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First 14 communities designated Chartered Value Exchanges by HHS

Organizations will have special access to Medicare data

After a year of reviewing applications from multi-stakeholder organizations across the country, the U.S. Department of Health and Human Services (HHS) has selected the first 14 communities to be designated Chartered Value Exchanges (CVEs). **(See the list of CVEs, pg. 27.)**

The CVEs represent one of four "cornerstones" on which HHS seeks to build its health care reform initiative, which involves:

- advancing interoperable health information technology;
- measuring and publishing quality information to enable consumers to make better decisions about their care;
- measuring and publishing price information to give consumers information they need to make decisions on purchasing health care;
- promoting incentives for quality and efficiency of care.

As CVEs, these organizations will reap a number of benefits, including:

- The ability to join a nationwide Learning Network sponsored by HHS' Agency for Healthcare Research and Quality (AHRQ). This network will provide peer-to-peer learning experiences through facilitated meetings, both face to face and on the web;
- Access to HHS experts and new tools, including an ongoing pri-

Key Points

- Involving all the stakeholders in a community enhances your odds for success.
- Community organizations share successes, failures with other groups across the country.
- Groups chosen as CVEs already have impressive QI track records.

vate web-based knowledge management system;

• Information from the Centers for Medicare & Medicaid Services (CMS) on physician-group level performance, which will be available this summer.

Bringing communities together

As multi-stakeholder organizations, the CVEs comprise representatives from numerous community groups, including providers (health systems, hospitals, and physician groups), health plans, employers, consumers, and insurance carriers. They work on the theory that the only way to optimize quality is to engage all of these groups.

While they have similar missions, each CVE has its own unique approach. "We were formed with a pure focus on value in health care," says **Karen Feinstein**, PhD, president and CEO of the Pittsburgh Regional Health Initiative, which was founded in 1998 as one of the first regional multi-stakeholder coalitions. "Our goal is to increase the quality of services provided and hopefully by increasing that quality taking waste, errors, complications, and inefficiencies out of the system so every dollar spent finds value," she says.

On the other hand, she says, the Alliance for Health in Grand Rapids, MI, is a regional health systems planning agency that has served a 13-county region in western Michigan for 60 years.

"Originally one of the federal health systems planning agencies, we are a strategic planning organization," explains **Bridget White**, vice president. "We convene the business group on health, the physician group on health, the nursing coalition, insurance companies and agencies, and so on."

The Puget Sound Health Alliance, based in the Seattle area, "was formed in 2005 at the instigation of the King County executive, who got frustrated with the rate of increase of health care costs," recalls **Margaret Stanley**, MHA, executive director. As a multi-stakeholder organization, she explains, "we can see both the supply side and the demand side; we work together, and get all the stakeholders at the table."

The alliance includes employers (both public and private), health plans, provider organizations (medical groups, hospital associations), and consumers.

Initiatives are impressive

Each of these organizations already has racked up an impressive list of quality successes — each with their own unique target areas.

"We have several targets," says Feinstein. "We started to look at what we buy with health care dollars that does not add value — such as error, waste, unnecessary procedures. We wanted to determine how a clinical service unit could deliver only high-value care, and we looked to processes that work in other sectors — such as the Toyota method. We then developed our own methods, which we call 'Perfecting Patient Care.'"

To spread this knowledge, the initiative created its own university. "Thousands of people — including QI professionals, trustees, nurses, and doctors — have gone through our university," says Feinstein. "We teach our method and have a whole series of champion programs. People sign

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on, do major projects, and demonstrate how they might use Toyota methods to eliminate poor care."

While doing this, she says, "We also feel in many ways we need to engage the employer and consumer — the people who purchase and select health care more directly. We can train people and have sites with excellent care, but the biggest reward will be when people select care from quality providers."

The Michigan quality story, says White, includes having several of its business executives, particularly from General Motors, playing a major role in the formation of The Leapfrog Group.

"We were one of the early Leapfrog rollout communities," she notes. "Then, the Michigan Health and Hospital Association wanted to 'play' this game. We began to realize the Leapfrog measures had some limits, and using volume as a quality proxy really missed the boat on some smaller and more rural hospitals, so we formed the Michigan Health and Safety Coalition in 2003. We took the Leapfrog standards, added additional criteria beyond volume for a little more definitive and inclusive set of hospital quality measures, and today we use them both."

Actually, the alliance's pursuit of quality began about 13 years ago when the business coalition on health became involved in value-based purchasing and HEDIS data. "The coalition said they were paying all this money and didn't even know what they were buying," White recalls. "So they started asking health plans to publicly report HEDIS measures. Then, this evolved into an expanded request for information and value-based purchasing." This approach, she notes, ultimately was adopted by the National Business Coalition on Health, which uses a standardized method for evaluating health plans and publicly reports results.

"From this, we began to understand what value and quality were, and the next place we looked was the hospital," White continues, noting it coincided with the Institute of Medicine's Landmark report "To err is human."

"Many of our hospitals also have their own dashboard of their own quality indicators," White notes, adding that the alliance is now focusing on physicians.

"I am really proud of our hospitals; they have really embraced the process and are genuinely engaged and committed to publicly reporting quality," says White. "The business coalition approached them a couple of years ago about using Lean tools and they have actively embraced implementing Lean systems. I'm also very impressed by their openness; Spectrum Health became the first hospital organization in the state to report charges for the most 100 frequent treatments."

In Seattle, the alliance has established clinical improvement teams in various chronic diseases and other areas — heart disease, diabetes, low back pain, depression, asthma, prevention, and prescription drugs. "We also have a hospital quality measures group and an affordability work group," adds Stanley. The clinical improvement teams are charged with determining what the quality measures and clinical guidelines should be, drawing from national standards, and recommending change strategies — what each party needs to do to make care of a given disease

Chartered Value Exchanges

- Wisconsin Healthcare Value Exchange
  Madison, WI
- Healthy Memphis Common Table
  Germantown, TN
- Greater Detroit Area Health Council
  Detroit, MI
- Niagara Health Quality Coalition
  Williamsville, NY
- Oregon Health Care Quality Corp.
  Portland, OR
- Pittsburgh Regional Health Initiative
  Pittsburgh, PA
- Puget Sound Health Alliance
  Seattle, WA
- Utah Partnership for Value-driven Health Care
  Salt Lake City, UT
- Louisiana Health Care Quality Forum
  Baton Rouge, LA
- Maine Chartered Value Exchange Alliance
  Scarborough, MN
- Minnesota Healthcare Value Exchange
  St. Paul, MN
- Massachusetts Chartered Value Exchange
  Watertown, MA
- Alliance for Health
  Grand Rapids, MI
- New York Quality Alliance
  Albany, NY

better. "These are most detailed for providers," says Stanley. "Ambulatory care measures might include using a disease registry, calling patients in for regular visits for diabetes care, or encouraging heart disease patients to take a cardiac risk assessment."

While it is too soon to track improvement, Stanley says the alliance will be surveying employees and others to see if they have followed its recommendations. "We published a report on Jan. 31 we called a 'community checkup,'" says Stanley. "We found room for improvement, and a lot of variation across and within measures. But this gave us a baseline."

What CVE designation means

The CVE leaders all agree their new designation will help them achieve their long-term goals. For Feinstein, engaging the employer and consumer is "the missing piece" in her organization's equation, and "that's where the CVE designation adds value to us. While we are creating high value and training these champions, we need at the same time to be demonstrating their value with hard data. We can't say someone went through our training and therefore a certain demonstration project has merit; we have to eventually say we develop providers who are better than the pack — and they have to be rewarded."

The best way to do that, she says, is to have insurers willing to pay favorable rates and pay for quality improvements made by these providers, "and also make that information known to the employers selecting plans and the consumers who make decisions within those plans."

"Data, data, and data" are paramount, Feinstein continues. "So much of this is predicated on giving consumers credible, reliable data," she explains. "We want to be fair — the

Technical assistance for CVE Learning Network

One of the resources being made available to the newly designated Chartered Value Exchanges, or CVEs, will be technical assistance provided by the Sacramento, CA-based Center for Health Improvement (CHI). The company is positioned to provide such assistance, as it is already playing a similar role in the Robert Wood Johnson Foundation initiative "Aligning Forces for Quality."

"We will be providing technical assistance for the Learning Network, which is similar to 'aligning forces,'" explains **Patricia Powers**, MPPA, CHI president and CEO.

"First of all, we conducted a needs assessment," says Powers. "We interviewed 25 or so experts in the field, asked them where they saw gaps in terms of [health care] products and services where the CVEs could benefit."

At her company's annual meeting in September, Powers says, she spoke to the community leader organizations, predecessors to the CVEs, and asked them what their priorities were. "Based on that and our experience with Robert Wood Johnson, we came up with products and services to offer them," she shares. "We talked with AHRQ [the Agency for Healthcare Research and Quality] and developed a plan for the next couple of years as to the technical analysis."

The analysis will involve conducting inventory across seven key content areas, looking at the business case for quality by sector, and creating an electronic performance measurement public reporting mapping system. "We will move from selecting the measures to how to aggregate data, what are the data sources, and how to create a report card in the community," Powers explains. "There are also off-the-shelf products that can be used locally to inform people about hospital and physician performance."

Hospitals and quality professionals will benefit in a number of ways, Powers asserts. "First, they will be getting the technical assistance; then, they will learn from each other — one of the key reasons to have a learning network. They will learn best practices and incorporate them into their own. They will also have exposure to national experts on all these topics. There are a number of wonderful initiatives, from Leapfrog to CMS' Hospital Compare, to AHRQ's [Healthcare Cost and Utilization Project] tool for looking at data. In short, they will benefit from being familiar with the myriad resources out there and how to incorporate them into their own community strategy."

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more data we have and the more we can show a realistic picture of excellence, the more we can go forward to encourage the use of those data. We hope not only to get data we never had — including drilling down to the physician level — we hope the collaborative will enable us to sort out the pros and cons. Having this national network and being connected to people like [Brookings'] Mark McClellan and the leadership at AHRQ will give us a better understanding of value and [enable us] to create better transparency for the consumer."

AHRQ, she explains, is "the home of the CVE — they are command central. AHRQ has designated facilitation to Pat Power and her group, called CHI, in Sacramento. **[See the sidebar, pg. 28.]** There will also be a string from Mark McClellan and his team at Brookings."

"We are all struggling with rising health care costs," adds **David Fleming**, MD, chairman of the Puget Sound Health Alliance and director of the Seattle/King County Health Department. "Our approach is to convene key stakeholders in delivery and jointly define measures for improving quality — which is one way to control costs. Actions at the local level need to be driven by local innovation, and being a CVE in that network enables us to learn what is and what is not working across the country. There needs to be a way of sharing information across these local organizations and this will enable us to do our work better."

People around the country are trying different QI approaches, he continues. "The CVE designation enables information to be collected, analyzed, and displayed at AHRQ, so AHRQ will now be able to serve as a clearing house for information."

One of the big benefits, Stanley adds, will be the Medicare data. "When we report to clinics on these performance measures, we will really have information that represents almost all their practice," she notes. "One of the advantages of public reporting is when we merge this information with our own information you get a much larger database and sample size is not as much of an issue."

"We think CVE designation will inspire and motivate us to continue the on path we are on," says White, noting that her organization is also participating in the Robert Wood Johnson Foundation initiative "Aligning Forces for Quality."

"In fact," she says, "out of the 14 CVEs, eight are 'aligning forces' communities." (For more on this initiative, go to: www.forces4quality.org/.)

Access to information is critical, White continues. "We are down the path on beginning to measure quality performance of physician groups and organizations, and in order to do that we need to aggregate data from commercial payers, and also work with our state to get Medicaid data," White explains.

"By being a CVE, the very large and important piece — data from Medicare — is available to us. Now we will have a very complete data set to measuring quality, publicly reporting quality, and most important, the doctors and organizations will have complete and meaningful data for quality improvement."

Hospitals will benefit from the CVE designation at "a couple of levels," says White. "First, many hospitals either own or partner with a physician organization, and they will really be seeing movement toward a higher level of system integration. As we see that across hospitals and physician groups — both primary care physicians and specialists — it gives us a more comprehensive and accurate look [at performance] for all our actionable set of quality measures on inpatients and outpatients, on which we can take more meaningful action on getting better health results."

Bridging the gap between inpatient and outpatient care is critical, she continues. "We really need to bridge that gap; take, for instance, chronic conditions," she offers, "they may account for as much as 80% or more of our total health care costs, according to research. We see a lot of repeat admissions, often because when patients leave the hospital they are stabilized, but they do not continue [proper care] at home. If we can bridge the hospital's successful results with the primary care providers, we will have more of a continuum of care and, ultimately, get better results."

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Urinary tract infections overlooked by hospitals

Small number of facilities use proven strategies

A relatively small percentage of hospitals in the United States have a strategic approach to preventing urinary tract infections (UTIs), according to a study recently published in the journal *Clinical Infectious Diseases*.[1] In fact, the researchers add, very few facilities are using certain strategies with proven benefits.

The study was based on a survey sent to infection control coordinators at 719 hospitals across the country (72% of the facilities responded). Among the findings:

- 56% of the respondents did not have a system for monitoring which patients had urinary catheters placed;
- 74% did not monitor catheter duration;
- only 30% reported regularly using antimicrobial catheters and portable bladder scanners;
- 14% used condom catheters;
- 9% used catheter reminders.

"Despite the strong link between urinary catheters and subsequent urinary tract infections, our study showed there is no strategy that is widely used by U.S. hospitals to prevent hospital-acquired UTI," says senior author **Sarah Krein**, PhD, RN, a research assistant professor of internal medicine and research investigator at the VA Ann Arbor (Michigan) Healthcare System. "The most commonly used practices — bladder ultrasound and antimicrobial catheters — were each used in less than one-third of hospitals, and urinary catheter reminders, which have proven benefits, were used in fewer than 10% of U.S. hospitals."

Moreover, notes Krein, nearly half of hospitals lacked a system that tells them which patients currently have a catheter, and three-quarters lacked a system that can tell them how long a patient has had a catheter or whether one has been removed. Nearly one-third of hospitals didn't even track the UTI rates in their patient populations.

Key Points

- Nearly half of hospitals surveyed lacked a system that tells them which patients have a catheter.
- Limited morbidity, relatively low costs may be behind poor performance.
- A reminder system is a simple, yet effective strategy for minimizing urinary tract infections.

Why is performance poor?

As for why hospitals are not performing better in this area, "we are not able to shed much light on this issue based on our quantitative data alone," says Krein. However, she adds, "we have another manuscript that will be published this spring in *Infection Control and Hospital Epidemiology* in which we provide some insights based on qualitative data that were also collected as part of the study."

In a related editorial in *Clinical Infectious Diseases*, **Lindsay E. Nicolle**, MD, of the department of internal medicine and medical microbiology at the University of Manitoba, Health Sciences Centre, offered some thoughts, while at the same time noting, "it is remarkable that so few facilities measure this risk exposure."[2] Nicolle posits that:

- There is limited morbidity that can be attributed to hospital-acquired urinary tract infections;
- It is uncommon to see death directly attributable to hospital-acquired urinary tract infections;
- Estimated costs of these infections are significantly lower than those for other health care-related infections.

Best practices available

Nevertheless, says Krein, there is evidence available to demonstrate which practices are and are not effective in preventing these infections. "As part of the study, we asked about the use of several practices that have been evaluated to prevent hospital-acquired UTI, including using indwelling catheters only when necessary, removing catheters when no longer needed via the use of various reminder systems, using antimicrobial catheters in those at highest risk of infection, using external (or condom-style) catheters in appropriate men, using portable ultrasound bladder scans to detect post-void residual urine amounts, and using alternatives to indwelling urethral catheters such as suprapubic or intermittent catheterization," Krein

notes. "Practices no longer recommended due to lack of evidence include use of antimicrobial agents in the drainage bag, rigorous frequent meatal cleaning, and use of bladder irrigation were also examined."

There are a number of strategies that hospitals might consider to improve performance, based on their patient population and available resources, notes Krein. "However, one approach that has been shown to reduce UTI rates and decrease the duration of catheterization for many patients is to implement a simple reminder system that asks doctors every day whether a patient's catheter is necessary, or even makes catheter removal the default action unless a physician says otherwise."

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Mortality, costs still declining in HQID demo

Premier: Hospital costs could decrease $4.5 billion

Mortality rates and hospital costs at facilities participating in the Centers for Medicare and Medicaid Services (CMS) pay-for-performance demonstration project continue to decline, according to analysis by the Premier health care alliance.

Premier claims that, based on data from participating Hospital Quality Incentive Demonstration (HQID) hospitals, if all hospitals nationally were to achieve the three-year cost and mortality improvements found among the HQID project participants for pneumonia, heart bypass, heart failure, heart attack (acute myocardial infarction), and hip and knee replacement patient populations, they could save an estimated 70,000 lives per year and reduce hospital costs by more than $4.5 billion annually.

Key Points

- Average improvement of 17.3% seen across all areas since beginning of initiative.
- All areas of a hospital must make quality a high priority.
- Reliability is a critical factor in measuring quality performance.

Premier collected a set of more than 30 evidence-based clinical quality measures from more than 250 hospitals across the country. (**For more on the demonstration project, see "Demonstration project continues gains in year two," *HBQI*, April 2007, pg. 43.)**

The analysis reviewed 1.1 million patient records, which represents 8.5% of all patients nationally within those clinical areas over the three-year timeline. For hospitals participating in the HQID project, the median Composite Quality Score (CQS), a combination of clinical quality measures and outcome measures, improved by an average of 17.3% across all clinical areas between the inception of the program in October 2003 and the end of June 2007

On the average, the median hospital cost per patient for participants in the project declined by more than $1,000 across the first three years, whereas the median mortality rate decreased by 1.87%. The median Appropriate Care Score (ACS), also referred to as "perfect process score," to designate when a patient receives all possible care measures within a clinical area, improved by an average of 52.6% across all clinical areas.

When Premier compared these data to those of non-participating hospitals, the quality score of hospitals in the HQID project on 19 publicly reported quality indicators was 6.5% higher.

Broad analysis

This analysis is "the broadest of its kind," according to Premier. "There are 1.1 million discharges associated with the data, and also very detailed clinical benchmarks — as well as all the related process benchmarks," explains **Richard Norling**, president and CEO of Premier. "As a result our database has fully loaded costs."

Norling goes on to say that the rate of quality

improvement in the project has "improved," if you will, over the three years. "The first analysis we did was year one, and if you look at overall improvement, year No. 1 was when we had the most variability in performance," he says. "As we went from year to year, all the hospitals got closer and the good ones got better."

Now, he continues, the project has a multi-year trend on the reduction of mortality and costs and constant dollars. "So we see a strong association at the patient level between executing processes being incented and lower mortality and costs. Year three corroborates year one as regards to those associations — the relationship between reliably executing evidence-based processes and a reduction in mortality and cost."

This only makes sense, says Norling. "Obviously, in year 'one' we had a lot of hospitals just getting into the program and ramping up," he notes. "By year three we saw an aggregate improvement pattern."

In addition, he says, there are many more hospital-specific analyses being conducted. "One hospital reduced heart attack mortality by almost 50%," he points out. "We can trend the results as time goes on, but there are a lot more very specific examples of hospitals that had incredible results in their communities."

The demonstration project was initially slated to last three years, but because of its success, notes Norling, CMS decided to extend it for an additional three years. "We are in year five and continue to have good results and examples," he notes.

Lessons learned

Norling says valuable lessons have been learned about what sets the high-performing hospitals apart. "I think probably the most important thing is that high-performing hospitals make quality a top priority; that includes the board, its relationship with the medical staff, the expectations of the CEO and the quality team," he says.

Reliability is another critical factor, Norling adds. "The results we are talking about make it clear that you have to reliably execute each and every evidence-based process," he says. "It underscores the importance of reliable execution."

In addition, he says, rather than just looking at their own data and internal capabilities, hospitals have had the chance to collaborate with other facilities and to learn from their successes — as well as their failures. "The collaborative approach is really significant," he asserts.

"We also learned that many of the improvements made were not necessarily complicated, but it takes tenacity to ensure they are being done each and every time for every patient," he concludes.

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Hand gel fails to curb infections on its own

Gel must be used in conjunction with other measures

While hand washing is strongly emphasized as a patient safety strategy, a new study published in the January 2008 issue of *Infection Control and Hospital Epidemiology*[1] indicates that hand washing alone may not be enough to ensure lower infection rates.

The study, conducted at Nebraska Medical Center in Omaha, examined the effectiveness of alcohol-based hand gels — thought to be more effective than soap and water. The findings were based on 300 hours of hand hygiene observations of nurses and doctors in two comparable intensive care units over a two-year period.

The researchers placed gel dispensers in the units, and every two months bacteria samples were taken from health workers' hands. Usage increased — from 37% to 68% in one unit and from 38% to 69% in the other. However, they found "no significant relationship" between rates of hand gel use and infections among patients. "Quite frankly, [the results were] a little bit disappointing," admits lead author **Mark Rupp**, MD, professor of infectious disease at the University of Nebraska Medical Center and medical director of the health care department of epidemiology. "But the take-home message is that hand hygiene is not a panacea; there is not a single cure for all infection control problems."

Looking at compliance

The initial purpose of the study, Rupp continues, was to examine not only infection rates, but also staff compliance with the use of hand gel.

"We performed a prospective, controlled study over a two-year period of time in these ICUs in which we were trying to ascertain whether the use of alcohol-based hand hygiene gel resulted in increased [hand washing] compliance and if it correlated with improved outcomes," he says. "Hand hygiene compliance rose dramatically in relation to when the gel was present in the unit, but unfortunately we saw no correlation with changes in the infection rate."

There was media commentary following the release of the study positing that Rupp's findings contradict the Centers for Prevention and Control (CDC) guidelines for hand washing, but he disagrees. "Some people interpreted [the results] wrongly and said hand hygiene was not effective and the CDC recommendations are incorrect, but what I think the bottom line is, is that the pathogenesis of nosocomial infection is complex — and no single intervention like hand hygiene will have a dramatic effect. In other words, hand hygiene is one ingredient in an overall recipe of infection control."

Other 'ingredients'

So, what are some other "ingredients" for Rupp's recipe? "You should pay attention to how you take care of urinary catheters," he advises. "Have ventilator patients positioned correctly and provide proper mouth care known to prevent ventilator-associated pneumonia, and use antibiotics prudently to avoid selective pressure for antibiotic-resistant pathogens. If you do all of these, along with maintaining a good, clean environment, then you will get a big impact."

There were some other findings of the research that were quite interesting, Rupp continues. "Every two months we cultured the nurses' hands and correlated what we found [in terms of microbial infestation] with other factors, like the length of fingernails and wearing rings," he relates. "Any length of fingernail over two millimeters in length was associated with increased carriage of microorganisms. Likewise, if you were wearing rings it was associated with increased numbers of microbes on the hands."

In terms of the findings concerning overall rates of infection, the authors did point out in the paper, says Rupp, that the research was "statistically underpowered" to find a small impact on the infection rate. "The rates were so low to begin with that it would be difficult to show a statistically significant impact," he notes. "That's why we designed it to be over a two-year time period; we hoped [the gel] would have a dramatic effect and we would see those changes."

Would things have been different if the compliance rate had been even higher — say 90%? "That's a great point; it may be that compliance was not high enough to give this hand hygiene maximal benefit," he responds. "Or, it could depend on the virulence of the organism underlying host immunity."

The bottom line, he concludes, is that the study should be viewed as "a cautionary tale."

Key Points

- Infection rates are relatively steady even though compliance improves significantly.
- Proper positioning of ventilator patients, proper mouth care, prudent use of antibiotics are important strategies.
- Long fingernails, rings can increase the risk of infection.

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Joint Commission releases proposed 2009 NPSGs

Changes in medicine reconciliation

The Joint Commission has released its proposed 2009 National Patient Safety Goals (NPSGs), and as one quality expert has opined, "It probably contained no surprises."

The proposals focus on new and revised NPSGs for the following topics:

• Goal 1: patient identification ;
• Goal 3: safe use of medications (laboratory accreditation program only);
• Goal 7: hospital-acquired infections focusing on methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*-associated disease (CDAD); catheter-associated bloodstream infections (CABSI); and surgical site infections (SSI) in acute care hospitals;
• Goal 8: medication reconciliation;
• Goal 13: patient involvement in their care;
• universal protocol.

"Your readers will probably want to spend the most time reading about medication reconciliation," says **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission.

"This turned out to be a goal everybody agreed with in concept, but it has been highly complicated to implement," Angood concedes. "As a result of comments from the field we reviewed all the issues; the components are essentially the same, but the language is refined."

So, for example, under the proposed new goal, a medication reconciliation list will still need to be generated; there needs to be ongoing reconciliation when a patient is transferred to another facility; the receiving facility needs to have an updated list as well as the patient; and when the patient actually leaves care they need to receive an updated list — as does the next provider of service.

"What is somewhat new is that for patient care areas where the medications are prescribed for a short term, a modified process can be utilized," says Angood. So, for example, if a patient goes to an outpatient facility for contrasts, they can have the meds list reviewed, but all the specifics of medication administration will not have to be determined.

"We assume that if they then receive no other medications, they will be able to be discharged without having to go through full medication reconciliation," he explains. "We've also made it more clear what the key steps and expectations are, to try to make it more practical."

"I guess they have addressed the issue, although we have not yet had to apply it in real life, so we're not sure it works," says **Patrice L. Spath,** of Brown Spath Associates, Forest Grove, OR.

Spath believes that Goal 8b could still present some difficulties. "When patients leave the hospital and are sent home, a complete list must be given to the primary care provider or the referring provider or known next provider. What if a patient had [emergency] surgery? They will have a surgeon, but the hospital may not always know who the primary care provider is, so this needs to be clarified." Spath predicts that "as people respond to these proposals, you would think they might raise this issue."

Key Points

- New language added for HAIs to include MRSA and CDAD.
- Nurses will not be allowed to identify surgical sites.
- Close alignment with Medicare could cause Joint Commission to overlook important topics

HAIs are new

Perhaps the most significant new goal for quality managers is the one dealing with hospital-acquired infections, says Angood. "We have an existing Goal 7, which initially focused on hand hygiene and reporting of HAIs where major disability occurs. However, we have added requirements related to multi-drug resistant organism infections, MRSA and Clostridium *difficile* — often called CDAD (*Clostridium difficile*-associated disease)."

In addition, he says, The Joint Commission has added some requirements in the universal protocol. "We held a summit in early 2007; a variety of professional organizations — as well as our own — had noted that even though it had been out for a year there had not been a change in the frequency of reported wrong-site surgery events. Everyone agreed the components were correct and we should continue to use them, but there needed to be a little more prescriptive language." The details, he says, have been made "a little tighter."

"There has been a debate about whether the surgeon was the one who should mark the surgical site, and that was cleared up with the 2009 proposed standards," says Spath. "I'm sure it will stay in because hospitals will be given RFIs [requirements for improvements] if they do not have the surgeon do it."

In the past, she notes, some hospitals were allowing nurses to mark the site, but "that will no longer be an acceptable practice," says Spath.

In addition, says Angood, the proposed new goals include added language concerning patient involvement in their own care, as well as patient

identification.

The latter "could be problematic," warns Spath. "It requires a two-person identification process if you do not have bar-coding, but that kind of double check is considered weak from a human factors engineering perspective — because the second person will often see what they expect to see." Still, she concedes, "It may be better than doing nothing." She also adds that this goal, as many of the new proposals do, "makes good common sense."

A shift in alignment?

Spath notes that the more recent versions of the NPSGs (which were started in 2003) "seem to align more with Medicare [standards] than with sentinel event [reports]. Take surgical infections," she offers. "How many sentinel alerts do they — [The Joint Commission] send out on infections? Yet what does Medicare push?" MRSA and bloodstream infections, she points out, "are things Medicare is focusing on now; this looks like a shift to more closely align the goals with [Medicare] priorities."

While "killing two birds with one stone" may make sense on some levels, Spath has her concerns. "I'm not sure we move as effectively towards improved quality and safety if all groups are focused on the same things," she offers. "For example, medication reconciliation is not something Medicare is focused on, so we might not have had it if the two were that closely aligned; the same thing goes for patient identification." In other words, she summarizes, there needs to be a balance.

Angood says the final goals will be published in May or June, and it is hard to predict how much the proposals will be changed — if at all. "It varies year by year in terms of what occurs between our [proposal] short list and the final goals depending on the feedback we get and the general discussion within our advisory group," he says. "The program is only five years old so we are still building and refining it; we will continue to get more rigorous as to how we choose our goals, how we review them, and whether or not they are adopted in some form." (For more information on the proposed goals, go to: www.jointcommission.org/Standards/FieldReviews/09_npsg_fr.htm.)

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NEWS BRIEFS

PA hospitals address preventable errors

The Hospital & Healthsystem Association of Pennsylvania (HAP) in Harrisburg has voiced the hospital community's support of a new Department of Public Welfare (DPW) policy, announced by Gov. Rendell, in which hospitals will not receive payments for preventable serious adverse events, which include surgery performed on the wrong body part and serious medication errors.

HAP is a statewide membership services organization that advocates for nearly 250 Pennsylvania acute and specialty care, primary care, sub-acute care, long-term care, home health, and hospice providers, as well as the patients and their communities.

"Pennsylvania's hospitals have worked collaboratively with the Department of Public Welfare on the development of a workable policy to

COMING IN FUTURE MONTHS

- Hospitals enlist the aid of efficiency experts to improve productivity
- Connecticut hospitals collaborate to prevent infections
- Massachusetts evaluates cost, safety benefits of CPOE
- New technology enables speedier diagnosis of MRSA

address when payment will not be made under the state's medical assistance program," said Paula Bussard, HAP senior vice president for policy and regulatory services, in a prepared statement. "We think that this new policy provides guidance for hospitals and the medical assistance program that will assure that payments are made to hospitals for medically necessary services, and not made when preventable serious adverse events occur during a hospitalization."

The policy, which is to take effect this month, codifies and standardizes hospitals' ongoing efforts to prevent adverse medical events. The policy will apply to preventable serious adverse events that occur during an inpatient stay that result in significant harm to medical assistance patients at a general acute care hospital.

"Hospitals recognize that preventable serious adverse events can have a profound effect on patients," Bussard said. "This policy represents another important step in Pennsylvania hospitals' efforts to provide the best possible care to each person who comes through our doors." ▼

Two insurers to stop paying for hospital errors

Two major insurance companies, Aetna and WellPoint Inc., have decided to stop paying for certain hospital errors themselves or prevent hospitals from billing patients for procedures that ended in hospital errors.

The insurance companies are choosing different sets of errors to not pay for. Aetna is using the 28 "never events" outlined by the National Quality Forum (NQF), while WellPoint focuses on four events from NQF's list. ▼

Study says low use of outpatient rehab after MI

Just 35% of heart attack survivors reported receiving outpatient cardiac rehabilitation services when surveyed by the Centers for Disease Control and Prevention. Only 21 states and the District of Columbia participated in the 2005 survey. Possible reasons for low rates of use include cost and lack of referral or access to services, the authors said. ■