# Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

AHC Media LLC


## IN THIS ISSUE




**OCTOBER 2007**
**VOL. 14, NO. 10 • (pages 109-120)**


# Award winner involves entire staff in quality improvement initiatives

*Hospital culture changes following leadership crisis*

Quality managers know that it's hard enough to get nurses and physicians to buy in to their initiatives, but at Columbus (IN) Regional Hospital, even non-clinical staff members are expected to make quality improvement one of their primary goals.

This was one of the approaches quality leaders adopted following the exit of their CEO in 1997 and an attendant crisis in confidence. And the approach seems to be working — Columbus Regional has received the 2007 American Hospital Association–McKesson Quest for Quality Prize, which evaluates organizations for their commitment to improving areas of safety, patient-centeredness, effectiveness, efficiency, timeliness, and equity.

The award committee shared with the facility's quality leaders some of the reasons why it was chosen, says **Thomas A. Sonderman**, MD, FACEP, chief medical officer. "They were very impressed with the fact that all across the organization, not just quality people but multiple levels of clinical and non-clinical staff are empowered to drive quality," he says. "They also cited our ability to drive down the incidence of VAP [ventilator-associated pneumonia] and surgical-site infections."

This move to involve the entire staff started several years ago,

## Key Points

- Have non-clinical departments identify activities that can contribute to improved outcomes.
- Create standing interdisciplinary teams to continually monitor best practices.
- Engender transparency and excellence with individualized scorecards for your staff and leaders.

says Sonderman, when the hospital's new CEO "really started to realize that the way to get people dedicated and engaged at work was to try to connect everyone to the bedside.

"Obviously, the bedside caregiver has a pretty clear, direct line and those clinicians can easily see how they directly affect patient outcomes; but he recognized that the non-clinical staff had a lot to bring to the table, too, and connecting them to outcomes would be a way to charge them up and keep the 'flywheel' turning."

How did management draw these non-clinical staff members into quality improvement initiatives? "One example would be the 100,000 Lives and Five Million Lives campaigns from [the Institute for Healthcare Improvement]," says **Kathy Wallace**, RHIA, CPHQ, director of medical quality management. "When we launched those efforts, I gave presentations to the facility staff, the materials management staff, and the environmental services staff."

The managers and directors of those departments were all present, she says. "I explained that they were there because we wanted to try to connect how they did their jobs with patient outcomes," she recalls. While she basically used the standard IHI presentation, she says, "in my own mind, I thought of examples to prime the pump — how biomedical engineering or facilities might see a connection."

But it wasn't until the departments themselves held follow-up sessions that they "really connected the dots," says Wallace. "For example, the facilities department was talking about how good, compliant hand washing was so important in stopping the spread of nosocomial infections.

"They decided that any report that came in about a non-functioning sink would be put way up in terms of prioritization; they said they would make a commitment to get to it within 24 hours. They made the same commitment with alcohol gel dispensers because they realized that every extra step would make it less likely that people would wash their hands." This type of action, says Wallace, demonstrated to the staff some concrete efforts they could make every day to help reduce infections.

## Growing from crisis

The Columbus Regional success story was born of crisis, says Wallace. "Our improvement work goes back a decade to 1997, when the medical staff took a vote of no confidence with the CEO," she recalls. "There was a loss of confidence in the medical staff and in the community."

"You hate to have a crisis, but it does serve as one heck of a motivator," adds Sonderman. "We were always good clinically, but 'good' can be the enemy of 'great.'"

Patient and physician satisfaction were huge parts of the challenge, he says, "but we learned very deliberate skills of finding out which were the best as far as techniques in driving patient satisfaction." Determining which are, in fact, the best is possible for any area of hospital service, says Sonderman. "Even tasty, warm food, getting trays to patients on time, or the best way to polish and clean a floor or turn a bed or

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

### Subscriber Information

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

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



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



AHC Media LLC

### Editorial Questions

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

a room around — when you take that approach and can really take it down through the whole organization, that's when I think quality really picks up."

"We knew we had to get back from the bottom," adds Wallace. "The new CEO, who had been the COO, took steps to reconnect with the medical staff. The staff wanted to provide great care, and they wanted happy patients, so we engaged everyone about how we could build things up. That was really our focus."

Benchmarking played a big role, she says. "We did a lot of benchmarking; we began benchmarking in nursing and became the first accredited magnet hospital in the state; we started benchmarking best places to work in Indiana and nationally — not necessarily to go after the award, but to learn what to do to get there." When you apply for such awards, she explains, "they tell you where you're at and what you need to do to improve."

The hospital also worked with the Baldrige Award people for the same reason. "We started a balanced scorecard to understand where we stood vis-à-vis our five pillars: people, satisfaction, quality and safety, growth and innovation, and financial," says Wallace. "Then a couple of years ago we adopted the vision that it was not enough to be a good community hospital anymore; we wanted to be the best in the country at what we do."

## Transparency is key

As the recovery continued, Wallace recalls, the new CEO stressed transparency as a key to success. "In terms of sharing data and information, we consider ourselves very transparent. Measurements are used everywhere and everyone knows how we do them," she says.

For example, she notes, they use a cascading scorecard system, which is used by all areas of the hospital. Based on selected key measures, "each of us knows how we are performing compared to how we would need to perform to be the best in the country," Wallace says.

So, for example, leadership has a scorecard that tells them what they need to do to improve on corporate measures. Then, "on a given unit, you'll see what you need to do for CMS, what your patient safety index is, your mortality rates, and so on," says Sonderman. "As you go down through the organization, there is a very deliberate alignment of the behaviors of people during the day that should drive hospital-wide goals."

In addition, every employee has a "passport" that shows one key measure for each pillar, and then the department or leader's goals. "They work with leadership, and see how their own goals are going to help their leader attain their leadership goals, so they can feed into achieving corporate goals," says Sonderman. "This way, every employee understands how they impact the total picture."

## Making practical improvements

Of course, it takes concrete commitments "on the ground" to engender improvement, and here, too, a sense of common responsibility is created. The VAP initiative, for example, was led by the ICU team — an intensivist and a clinical nurse specialist. However, adds Sonderman, best practices were benchmarked and everyone on the care team — including the dietary staff, the pharmacy, and the family — would huddle at the patient's bedside and discuss the clinical aspects of care.

"This way, the care for that day is optimized," says Sonderman. "It also helps with discharge planning, because everyone knows where everyone else is at; it's a wonderful forum to get everyone on the same page."

"We also have interdisciplinary teams that work across all areas of the hospital to provide evidence-based practices," adds Wallace. The teams are co-led by a clinical nurse specialist (CNS) and physician champions. "They find out what is in the literature, and what we need to do at this hospital in order for the best care to be provided," says Wallace, noting that these teams remain permanently in place and are continually focusing on ensuring that improvement is "hardwired," and as new evidence comes out it is immediately implemented. "They work on designing processes in order for us to deliver the new best practice as soon as possible," says Wallace.

"They also monitor medical societies and scan their sites for changes in parameters," adds Sonderman. "They tell us if anything needs to change in protocols and pathways."

## Part of the culture

The interdisciplinary team approach, says Sonderman, is one of several indications that "the

way we do things" has really become part of the culture. "I know it gets to be a cliche, but when you involve the physician clinical leader and a CNS, who has in-depth training, with a great quality team and run a rigorous program, and involve frontline staff in a team that has truly been pushing improvement, you will make that improvement stick."

"We see every employee concerned about being the best," adds Wallace. "They are so engaged every day; they all want to come to work to deliver great care."

While the award is "great cause for celebration — an external validation that we think we are working on the right things," says Sonderman, "we never really consider ourselves to be awards junkies; we do not chase awards. These evidence-based best practices are the way to go about it, and along the way there has been a lot of learning and getting feedback reports to tell us what we need to work on next."

Columbus Regional, says Wallace, is always looking for that next quality challenge. "We never stop; you never think you're there — there's always room for improvement," she asserts. "Our goal is for every patient to receive every treatment every time, so the work continues."

*[For more information, contact:*
***Thomas A. Sonderman**, MD, FACEP, Chief Medical Officer; **Kathy Wallace**, RHIA, CPHQ, Director of Medical Quality Management; Columbus Regional Hospital, 2400 East 17th Street, Columbus, IN 47201. Phone: (812) 379-4441.]* ■

# Aortic dissection patients may have new hope

*New way to predict post-hospital death risk*

Survivors of aortic dissection may improve their odds of long-term survival with more aggressive follow-up care and more targeted discharge instructions, based on the findings of a new study in the *New England Journal of Medicine*.[1]

An international team of researchers, led by University of Michigan Cardiovascular Center experts, propose a new way to predict post-hospital death risk for aortic dissection patients, and a new model for the mechanism behind that risk. Their research focused on partial clotting in what is known as a "false lumen" — the channel created when the layers of the aorta separate like two layers of an onion. This channel runs alongside the "true" lumen, which is the hollow middle area of the aorta that acts as the pipeline for blood to flow out of the heart and down through the abdomen.

What made the researchers suspect partial clotting in the false lumen? "At our hospital we follow these patients in our clinic, and [some of these clots] just take a more aggressive course — the clot gets bigger much faster than others," explains **Thomas Tsai**, MD, MSc, of the University of Michigan Cardiovascular Center in Ann Arbor and lead author of the article. "We noticed the [MRI] scans would show partial clotting and that caught our eye, so we decided to investigate." No other researchers "had really looked at this before," he asserts.

The study involves data from 201 patients with dissections in their descending aortas, who were discharged from the hospital after treatment and followed for up to three years or until death as part of IRAD, the International Registry of Acute Aortic Dissection. (IRAD, which is headquartered at the University of Michigan Cardiovascular Center and supported in part by the university's medical school, the Mardigian Foundation, and the Varbedian Fund for Aortic Research, includes data from 22 large medical centers in 11 countries.)

The paper is based on retrospective clinical data from 114 patients who had a patent false lumen when they were admitted to an IRAD hospital, 68 patients who had a partially thrombosed (clot-filled) false lumen, and 19 who had a completely thrombosed false lumen.

By the end of the three-year follow-up period, nearly 25% of the patients had died. However, the researchers found a significant difference in death risk:

- 13.7% of the patients with patent (clear) false lumen had died, compared with 31.6% of the partially thrombosed patients and 22.6% of the completely thrombosed patients. This difference held up after other factors were corrected for.

## A matter of survival

This research — and the findings — were of great import because of the high mortality rates among these patients, notes Tsai. "With aortic dissection of this type [Type B, in the descending

## Key Points

- More aggressive follow-up care and more targeted discharge instructions should improve outcomes.
- At present, about 25% of discharged patients die within three years.
- Amount of clotting in false lumen appears to be key indicator of risk.

aorta], most survive discharge, but once they leave the management is unclear as to what mode of action is best," he says. "The current protocol is to follow with imaging, and once the aorta becomes large enough [just how large, he says, is undefined] you may operate on it or take some other action."

With a three-year mortality rate of 25%, finding more targeted methods of follow-up could clearly make a big difference, he continues. "Our findings provide the possibility for physicians to look for other factors in the imaging tests above and beyond just how big the dissection is — like other features that either show the need for earlier surgery, or the safety of holding off."

A more sophisticated mode of treatment, he adds, would home in on the status of the false lumen. "At present we are not looking specifically at each lumen, whether it is false or true," says Tsai. "We should challenge ourselves to look at what happens within the false lumen: Is it clotted? Is it partially clotted? Where are the tears? We need a better understanding about the anatomy of dissection."

Current scanning technology enables such studies, he asserts, "but we still need experts who will be looking for this; most radiologists now will look at the size and don't know to look at anything else. You have to specifically ask for what you want, but if you do, they can do it correctly and get that information."

### Should discharge instructions change?

While noting that the team's findings are "not yet completely substantiated," Tsai says it's not too soon to be considering an adjustment to discharge instructions and patient follow-up.

"Currently the implication is that we as physicians should be cognizant of what the anatomy of the dissection is when the patient leaves," he says. "If you see a partial thrombosis when the patient is leaving the hospital, you may say to them, 'Your dissection may be more risky for getting larger; we should make sure to image you again in one month,' and make sure to ask the radiologist what is going on with the false lumen."

Discharging physicians will recommend "frequent follow-up imaging," which could be every three, six, or nine months. "In addition to looking at more than just size, we should potentially try to refine how frequently we do follow-up imaging," Tsai suggests. "However, radiation exposure does not come without cost, so we need to better refine just what we are looking for."

### Reference

1. Tasi TT, Evangelista A, Nienaber CA, et al. Partial Thrombosis of the False Lumen in Patients with Acute Type B Aortic Dissection. *N Engl J Med* 357:49, July 26, 2007.

*[For more information, contact:*
***Thomas Tsai**, MD, MSc, University of Michigan Cardiovascular Center, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-5853. Phone: (734) 945-9408. E-mail: hsianshi@umich.edu.]* ■

# Premier launches new hospital QI collaborative

*Focus closely on creating a 'template' for reliability*

Following closely on the heels of its successful Hospital Quality Incentive Demonstration (HQID) project with the Centers for Medicare & Medicaid Services, Premier Inc. is launching Quest (quality, efficiency, and safety, with transparency), a voluntary three-year program that will reward hospitals that achieve certain quality and efficiency measures and help them share best practices.

Performance will be measured in five areas:

- Mortality ratio, which will be risk-adjusted, aimed at eliminating all avoidable deaths;
- Appropriate care, which will measure the percentage of patients receiving "perfect care" as defined by national standards, raising the bar to suggest that all patients should receive appropriate care every time;
- Efficiency, which will measure adjusted cost per discharge;
- Harm avoidance, measures of which will be

developed over time by the program, taking into consideration the multiple existing industry standards from the likes of the Agency for Healthcare Research and Quality and the National Quality Forum;

• Patient satisfaction, which will utilize CMS's HCAHPS patient satisfaction measures as a metric to drive improvements in satisfaction.

As of this writing, 60 hospitals have joined the program, which Premier, of Charlotte, NC, expects to launch in October with 100 participants.

### Beyond P4P

While it will clearly have a pay-for-performance component, the goals of Quest move beyond that single focus. "The rationale for Quest is to move us closer to our goal of improving the health of communities by establishing these dimensions [bulleted items above] and working on what we think are the measures that really matter to us as an industry," explains **Meg Horgan**, Premier's vice president of customer services and performance improvement. In other words, she notes, Premier is seeking a "template" for reliability.

With the Department of Health and Human Services moving toward value-based purchasing, Horgan notes that "the ability to test these measures will help us get there." However, she adds, "we have a primary goal of moving all hospitals into the top quartile of all these areas simultaneously. Many hospitals have pockets of excellence; we are looking to achieve reliable care for all these areas."

### A logical extension

Horgan notes that Quest is "absolutely" a logical extension of HQID and other initiatives. "When you look at HQID, it was really a great start — focused on and achieving certain goals. The reward system helped, but we are looking for broader measures — not just for Medicare, but for all payers, and also broader populations — all patients. "

As for lessons learned from HQID, Horgan says, "We learned that the organizations that were successful really had established cultures of quality; their leaders were totally engaged; their efforts were data driven; there were systematic processes in place; clear accountability for results; and an understanding of and commitment to sharing best practices. These were the major drivers we continue banking on for Quest."

## Key Points

- Measurements will include mortality, appropriate care, efficiency, harm avoidance, patient satisfaction.
- Improving health of communities is one of program's primary aims.
- Goal is to move 50% of participants into the top quartiles for all measures.

As for new directions, Horgan sites an expansion of measures and types of measures. "Also, we are looking at being able to influence the industry on what the right measures are," she says. For example, in terms of mortality, "we will be evaluating multiple models that are out there now for determining risk. Our goal is to test measures, to correlate process measures with outcomes and inform the industry about what measures matter as we build reimbursement around them."

Horgan is quick to note that Premier will not be creating new measures. "We will draw upon ones that are already out there," she explains. "But we will use industry experts and our charter members to come to some consensus on which ones they feel are the right ones to use."

### Evaluating performance

Once Premier has the charter members use their data to determine a baseline, says Horgan, "our goal is to move 50% of them into the top quartiles for all the measures in three years." Premier will not be accepting any and all hospitals as participants, she emphasizes. "Qualifications include being able to use standardized tools, having a committed executive team, and demonstrating an alignment of organizational goals with Premier's goals," she says. "They also need to be willing to be transparent with their results."

Ideally, she says, data sharing would occur monthly. "Right now, most of our hospitals send us data quarterly," she says, "but we've learned that the faster they can get the data, the faster we can evaluate their performance and the faster they can improve and share results."

How will the rewards differ from, or be similar to, those offered in HQID? "The biggest difference is it will not be restricted to CMS or Medicare patients," says Horgan. "Also, it will

not strictly be P4P, but rather rewarding those facilities that get into the top quartile." At present, she says, Premier is in talks with insurance carriers about setting aside funds for the reward pool. "That will be finalized in October," she predicts.

Finally, she says, Premier will be assisted in pursuing its "reliability" goal by the Boston-based Institute for Healthcare Improvement (IHI). "IHI will be providing technical assistance in terms of helping to build our internal capacity to spread new ideas and disseminate them broadly," Horgan explains. "They look upon will, ideas, and execution as essential elements for strategic improvement, and we are looking at hospitals developing a reliable system to be able to execute the right care all the time. It's the strategy around how you do this that makes it reliable, and we believe with their strategic guidance we will be able to do this successfully."

*[For more information, contact:*
***Meg Horgan**, Vice President of Customer Services and Performance Improvement, Premier Inc., 2320 Cascade Pointe Boulevard, Suite 100, Charlotte, NC 28208. Phone: (704) 357-0022.]* ■

# Collaboration accelerates safety improvements

*Open communications help drive success*

The Indianapolis Coalition for Patient Safety (ICPS), established in 2003, has made significant strides in a number of areas through collaborative initiatives, say its leaders. Among its successes to date are:

- The reduction of ventilator-associated pneumonia (VAP) cases in intensive care units;
- Improved identification of patients most at risk for heart or respiratory failure before they're in trouble;
- The establishment of rapid response teams.

The number of VAP cases in the city have dropped significantly, according to ICPS, with some local hospitals going more than a year without a case — and one going without a case of VAP for three years. After the institution of a rapid response team, one member facility reported that "code blues" had dropped 60% in 18 months.

The ICPS comprises chief executive, medical, nursing, and pharmacy officers from Clarian Health, Community Health Network, Richard L. Roudebush VA Medical Center, St. Francis Hospital and Health Services, St. Vincent Health, and Wishard Health Services. In addition, there is participation by entities such as Eli Lilly and Co., WellPoint Inc., Indiana University, Purdue University, and Regenstrief Institute Inc.

### 'Non-compete' agreement

The coalition got its start when the chief medical officers of the major systems, in concert with Eli Lilly, began talking about how to put on an educational program to heighten awareness of safety in the city, recalls **Glenn Bingle**, MD, PhD, FACP, chair of the ICPS and Community Health Network vice president for medical and academic affairs. "In planning for that, we realized we could do more than educate the public; we could share information and take on a project together," he explains.

They began studying out-of-state coalitions, and contracted with the National Patient Safety Foundation to facilitate their first meetings, which resulted in the formation of the coalition. "The CEOs all agreed they would not compete on safety issues, and that set in motion the establishment of our agenda," says Bingle.

The ICPS has a working group of CMOs, nursing officers, pharmacy officers, and safety officers that sets the operational and tactical agenda for the improvement projects. "They in turn charter working groups of leaders in each organization to take on the initiative," says Bingle.

"We figured out early on that the more we could cooperate and standardize the better our success would be," says **Kathy Rapala**, JD, RN, director of the ICPS and Clarian Health's director of risk management and patient safety. Part of what happened over the first few years, she says, was creating a culture of cooperation among the

## Key Points

- Participating systems take a 'non-compete' pledge to ensure transparency.
- Those facilities with appropriate experience, expertise are selected to lead specific initiatives.
- Participants meet frequently in early stages of each program, then taper off in tactical phase.

members. "When you work for competitive organizations," she explains, "It takes time for cooperation to jell."

The first joint initiative involved the "do not use" abbreviations, says Rapala. "We added a couple of others [to those of The Joint Commission] based on our expertise and compared culture surveys around the hospitals," she recalls.

## Following the model

That model of drawing on the experience and expertise of individual members has continued, notes Bingle — with help from outside organizations as well. For example, the VAP and identification of high-risk patient initiatives were part of the Institute for Healthcare Improvement's 100,000 Lives campaign, and "the coalition decided they would implement all six of the 100,000 Lives initiatives," he says.

Then, the group looked at which facilities had the expertise, or more experience, with a given strategy, and in each case that system was assigned to be the leader. So, for example, Community Health was the leader of the rescue team (rapid response team) initiative, because they had implemented theirs in 1995.

While Community Health shared its model, the individual systems still had to adapt it to their own unique needs, Bingle explains.

"Some of our systems are major teaching institutions, while others are not," he notes. "So what is applicable to one is not applicable to another. For example, in teaching facilities, house officers and fellows are involved [on the teams]."

The work teams openly share the "how-to's" of the programs, says Bingle. They meet regularly, rotating the site. "The frequency depends on how far along we are with implementing the strategy," he says. "In the early stages we meet more frequently; if we are into tactical implementation, then we meet less frequently." Results are shared both in person and electronically.

"As you know, these are process strategies," he continues. "If you implement this process, you have a better chance of improving outcomes — but the efficacy of that strategy often is dependent on a bundle, a series of several processes that if implemented correctly all roll up."

So, for example, with a rescue team you are aiming to reduce the number of codes on the med/surg unit, but at the same time you may also reduce that number in the ICU because patients may be transferred prior to having a code.

## Results are positive

Since the ICPS is a collaborative, hospitals will start their programs and show improvement at different rates, with different baselines so it is difficult to state "collaborative-wide" rates of improvement. Still, says Bingle, "a lot of the effects" of the collaborative are already being seen.

"Some members of the coalition have had dramatic reductions in the number of codes in med/surg," he says. In terms of VAPs, "we saw improvement across our own ICUs; one of them has not had a VAP for three years and that continues today. That's pretty spectacular improvement; previously, in a given year we might have had six to 12."

Rapala says the coalition has begun to narrow its focus, after having met with Jim Conway, senior vice president of IHI, who suggested they try to attack fewer areas, but in greater depth. "One thing I've learned as director is that if you have to make a quick decision, you really need the right infrastructure," she says. "This year we've been really trying to ground ourselves in initiatives; one of our member hospitals had a heparin event so as a city we felt they had to lead the way in our anticoagulation therapy initiative."

The ICPS has now formally begun to collect data coalition-wide. "This opens up new issues of validation and how to use the data," says Rapala.

The state of Indiana, impressed by the coalition's achievements, is now looking at a statewide collaborative as well. "We will interface with them," says Bingle. "We believe health care is a regional issue."

He also believes it is a moral issue. "It would really be unethical for us not to share information if we knew a safer way to provide care," he asserts. "We know that 60% of our patients go between each others' systems. How, then, can you improve safety unless you improve it for everybody?"

*[For more information, contact:*

***Glenn Bingle**, MD, PhD, FACP, Vice President for Medical and Academic Affairs, Community Health Network, 1500 North Ritter Avenue, Indianapolis, IN 46219. Phone: (317) 355-5381.*

***Kathy Rapala**, JD, RN, Director of Risk Management and Patient Safety, Clarian Health, Indianapolis, IN. Phone: (317) 340-6256. E-mail: Krapala@purdue.edu.]* ■

# Palliative care program stresses teamwork

*Uses hospitalists trained in palliative care*

What makes an award-winning palliative care program? In the case of the program at the University of California at San Francisco, it's the combination of a collaborative approach to individualized patient care; extensive use of hospitalists; and a program that educates practicing physicians and medical, nursing, and pharmacy students and residents.

Those are some of the factors cited by the American Hospital Association when it recently named the UCSF program as one of the three winners of its annual Circle of Life Award for innovative efforts to provide end-of-life care.

"One of the problems in modern hospitals is that all these professionals — doctors, nurses, social workers, pharmacists, physical and occupational therapists, and chaplains — typically work independently," notes **Eva Chittenden**, MD, assistant professor of medicine at UCSF and acting director of the palliative care service at the UCSF Medical Center. "One of the things we do is break down these barriers. We all discuss the patients and learn from one another, and end up giving patients better care that's comprehensive and individualized."

## Collaboration a necessity

Interdisciplinary, collaborative work is essential to such a program, notes Chittenden, asserting that "you can't be a palliative care service without being a collaborative."

Nevertheless, it is the way the collaborative unfolds at UCSF that helped earn it national recognition. On a daily basis, the team meets at 9 a.m. on the wards. It includes a physician, a social worker, often a pharmacist, a chaplain, and often a nurse as well as trainees — fellows, residents, medical students. "We meet in a room and discuss all the patients on the service," says Chittenden. "Then, depending on the needs of the patients that day, we break into smaller groups and work with them — or we may see the patient as a team." Often, however, the size of that team is limited for fear of overwhelming the patient and family.

The team often will touch base in the afternoon as well as to reconvene and discuss what has happened during the course of the day, says Chittenden.

Every other week there is a formal interdisciplinary meeting for two hours. It includes all the physicians on the service; the head of the chaplaincy program and the chaplains; and nurses who are leaders but may not round with the team on a daily basis. Complementary alternative medicine providers are also present, says Chittenden. "We will discuss the patients in a larger framework, and talk about service needs and administrative issues," she explains.

## Key Points

- Hospital sees teaching future generations of providers as part of its role.
- Medical, social, psychological, and spiritual goals comprise individualized care plans.
- Having hospitalists in a hospital improves the chance of palliative care program being a success.

## Individualizing care

Providing "individualized" care, says Chittenden, "means we are focusing the care on the goals and values of that particular person." In other words, the team does not use a "one-size-fits-all" approach.

"We sit down with the patient, and whoever is important to them, and start by asking that person, 'What's important to you?' 'What are you looking for in the future?' 'What worries you?' 'What do you want to accomplish with the time you have left?'" Chittenden relates. "We discuss their hopes, goals, dreams, worries, anxieties, and fears, and then try to make the medical care we provide fit those feelings, to help achieve those goals." Those goals, she adds, can be medical, social, psychological, or spiritual.

"Let's say, for example, that someone's goal is to get home and spend time with their family — and we're talking about meaningful time," Chittenden offers. "That patient has to have excellent symptom management. If they have severe pain or shortness of breath or significant nausea, they are not going to enjoy their time with their family." Too often, she notes, providers will focus on the disease, and not on issues such as these.

If a spouse or child is in complete denial about the situation, a chaplain or social worker may be brought in for conversations to help everyone understand the patient's status and feelings. "It if

is a cancer patient, they can help decide if the patient will have another round of chemotherapy," says Chittenden. "The patient may consider the burdens greater than the benefits; they may not want to go to the clinic every few weeks to get an infusion that will make them feel sick if the potential benefit is less than 10%."

### Using trained hospitalists

The hospitalist group at UCSF is one of the first of its kind in the country, say Chittenden. "We have a large group — at this point, maybe 25 to 30," she says. "We have a core group of six on the service who are certified in palliative care." One of the benefits is that, as hospitalists, they are in the hospital all day long. "This is wonderful, because we need to spend time with the patients and their families," says Chittenden. "We are used to working with an interdisciplinary team."

In addition, she says, it adds to the job satisfaction of the hospitalists. "I like the fact personally that I get to do both types of work [general hospital care and the palliative care]. They are very different," Chittenden shares.

The hospitalists can perform this dual role, she explains, because of their training. "In our [basic hospitalist] training, we often do learn about some of the core skills in palliative care, but we have gone on to get more training, which is critical," Chittenden notes.

Chittenden adds that research by her group shows that having hospitalists in a hospital improves the chances of your palliative program being successful — even if they are not on your service. "They may be an additional source of referrals," she explains.

### Education part of hospital's mission

Training the next generation of providers "is a core part of our mission," says Chittenden. "We have education programs in our medical school, nursing school, and pharmacy school — in preclinical and clinical areas." In addition, she says, there are programs for medical residents, and for practicing physicians. "We also have a fellowship program — for residents who finished internal medicine and who want to have one or two years in palliative care training."

The clinical elective for fourth-year students has been available since the palliative care program began in 1999, and now 30% of the students elect to take it, Chittenden says. "It's a little early to tell if [graduates of the two-week hospital program] will work with us," she adds.

Of the internal medicine residents, five have gone on to do palliative care fellowships. "This is really new," Chittenden observes.

UCSF also has established the Palliative Care Leadership Center to educate and mentor hospitals around the country interested in starting their own programs. "A group from an interested hospital makes application and comes to our program, which is a very intensive two-day course," Chittenden says. "There is a lot of individual attention and mentoring as they go through a set of modules we created, followed by a year of telephone mentoring."

*[For more information, contact:*
***Eva Chittenden**, MD, Assistant Professor of Medicine, University of California at San Francisco, Acting Director, Palliative Care Service, University of California at San Francisco, Medical Center, San Francisco, CA. Phone: (415) 514-1758.]* ■

NEWS BRIEFS

## QIO developing outpatient quality measures

Under a new contract with the Centers for Medicare & Medicaid Services (CMS), the Oklahoma Foundation for Medical Quality (OFMQ) will collaborate with The Joint Commission to develop the first national standardized quality measures to assess performance in hospital outpatient facilities. The measures will be used by CMS for public reporting, performance-based financial incentives, and quality improvement.

The Tax Relief and Health Care Act of 2006 provides for the development of measures to assess the quality of care furnished by hospital outpatient settings, which may include emergency rooms, hospital-affiliated clinics, and ambulatory surgery facilities.

The contract calls for the development of technical specifications and a pilot test of an initial set of five measures to be released this summer. ▼

## Health leaders name quality 'favorites'

Health information technology, public reporting of quality measures, and financial incentives to improve care are among the strategies favored by health leaders to improve health care quality and safety, according to a new survey by the Commonwealth Fund. The survey, entitled, "Health Care Opinion Leaders' Views on the Quality and Safety of Health Care in the United States," is the 11th Commonwealth Fund Health Care Opinion Leaders Survey.

The on-line survey was completed by 214 opinion leaders in health policy, health care delivery, and finance. Nine in 10 respondents said Medicare should require all health care providers to use electronic health records within 10 years, and 70% said the federal government should play a leading role in financing health IT. Six in 10 respondents support public reporting on health care provider performance, and five in 10 support pay for performance and other financial incentives to improve health care quality. Three-quarters of respondents favor reforming Medicare payment to encourage "medical homes" that coordinate patient care.

Favored strategies for improvement include accelerating the adoption of health information technology, public reporting of providers' perfor-

***COMING IN FUTURE MONTHS***

- Interactive voice response system improves patient safety following discharge
- Health system suspends more than 100 employees for viewing EHRs
- Are patients' spiritual needs an appropriate concern for quality professionals?
- Study identifies error-prone medication abbreviations

mance on quality-of-care measures, financial incentives for improved care, and stronger regulatory oversight. Opinion leaders' survey responses closely align with the principles put forward by the Commonwealth Fund's Commission on a High Performance Health System. ▼

# The Joint Commission names new president

The Joint Commission has appointed Mark Chassin, MD, its next president. The appointment will be effective Jan. 1, 2008, when Dennis O'Leary will become president emeritus. Chassin is an executive vice president at Mount Sinai Medical Center in New York and chair of the health policy department at Mount Sinai School of Medicine, where he has focused on quality improvement initiatives. He is a member of the Institute of Medicine and co-chaired its National Roundtable on Health Care Quality, and is a former commissioner of the New York State Department of Health. ▼

# This year's 'Most Wired' take balanced approach

A "balanced scorecard" approach has replaced the dominant role of financial assessments in evaluating information technology (IT) plans among the nation's "100 Most Wired Hospitals and Health Systems," identified by the 9th annual survey and benchmarking study by Hospitals & Health Networks magazine.

The foundation of the new approach — which puts non-financial quantifiers on an equal basis with return on investment — is measurement, the survey found. This year's "most wired" hospitals show better outcomes in four key areas:

- mortality rates;
- Agency for Healthcare Research and Quality patient safety measures;
- Hospital Compare core measures;
- average length of stay.

Each year since 1999 Hospitals & Health Networks has surveyed the nation's hospitals on their use of IT to accomplish key strategic and operational goals. This year, 541 surveys were submitted by hospitals and health systems representing 1,217 hospitals.

Compared with other organizations, the Most Wired:

- Conduct more pre- and post-implementation evaluations of IT projects.
- Maintain a larger proportion of their medical records in a paperless format.
- Provide digital imaging to more clinical disciplines in a wider range of settings.
- Employ a broader set of telemedicine services.
- Deploy more IT educational resources for staff. ■