected on the medication administration record. It's not just a simple change once it's in an order set," he says. "So it speeds up the process initially, but slows things down on the maintenance side."

Quality professionals have tried to build choices and prompts into the hospital's post-operative order sets to drive the care as close to evidence-based practice as possible with high reliability, says Abramson. "It remains a daunting task, as the algorithms that drive the care must remain flexible enough to customize care for an individual patient requiring variation for valid clinical reasons or based on patient personal choice," he says.

Whenever a system is automated, there is danger in creating over-reliance on the infallibility of an "expert" system, says Abramson. "The caveat in these order sets remains that unless we ensure that it does not supplant or negate critical thinking on the part of clinicians, rather than improving care we may cause harm," he says.

Still, Abramson firmly believes that standardized order sets are essential to reducing variance. "But we must never lose sight of the importance of recognizing that these are tools, not actual practice," he says.

Perform due diligence

If you choose to purchase order sets from outside companies, you still need to perform due diligence with your staff to ensure it fits with the way you do the work and that staff accept the content as consistent with their clinical opinion, says Abramson.

"If you just accept somebody else's order sets and don't do any due diligence with them, you can end up with something that isn't as good as it should be, and can be potentially dangerous," says Abramson.

When order sets originate outside of a facility, whether purchased from a vendor or communally shared through inter-facility cooperation, each individual order within the set must be scrutinized as to either the value added to the process to conform to standards of care, standards of practice, patient safety, and promoting of desired clinical outcomes, he stresses.

"Order sets impact the practice of these health care team members, and ultimately the quality and safety of care provided to patients," says Abramson. Performing due diligence requires multidisciplinary teams that will provide or have their service impacted as a result of a required action within a given order set.

For example, pharmacists should review medication orders to ensure proper dosing, modifications necessary for formulary compliance, and the absence of medication interactions. "This avoids potential reproduction error, as has been demonstrated when a published protocol has a printing error — such as a chemotherapy protocol published a few years ago that had a misplaced decimal point leading to a significant dosing error on a cancer ward at a leading hospital," says Abramson.

Performing due diligence in this manner serves as a "failsafe mechanism," says Abramson. "Think of it as a failure mode effects analysis testing the capability of the system to accurately and reliably deliver the desired care by those charged with that responsibility," he says.

Order sets have helped significantly with compliance for cardiac and pneumonia measures, says **Sue Smith**, RN, BA, quality information analyst at Presbyterian Hospital Matthews (NC). "Those are the more time-sensitive diagnoses with time frames for antibiotics with pneumonia and aspirin and beta blockers for [acute myocardial infarctions]," she says. The sets also have improved compliance with ordering of appropriate antibiotics. "We no longer have physicians ordering whatever they feel is the most appropriate. They have the evidence-based ones listed on the order set for them to choose from," says Smith.

For the Surgical Care Improvement Project, post-operative order sets are used that are specific for physician groups, such as gastrointestinal surgeons. "We are trying to get to the point where we can have the appropriate antibiotics ordered preoperatively," says Smith.

As a 102-bed community hospital, hospitalists take care of the majority of inpatients. "We've had good buy-in from those physicians," says Smith. "We also have a set that that group uses for anyone with a cardiology admission diagnosis."

The organization was having a difficult time complying with the requirement to stop antibiotics within 24 hours post-operatively. "Some physicians were just writing to continue until a patient was discharged, without documentation of an acute infection, and that is one thing we are trying to get away from," says Smith. Since this was added to the post-operative order sheet, compliance has improved significantly. "We also got pharmacy to buy into the discontinuation so they are flagging those post-operative antibiotics. It all comes down to communication," says Smith.

A physician champion is the individual who handles issues with a physician being noncompliant, and also educates physicians before an order set is created that will impact their practice. "We want to be sure we have their buy-in, so our physician goes to their practices and speaks to them about that," says Smith. "This is a peer-to-peer communication coming from another physician. Sometimes nurse-to-physician communication is not regarded as highly."

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THE QUALITY - CO$T CONNECTION

Fortifying individual case review activities

Screening cases for peer review

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Joint Commission standards require ongoing professional practice evaluations of physicians and licensed independent practitioners (LIPs). One aspect of this evaluation involves collection and evaluation of performance results — using process measures and outcome measures. This component of The Joint Commission standards was covered in last month's column. In the second part of this two-part peer review series, individual case review is covered.

Case review involves analysis of the circumstances surrounding an individual case to determine if the practitioners involved met the standard of care. The review is conducted for the purpose of judging the competence and professional conduct of practitioners. To ensure the review is objective and fact-based, a peer physician or LIP should do it.

Peers are individuals who share the same profession and have similar training and privileges. When general medical management issues or professional behaviors are being evaluated, a peer with comparable skills can often objectively examine the facts of the case and render a knowledgeable judgment. If the judgment requires the peer reviewer have specialized expertise or skills, then someone considered competent in that specialty

Figure 1
Common Types of Events that Undergo Peer Review

- Unexpected death
- Any complications of treatment resulting in:
  - corrective surgical procedure
  - brain damage
  - motor weakness
  - sensory nerve injury
  - total or partial loss of limb or use of limb
  - organ loss or impairment
- Procedure on wrong patient or body part
- Unexpected hospital admission within 24 hours for same/similar complaint seen in the emergency department
- Unexpected hospital readmission within 24 hours for same/similar complaint seen in the hospital
- Significant procedure complication (e.g., infection, seizure, hemorrhage, anaphylaxis, etc.)
- Discrepancy between pre-operative and post-operative pathological diagnosis
- Sentinel event involving a physician or LIP
- Practice outside scope of care or privileges
- Adverse outcome due to delayed or inappropriate diagnosis
- Patient/family complaint involving a physician or LIP

Figure 2
Events Undergoing Peer Review in Radiology Services

- Puncture site complication
- Hematoma (requiring transfusion, surgery or delayed discharge)
- Occlusion
- Pseudoaneurysm
- Arteriovenous fistula
- Contrast extravasation
- Non-puncture site complication
- Distal emboli
- Unintended dissection/occlusion of selected vessels
- Contrast reaction
- All idiosyncratic reactions
- Major reactions (respiratory symptoms)
- Contrast-related death
- Non-idiosyncratic reactions (hypertension, nausea, vomiting, bradycardia)
- Contrast-induced renal failure (increase in serum creatinine by 50% or by 1 mg/dL within 48 hours of the procedure resulting in an abnormal serum creatinine level)

should evaluate the case. For instance, it may not be appropriate for a cardiac surgeon to evaluate a case involving pediatric heart surgery unless the surgeon has pediatric surgery training.

All physicians and LIPs should have some of their cases reviewed. It is not sufficient to evaluate individual competence solely based on aggregated performance measurement data. While

CNE *questions*

9. Which is true regarding compliance with the National Patient Safety Goal for reducing harm of anticoagulation therapy?
A. Nursing assistive personnel should be performing the required assessments.
B. No additional education of staff will be needed.
C. Patient compliance with outpatient therapy will need to be monitored.
D. Less frequent monitoring is now required.

10. Which is The Joint Commission's preferred method for evaluating compliance with hand hygiene requirements?
A. Monitoring the volume of solutions.
B. Direct observation.
C. Self-reports.
D. Patient complaints.

11. Which was a finding of a study regarding physician attitudes toward error disclosure?
A. Malpractice lawsuits were the only concern identified by physicians.
B. Physicians were only in favor of disclosing minor errors.
C. All physicians who supported error disclosure reported disclosing both minor and major medical errors.
D. Almost all physicians said they would disclose a hypothetical error, but fewer than half have actually done so.

12. Which is true regarding standardized order sets?
A. They can show both whether a test was ordered and whether it was actually done.
B. Health care providers should be involved in their development.
C. Changes to requirements are easier to make when order sets are used.
D. Order sets should not be customized for individual patients.

Answer Key: 9. C; 10. B; 11. D; 12. B.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

performance data are useful, there are many professional performance factors that cannot be adequately evaluated based on numbers alone.

The number of cases that need to undergo review for each practitioner is dependent on the volume of patients seen. The medical staff should establish a minimum case review requirement, such as 10%, and apply that requirement uniformly across all disciplines. The Joint Commission standards are silent on this issue — stating only that the medical staff define the circumstances that require evaluation of a practitioner's performance and the methods that will be used. Surveyors judge compliance with the standards by comparing what is actually occurring with the stated case review policies of the medical staff.

The medical staff should establish criteria for selecting cases that will undergo peer review. Some cases will be reviewed for appropriateness of blood and medication use, utilization practices, and surgical appropriateness. Other cases will be selected to evaluate general issues related to medical assessment and treatment of patients. These cases are commonly selected for review after a particular event occurs. The common types of events that prompt case review are listed in Figure 1. Each medical staff department or subspecialty may identify additional events requiring peer review that are unique to particular patient populations or interventions. In Figure 2 are examples of events that undergo peer review in one hospital's radiology service.

Screening cases for peer review is often a multi-step process. Events may be identified concurrently, while the patient is hospitalized, and retrospectively, during chart review by staff in the QM or health information management department. A referral from infection control, risk management or another clinical department may cause a case to be flagged for peer review.

In some hospitals, all events undergo some type of peer evaluation. However, it is common for professional staff in the quality department to conduct a first-level review using criteria approved by the medical staff. For instance, in the case of a patient's death, the medical staff may elect to review the case only if one of the following circumstances is present:

- Lack of documentation of patient's deterioration during 48 hours preceding death.
- Change in patient's condition with no action taken during 48 hours preceding death.
- Lack of agreement between the patient's premortem and post-mortem diagnoses.
- Death appears to be related to a communication failure among practitioners.
- Lack of documentation explaining the death.
- Lack of documentation that the death was expected.
- Death appears related to an incident or a complication of treatment.
- Death within 24 hours of admission (except in cases in which death is anticipated and clearly documented).
- Death within 72 hours of transfer out of a special care unit (unless the transfer was made because death expected).
- Death during a surgical procedure or death is suspected to be related to a surgical procedure.
- Death appears to be related to treatment choice, including medication.

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- How to take action on safety culture data
- Obtain data for low-volume practitioners
- Identify triggers for focused review
- Take your rapid response team to the next level

• There is reason to think death may have been preventable.

Once a case has been identified as needing peer review, the flow of the review process varies among hospitals. In some hospitals cases selected for review are assigned to a multi-specialty medical review oversight committee comprised of physicians and LIPs from each department. Senior administrative leaders may also sit on this committee. Cases determined by the oversight committee to need further investigation go to the relevant medical staff departments for general and specialty-specific medical review. In other hospitals, the flow is reversed with cases first being reviewed at the department level and questionable cases sent to a multi-specialty medical review oversight group for broader evaluation. Some hospitals have only one level of review; either by an oversight committee or by peer review committees within each medical staff department. Regardless of the flow of the review process, if the case needs to be evaluated by a peer with specialized expertise or skills and there no practitioner at the hospital that meets these criteria, arrangements should be made for external peer review. (For more information on external peer review policies, see "Meeting more explicit peer review imperatives," *Hospital Peer Review*, August 2007.)

To meet the intent of the Joint Commission standards, peers should review some cases of every physician and LIP. If no cases are identified through routine event screening activities, then a random sample of the practitioner's cases must undergo review. Don't want until right before the practitioner's reappointment to review these cases. At least semi-annually identify practitioners that have not had some type of case review during the previous six months and select a representative sample to undergo peer review. To prevent the need for this periodic analysis, some hospitals routinely conduct peer review for one or two randomly selected cases for every practitioner. These reviews are done in addition to the cases identified through the event screening system.

The objective of case review is to validate that physicians and LIPs are competent to perform the patient care privileges granted to them by the hospital. At the same time, case review should be viewed as an educational process. Information derived from the evaluations should be used to educate individuals about how to improve their skills and reduce errors. Punitive action for misconduct or practice irregularities is a last resort – taken only in egregious situations or when other interventions have failed. Properly designed, case review is outcome based with the process used to:

• identify events that present improvement opportunities;

• recommend actions to lessen future occurrences of the event; and

• implement those recommendations with the individuals involved.

The ultimate goal is to continually assess and improve the quality of care provided by physicians and LIPs and minimize the system factors that impact professional practice. How to review cases so this goal can be achieved will be covered next month in part 3 of this series. ■