

Healthcare Benchmarks and Quality Improvement

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JULY 2008

VOL. 15, NO. 7 • (pages 61-72)

CMS proposes a vast expansion of its quality measures program

Closer ties between performance, payment put more pressure on QI

In a dramatic effort to expand its quality program for hospital inpatient services in fiscal year 2009, The Centers for Medicare and Medicaid Services (CMS) has proposed the addition of 43 new quality measures for which hospitals will have to report data in order to receive the full annual payment update for their services. This would more than double the current number of quality measures in place.

In addition, CMS is proposing to more than double the list of hospital-acquired conditions (HACs) for which it will no longer pay hospitals at a higher rate for the resulting increased costs of care (so-called "never events"). The nine new conditions, which are being added to the current eight, would be effective Oct. 1, 2008. (For a complete list of the proposed changes, go to: www.cms.hhs.gov. In the blue bar at the top of the page, click "Newsroom." Then, under "Media Releases," click "Fact Sheets," and then click the topic you wish to view.)

While the final rule will not be issued until about Aug. 1 (comments were being accepted through June 13), quality managers are already expressing concerns about the short "window" until the new requirements are enacted, and the additional burdens they will put on quality departments.

"First of all, there is a need for awareness of the measures and

Key Points

- They may be called 'never' events, but not all of them are preventable.
- Quality managers will have to 'staff up' to meet new CMS requirements.
- Even electronic documentation systems may require some re-tooling.

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the implementation timeline,” notes **Rita Stockman**, RN, MSA, director, accreditation and quality at William Beaumont Hospital in Royal Oak, MI. “Some changes will be initiated Oct. 1, so the timeline is the key. Each organization must first become familiar with the inclusions or exclusion of measures; this is a lot of measures. Then, you need to look at the personnel required to investigate the data.”

This translates “the need to expand and change how we fundamentally manage the quality department,” she continues. “And, if you relay your information on an EMR (electronic medical record) you have to make sure [the new measures] are “baked” into your coding or EMR; if not, you have to re-design it and put it back into the infrastructure of the medical record.”

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. Periodicals postage paid at Atlanta, GA 30304 and at additional mailing offices. 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 \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. 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.)

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Editorial Questions

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

Patrice L. Spath, of Brown Spath Associates, Forest Grove, OR, agrees. “All hospitals are going to have to hire more people,” she says. “I read some comments recently by a hospital CEO who said we are spending more and more resources on collecting data and less and less on taking care of patients. You may eventually reach a breaking point; if you have people who could have prevented pressure ulcers sitting in an office collecting data you are not improving quality of care but the quality of the Medicare database.”

Spath is also concerned about the implications for EMRs. “Even in a sophisticated system, I don’t know if all these data elements can be pulled from the records,” she observes. Additional time will be required, she notes, not just to add the data elements, but to have someone else watch what is going on concurrently — “to make sure you don’t have to report something that is not being done.”

For example, she says, if a beta-blocker is not ordered at discharge and someone calls the physician to ask why it wasn’t, the reasons have to be documented. “It’s also a matter of intervening while the patient is getting care, so you don’t have to end up reporting something you didn’t do,” Spath adds.

Are measures ‘fair’?

Beyond the additional work, say the experts, some of the expectations set forth by CMS for the “never” events may not be realistic. “Even the things in the original list that people are now dealing with are not necessarily preventable events,” Spath argues. “Things like urinary tract infections [UTIs] or pressure ulcers are not always preventable. They happen every once in awhile and you can’t do much about them, but they got grouped in these events.”

Alice G. Gosfield, a health care attorney who heads the Philadelphia-based firm that bears her name, agrees. “There is no question that one of the problems with never events is that among those the National Quality Forum has identified are some about which there can be quibbling,” she says. “There is no quibbling over wrong-site surgeries, but bedsores, as an example, are a real issue, depending on the condition of the patient upon admission.”

Gosfield emphasizes that she is not a clinician, but adds: “As I understand it, people who come to the hospital from nursing homes or languish in bed for awhile may have incipient [bed sores]; they show up in a degraded condition, other circumstances exacerbate the problem, and it

becomes fully obvious.”

“We work hard to prevent ventilator-associated pneumonia and surgical site infections, yet these are areas where our controls are limited,” adds Stockman. “We can’t always predict what the body’s response will be.” For conditions like UTIs, she continues, protocols can be followed, but for some of the new onset conditions, such as delirium, her response is, “good luck with that!” Iatrogenic pneumothorax (collapse of the lung) may present similar challenges, as this is a condition that certainly can be identified but not necessarily prevented. “These are certainly things we can strive toward, but some of it requires a more thorough medical history and communication of clinical information upon admission,” Stockman asserts.

For all these reasons, says Stockman, “you have to be as fully aware as possible of the patient’s admitting condition. It affects all care, and for a quality person to trace each element of the event or condition of the patient, you have to look all the way back to their status at the time they entered the health care system.”

Who is harmed?

“Let’s focus on the real issues,” offers Gosfield. “It’s not like the hospital would be paid nothing. They will still be paid for what the patient was admitted for, but if it degenerates, CMS argues you should have been clear on what you have been admitting patients for to begin with.

“The point of the never event policies, though, is not to punish people, but to create an incentive to develop systems that work better and prevent problems,” she continues. She concedes, however, that “the level of problem analysis that is necessary to be able to prevent these errors is not without challenge,” pointing to the recent, well-publicized incident in Minnesota where the wrong kidney was removed from a patient (See “Wrong-site surgery: We’re not doing all that we can,” *HBQI*, June 2008, p. 49)

“I am told the problem arose because when the X-rays were done, they were mislabeled,” Gosfield says. “All of the checks after that confirmed action to be taken in accordance with a mislabeled image, so where the problem can begin may be very far from the site of the ‘never event.’”

Which is precisely Spath’s concern — along with her fear that patients may not ultimately benefit from these additional measures. “What continues to concern me is that hospitals might ‘cherry pick’ patients,” she says. “As more and more data are

required, and as hospitals naturally want to look good, the less likely they may be to want to admit someone who is 65, with multiple co-morbidities and more likely to develop pressure ulcers or get a UTI. That raises the issue of ethics — are we going to start admitting only healthy patients?”

There is certainly the chance that not everything that is present on admission would be found, says Gosfield, “but that does not mean you wouldn’t admit them.”

A liability issue?

But Spath is not so sure, fearing that never events are things that plaintiff’s attorneys would “love.” “This says to the public that all these things shouldn’t happen, so consequently every time one of them does happen, you could have a lawsuit,” she posits. “It basically creates a list that is a menu for patients’ attorneys.”

This has a real risk management twist, she asserts. “Why would I want to admit people with all these problems?”

Spath points to a recent article in the *Journal of the American College of Surgeons*¹ that indicates others have similar concerns. Spath says it uses “liability fears” as a motivator to practice infection reduction guidelines.

But Gosfield says these events might not present such a serious liability issue. “From a litigation perspective, the real issue is the standard of care,” she explains. “Proximate cause — what created the injury — is an essential aspect of proving a case. The mere fact that a never event occurred won’t in and of itself be dispositive of liability, but it sure puts the care into the category of: How will you justify what happened?”

In addition, she points out, most such cases end with a settlement and an apology.

Economy against us?

Finally, says Stockman, the economy may present quality managers and health care providers with another difficult challenge. “People make choices about health care, [and because of the poor economy] it’s more likely people will enter the health care system with a higher level of acuity than years ago,” she says. “So our risk as a facility will exponentially increase just because of the economy. The patients come in, they are sicker because they refrained from getting the care they needed, and it’s more likely they will present with a higher number of co-morbidities.”

Key Points

- Quality executive: You can't have quality without transparency.
- Patients come up with practical recommendations to improve care.
- Patients go through a thorough selection process.

For example, she says, it will “absolutely” increase the number of people who use EDs as primary care, “and that will have a huge domino effect.”

Such trends, she continues, “are some of the things we as an organization truly cannot control from a clinical standpoint.”

Still, Gosfield argues, most of the quality requirements address things hospitals “should be doing,” and basically raise “a payment issue associated with what should be the standard of care.” She does concede, however, that quality managers “may have to reprioritize.”

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Reference

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‘Transparency community’ involves patients

Patients placed on key hospital committees

At St. Joseph’s PeaceHealth in Bellingham, WA, a former patient has been sitting on the facility’s medical executive committee for more than a year. Another patient is part of the interview team that is selecting a new CEO. These are just the latest in an ongoing stream of initiatives that have placed patients on many key hospital committees.

It’s all part of the “transparency community” established by PeaceHealth, a health system located in the northwestern United States. Its organizational chart would be the envy of a major corporation: At the top of the chart sits the

PeaceHealth board and executive team, comprising the advisory group (board members, patients and staff); the project management team (which coordinates the work of all transparency teams); and regional champions. Reporting to them are:

- change management: the quality improvement leadership team;
- communications team: this team provides regional liaison between communications and QI;
- measures team: they evaluate and refine measures;
- technical team: responsible for the transparency web site;
- patient medical records access team: develops a strategy for giving patients access to their electronic medical records.

The initiative got its impetus about six years ago, “partly as result of our hospital and our community being recipients of one of the Robert Wood Johnson and [the Institute for Healthcare Improvement] grants for ‘Pursuing Perfection,’” notes **Marla Sanger**, RN, MBA, vice president, quality and process improvement, noting that there were only seven recipients of the grant in the United States. “We had the opportunity to network with our colleagues; each approach was different, but we were all very focused on the patient’s health and well-being, their experience throughout the continuum of care, and patient-centered care.”

One of the key messages the system adopted at this time, she recalls, was the creed: Nothing about me without me. “The point is that information belongs to the patient, and we are here to partner with the patient to optimize their experience and outcomes,” Sanger explains. “If you have knowledge, you can make informed decisions, but you can’t have that without transparency.”

Invitations issued

In 2002 says Sanger, who headed up the inpatient efforts at St. Joseph’s related to the “Pursuing Perfection” grant, “we invited patients to be part of the [program’s] design, planning, and decision making,” she says.

“At that time we had some patients in the hospital working on medication reconciliation and improving care for diabetes, and we also had patients on PI teams,” says Sanger. “One patient, who was on diabetes care, was later invited to be part of the pharmacy and therapeutics committee.”

That invitation came in 2004, says Sanger, and it was the first time a patient was asked to become part of a medical staff committee.

“It’s been a journey,” Sanger concedes. “When the concept was first introduced, some worries came up.” For example, she notes, the staff wondered if the patient would be able to keep information confidential, and some said they might feel uncomfortable speaking candidly. They also feared that the patient would ask for information that they just couldn’t provide.

“We addressed these issues one at a time,” says Sanger. “At the very beginning, we just said we didn’t know how things would unfold, but as we started to gain experience, we were able to say that most concerns proved to be unfounded. There’s now enough volume of experience to know that those things do not play out as real worries.”

All patient participants go through a “modified” orientation process similar to that given to all the hospital volunteers — fire safety, a brief infection control course, and so on. “Then, depending on what team they’re on, training gets customized,” says Sanger. “For example, the lady on the MEC spent two days observing an orthopedic surgery and following the intensivists around so she could gain a better understanding of their work.” And, as with anyone who joins the staff, they are asked to sign a confidentiality agreement.

On to the MEC

Putting a patient on the MEC was “a logical extension” of what had already been happening, says Sanger, noting that “we felt we were getting value from having patients sit in on other committees.”

This latest move began a couple of years ago when the immediate past chief of staff, as she was rotating off, asked the MEC to add a patient. “She prefaced her remarks by saying that patients had been involved on different teams already, and she believed it was important to improving quality that they have a seat at the MEC table,” recalls Sanger, who is a non-voting member of the MEC.

The group expressed many of the same concerns that others had previously voiced, “but she said that any group that had had a patient on

their team felt it added value, and most said they would never go back to the way things were before,” says Sanger.

Still, the group was not comfortable with having a patient there if they were talking about a specific clinician PI plan or disciplinary action, or credentialing or privileging. “She said that was fine, that the group could excuse the patient during those parts of the meeting,” says Sanger. “They voted approval that day — assuming I could find the right patient to invite.”

Making the selection

That took several months, because of the criteria that were used. “We wanted someone who had enough experience to be a member of a team, and who showed they could work collaboratively, solving difficult problems,” Sanger says. “They could not have a personal agenda, and had to be able to safely hold all confidentiality.” Potential candidates were screened by the members of the committee.

The top candidate turned out to be someone whose daughter worked in the medical staff office. “She had been on the board of a credit union and other groups as well,” says Sanger. “They asked her how she could handle all the private information she would hear, and she responded that most people are even more private about their money than their medical care, and she had been successful dealing with that.”

They also asked her if she could handle the sometimes rough tone of the meetings, and she replied that she has successfully worked with Texas oil men in contentious situations and felt she could handle whatever came her way.

For the first four to six months, says Sanger, the patient would be asked to get up and leave the room during sensitive parts of the meetings. “Then, all of a sudden, the chairman — who had always asked her to leave — forgot to do so, but she got up and stepped out anyway.” After she had been attending meetings for close to a year, says Sanger, the committee voted to allow her to stay, and today “she is a full partner.”

Positive changes made

Sanger says the hospital has clearly benefited from having patient input. For example, she says, one patient who works in surgical infection prevention is a retired nurse, and made some suggestions about making hand hygiene gel more easily accessible — and the hospital listened. “She came in one

day, and saw gel dispensers everywhere she looked,” Sanger says. “She felt she had really made a difference.”

These experiences “make patients feel very connected; it gives them some sense of accountability for the hospital and a deeper understanding of the complexity of providing health care,” says Sanger.

Sanger “highly recommends” this approach to other facilities. “I can’t emphasize enough how important I think it is,” she says, while cautioning that real success “requires ongoing nurturing.”

As for the link between transparency and quality, Sanger is emphatic. “It’s hard for me to even separate the two in my head,” she says. “Transparency is an integral part of quality.”

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Approach for treating methadone patients created

Challenging patients are paired with experienced staff

The professionals in the addiction treatment services team at Johns Hopkins Bayview Medical Center in Baltimore have created an approach for treating methadone patients, called the motivated stepped care (MSC) model, which has decreased positive urine tests from 74% to 54% and increased group counseling attendance from 14% to 65%.

The model, which won the facility a coveted Codman award, features a patient/provider matching protocol that puts the most severely affected patients under the care of the most experienced and highly trained staff, along with behavioral contingency plans to reinforce adherence to recommended treatments.

“We had noticed at the methadone treatment clinic that patients were not attending scheduled counseling sessions at anywhere near the rates that we needed; research shows the more they attend and the longer they attend the better the results,” notes **Van King**, MD, associate professor, department of psychology and behavioral Science at Johns Hopkins. “The problem was, how to get them motivated to attend these impor-

Key Points

- Patients are required to attend sessions in order to receive Methadone.
- Medication alone will often not result in positive outcomes.
- Patient care is ‘stepped’ up or down depending on progress.

tant meetings.”

‘Carrot and stick’

The team came up with what King calls a “behavioral motivating” approach: They required the patients to come to meetings in order to have access to methadone. “In order to come and get the methadone, which in and of itself is helpful, they had to participate more completely in group and therapy sessions,” King explains. “Ultimately, availability is based on whether you come to treatment.”

Often, he notes, there is no rehabilitation if a patient just comes for meds and other treatment. But doesn’t denying a patient medication that makes them feel better raise ethical questions? “The fact of the matter is that anytime physicians agree to treat a patient it’s based on a collaborative approach,” says King. “You don’t just hand out drugs to people if you do not think they will ultimately benefit from them.”

Based on the team’s observations, he continues, “handing out [methadone] can be helpful, but it’s not unusual for people to continue to deteriorate. Maybe they will take the methadone but [without counseling they will still] use alcohol or cocaine; their relationships will continue to deteriorate, and so on. The idea here is that by patients coming to more complete treatment and maintaining abstinence for a longer time they can actually start to rehab in a very significant and meaningful way.”

And how do patients react to this ‘either-or’ proposition? “This gets the patient’s attention,” King observes.

Matching patient, treatment

The second aspect of the program, which makes it not only successful but “efficient and economical,” in King’s words, is that it tries to match the intensity of treatment to the severity of the problem. “When the patient first comes in, they get a basic level of care — educational group sessions one or two hours a week,” says King. “If

they continue to use, in a step-rated fashion they are assigned to more counseling to address those problems.”

Currently, the program has four steps of care. “If they come in at ‘two’ and do great, they step down,” notes King. He explains that level three includes additional group counseling sessions, and four “is like an intensive outpatient level of care — and they stay there until they get some initial control of their drug use problem.” When they are somewhat stabilized, they are reduced in care again and continue to be monitored with urine tests.

The more severe cases also are matched with more experienced staff. “One thing we noticed is that a lot of these patients who do poorly may have other psychological disorders, and tend to be more disordered in general,” says King. “What we have done is for group therapy sessions we have the most experienced staff; they can tend to more complicated issues that counselors may not be equipped to deal with.”

What’s more, says King, “Patients can be disruptive or disgruntled and often it takes a more experienced person to help direct them in a more positive way.” In addition, he notes, there is a lot of turnover among counselors, “And it’s a long-term treatment process; we expect these patients to stay with us for years.”

Staff develop plans

The entire staff were involved in program development from the start, notes King.

“One of our supervisors developed computerized data tracking sessions, and the staff had input into how we ended up implementing it,” he says. “The group sessions we took from standardized cognitive behavioral manuals.”

Another key to success, he says, was the overall approach. “What we do is use therapy in a thoughtful and consistent fashion,” he says. “Patients are told about the requirements right up front.” Initially, he says, there were complaints about the group sessions because “nobody likes them at first” — but he adds that “we never hear that now; they are a valued part of our treatment.”

Because patients are motivated to see the staff more often, he explains, “we are often better able to improve their engagement and relationships. A lot of them are demoralized when they show up and do not believe they can stop using.”

This model, he asserts, can easily be replicated

by other facilities. “The nice thing about it is that you can use the same basic principles, but not necessarily use the exact same protocols we do,” he says. “You may not have the staff to do so many groups, for example.”

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What if physicians don’t believe your quality data?

Your reaction will determine if you obtain buy-in

Have you ever presented physicians with carefully analyzed data to demonstrate areas in need of improvement — and then discover that your findings are disputed?

If physicians don’t believe in the validity of your data, they won’t use the findings to change their practice or address the systems of care that result in missed opportunities to provide guideline-based care, says **Dale W. Bratzler, DO, MPH**, medical director of the Oklahoma Foundation for Medical Quality in Oklahoma City.

If you fail to address improvement opportunities that are identified in your organization’s performance measure rates, this means that care may not be consistent with guideline recommendations. This could result in your hospital showing up as an outlier, says Bratzler.

“Perhaps the most common pitfall or mistake for quality professionals is to try to promote compliance with national performance measures without carefully working with the medical staff to get buy-in and working to find physician champions for the clinical topics,” says Bratzler. “My perception is that those hospitals for which there is medical staff buy-in to the concepts being measured do better on the quality measures.”

Having a physician champion to support the work of quality professionals can be particularly helpful in promoting best practices. “Using resources from the physician’s own specialty societies, most of which have endorsed aspects of the core measures, is useful,” says Bratzler.

Another pitfall is “blindly believing” that every single case should pass the performance measure, says Bratzler. While rates of performance for most measures can be very high, with benchmark rates

for most measures near 95%, the measure specifications do not account for every possible clinical exception to the measure. Therefore, compliance with measures should be high, but the target may not be 100% for many measures.

“On occasion, a case will fail the performance measure for legitimate clinical reasons,” says Bratzler. “To achieve perfect care on a measure, you have to have a perfect measure. And we do not.”

Benefits of buy-in

If physicians believe that quality data are timely and valid, it prompts them to find ways to provide better care, says **Debbie Kiser**, RN, MBA, CPHQ, director of clinical quality management at the Charleston (WV) Area Medical Center. “Some may be unaware of their own outcomes or data involving a specific issue. They may strive to become better due to competition with their peers,” she says.

Buy-in from physicians encourages them to become involved in necessary changes to promote quality patient care. It also means they are more aware of what information is being measured externally and presented to the public regarding patient care at your organization, says Kiser.

At Mission Hospitals in Asheville, NC, the implementation of The Joint Commission’s new requirements for ongoing and focused evaluation of practitioners has created “a surge of physician-level reporting,” says **Tom Knoebber**, CPHQ, Six Sigma Black Belt and director of performance improvement.

“By far, the largest issue with physician data is clean attribution,” says Knoebber. Health care is becoming more of a team activity, and rarely does a single physician provide the entire treatment plan for a patient, he explains. A consultant, for example, might impact a patient’s complication rate, length of stay or even cost of care.

“Without physician buy-in for their performance data, there will always be an ‘out’ that they were not responsible, regardless of how well you promote the ‘captain of the ship’ mentality,” says Knoebber.

At Mission, physicians currently receive a semi-annual report card, with a limited number of indicators for the areas of service quality, technical quality, and citizenship.

“The current process is somewhat manual, using a data export file to an Excel macro,” says Knoebber. “With the implementation of comput-

Key Points

- If you fail to address improvement opportunities, care at your facility may not be consistent with guideline recommendations.
- ‘Perhaps the most common pitfall’ for quality professionals is to get buy in and enlist a physician champion.
- Clinician ‘story-telling’ is good for getting additional buy in for QI projects.

erized physician order entry, we hope to have more procedural-level data and less case-level aggregate data at the physician level. That should minimize the attribution issues.”

Get physicians to educate others

When data have been questioned by physicians at Wellspan Health in York, PA, the measure is first reviewed, including operational definitions with the inclusions and exclusions. “That has always proven enlightening to the clinician,” says **Susan P. Nelson**, MBA, RHIA, CPHQ, director of quality management.

“They tend to think within the parameters of how they treat the patient, but not with all the ‘if A, then B’ type of exclusions that are incorporated within valid measures,” says Nelson.

Second, a sampling of the primary source documents are pulled and reviewed with the questioning clinicians. “That allows for clarifications and teaching moments, concerning what needs to be documented to allow the clinical care delivered to be ‘counted,’” says Nelson.

Both of these clarification and validation efforts have proved to be beneficial to both the care provider and the data collector. “These episodes have resulted in clinician ‘storytelling’ at other meetings and forums where data are presented,” says Nelson.

For example, physicians were unclear about all the components and operational definitions for the Centers for Medicare & Medicaid (CMS) quality measures for heart failure discharge instructions. “I spent significant time with one of our physician leaders to be sure that he was clear that when discharging the patient his documentation needed to include both instructions for things to do and documentation about why he would be excluding the patient from the guideline,” says Nelson.

As that physician’s compliance with the measure got closer and closer to the top 10% benchmark, he shared his story with members of his medical staff department. “That storytelling did

more to improve the overall compliance with the recommended guideline than any prior education and reminders, such as the infamous laminated pocket cards," says Nelson.

What to do when challenged

If any one piece of data is suspect, then the entire report is viewed as unreliable and unacceptable by that physician, and most usually the group. "We have had this problem in our institution and that specific report has not been used," says Kiser.

The report involved CMS measures and denoted numbers to "responsible physicians" per specific definitions. "Several physicians did not think that certain measures should be assigned to them, so therefore they thought the data were incorrect," says Kiser. "We have taken this information to specific groups, such as hospitalists, that they use to review their members for quality and give possible bonuses. We are also using these measures as indicators for some departments for use in credentialing."

Quality professionals at Charleston Area Medical Center work hard to validate data prior to distribution and, most importantly, explain the data and the methodology behind it, says Kiser. "I believe that explanation of new reports and/or data is crucial to acceptance," she says.

Many times, it is not that the data are incorrect, but that the methodology is unfamiliar, and thus, not readily accepted by physicians. "In these cases we may begin with small groups, using the data for other work so that it becomes more familiar and, hopefully, acceptable," says Kiser. "This is the process we are now using for the aforementioned report."

Unfortunately, assuring that data are accurate is a time-consuming chore — difficult to do with limited resources. "We have no tricks for this — just internal validation processes. This may delay the distribution of the data somewhat, but assures acceptance by the physicians," says Kiser.

For example, a process for internal validation goes into play if the organization falls below a certain percentage during an external validation. "We have a team for each focus area of the CMS measures. Members of the team review certain cases each month after abstraction to assure accuracy," Kiser says. "Since the average abstractor reviews approximately 400 to 450 charts a month, we understand that we are human and mistakes can occur."

For example, an abstractor might miss a physician's documentation of a contraindication for

angiotensin-converting enzyme (ACE) inhibitor at discharge, which is noted as a failure for that indicator. When the team reviews the chart, they find the documentation, which they communicate to the abstractor. The abstractor reviews that part of the chart again and changes the answer within the collection tool.

On the other hand, the team may communicate what they think is missed documentation that turns out not to be acceptable. "That is why, when contacted regarding an inaccuracy, the abstractor re-reviews the record," says Kiser. "The teams are not as knowledgeable of the abstraction guidelines. So they may inaccurately identify a 'correction.' We spend a great deal of time trying to verify an answer, either way, when there is a question from a team."

With other databases, such as the Society of Thoracic Surgeons and the American College of Cardiology, a quality nurse double checks the data against the organization's internal data warehouse before distributing them to physicians. In some cases, physicians review data themselves. "We have an emergency department physician that reviews all 'failures' regarding CMS indicators and responds to each," says Kiser. "There is also a physician closely involved in the sepsis data collection review."

Physicians are encouraged to contact the quality management department if they believe any information to be incorrect or misleading. "We will re-review the data, or provide them with the case numbers so they can review it themselves," says Kiser.

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Surveyors finding problems with medication standards

Nearly half (43%) of hospitals surveyed in the first half of 2007 were not compliant with The Joint Commission's standard requiring medications be properly and safely stored, and 20% were non-compliant with the requirement for medication orders to be written clearly and transcribed accurately. Here are some of the non-compliant areas surveyors are finding for The Joint Commission's medication management standards:

- **Processes to ensure medications are stored under suitable conditions for product stability.**

"This is a requirement that we see organizations struggle with a fair amount," says Pat Adamski, RN, MS, MBA, director of The Joint Commission's Standards Interpretation Group. "That is probably the top issue that we see."

For example, if a medication needs to be refrigerated, the temperature must be monitored to ensure it's maintained within a certain range, by using a thermometer that alarms when it's out of range, or by doing a manual check every day. And if the temperature is out of range, there needs to be a consistent process followed for correction.

"If the temperature in the refrigerator goes out of whack, which does happen from time to time, do the staff involve the pharmacy to come up and evaluate whether the medication needs to be disposed of?" asks Adamski. "And what is done while you are waiting to get the refrigerator repaired, to make sure that the medication stays at its appropriate temperature and potency?"

Staff may forget to check temperature readings on a given day, but another more serious concern is failure to act if the temperature is documented as out of range.

"That is where people sometimes drop the ball," says Adamski. "The staff may be diligent about writing down a temperature, but if they don't pick up the phone and call somebody when it's out of range, they are defeating the whole purpose."

- **Policies for what practitioners do after they obtain medications.**

The organization needs to specify how a medication is stored between the time the health care practitioner retrieves a medication and when he or she administers it. "Sometimes physicians, nurses, and respiratory therapists like to put medication into their lab coat or uniform pockets or storage pouches. If the organization allows

Key Points

- Nearly half (43%) of surveyed hospitals in the first half of 2007 were not compliant with the standard requiring medications be properly and safely stored.
- One of the top issues The Joint Commission sees is facilities not ensuring medications are stored acceptably for product stability.
- Review occurrence reports with risk managers and ask frontline staff what procedures they find difficult.

that, we want to know how they assess the process to make sure the security and stability of the medication is maintained, and that any infection control issues are addressed" says Adamski.

- **Making sure that expired, damaged or contaminated medications are segregated.**

"Those medications need to be kept away from all the other medications the staff are going to use, until they can be removed from the hospital," says Adamski.

- **Removal of concentrated electrolytes from patient care units.**

"Only in very specific situations are they allowed to be there, because of the potential for safety issues if an electrolyte is administered in its concentrated state and not diluted," says Adamski. "We took care of that a couple years ago with a National Patient Safety Goal, but now that it's back in the standards, every now and then we'll see it scored."

- **Policies and procedures for medication orders.**

"Whether or not the organization allows certain things must be clearly identified, so staff know exactly what the expectations are," says Adamski. For example, policies must state whether an indication for use must be within the medication order itself, or if it can be documented anywhere within the medical record. Special precautions for look-alike, sound-alike drugs must be identified, and processes must be defined for staff to follow if they can't read an order because it's illegible.

"Then, we want the organization to weigh in on whether they will allow certain types of medication orders, and if they do, we want to know how they manage those processes," says Adamski.

For instance, a policy for range orders may not give staff enough guidance for when to give specific dosages. "Or sometimes there is an issue with the titration of the medication — what allowance do the staff have to titrate a dose up or down, and is that within their competency skill set? Also,

blanket reinstatement orders can never be allowed, and that must be clearly defined," says Adamski.

Most of the time, however, policies are specific enough — the problem is that they aren't being followed all the time. "Occasionally we will come across organizations that have not defined one or more of the requirements, but generally speaking, they have a pretty robust set of medication management policies," says Adamski. "But there is a lot of opportunity for staff, being human beings, to miss an aspect of a policy and procedure. That's what we see most often scored in this standard."

Adamski recommends using standard MM 8.10, which requires evaluation of the entire medication management system, to identify points where your organization may be vulnerable and drive your data collection efforts.

Review occurrence reports with risk managers, and ask frontline staff what procedures they find problematic. "It could be that the policy itself needs to be revised," says Adamski. "If people don't follow a policy, there is usually a reason. It could be totally impractical in terms of their work flow. Or when the policy was developed things were different, and it's never been updated."

Assessing compliance with policies is an area where many quality improvement initiatives fall short. "The organization may develop a wonderful set of policies, and have everybody sign a piece of paper saying that they have read the policy and will follow it — and then they stop," says Adamski. "They don't go back to see what is really happening — if staff are really following the policy. This is one of the biggest problems I see."

You can do this by interviewing staff, performing observations or doing random checks, in order to "close that PI loop" to evaluate whether a policy is being implemented as intended, says Adamski.

The Joint Commission has revised its medication management standards through a Standards Improvement Initiative in order to make them easier to understand, but the requirements will essentially remain the same, reports Adamski. "The intent is to get rid of a lot of the jargon and make them much clearer for the organizations," she says. ■

Florida hospital cuts failed pediatric sedation rate 98%

Parents are involved in quality improvements

During an October 2003 survey conducted at Fort Lauderdale, FL-based Broward General Medical Center by The Joint Commission, surveyors recommended improvements with the organization's pediatric sedation process. In particular, they found fault with the administration of sedation for outpatient diagnostic procedures.

"It was noted that the pre-procedure assessment was not complete," says **Suzan M. Sattler**, RN, BSN, the hospital's performance improvement regional manager.

Compliance with history and physicals, the American Society of Anesthesiology's (ASA) classification system, and Mallampati scores were not meeting the standard, surveyors found.

"Sedating children for diagnostic or therapeutic procedures is a complex process," says Sattler. "At the time, the sedatives used, techniques employed, the personnel provided, and safety standards varied greatly from one location to another, even within any given institution."

The organization's goal was to increase the efficiency and safety associated with the delivery of pediatric sedation. A standard protocol was needed to reduce the failed sedation rate and cre-

Key Points

- In a survey of Broward General Medical Center, The Joint Commission found fault with the administration of sedation for pediatric outpatient diagnostic procedures.
- There is a great deal of variation among health care facilities on sedatives use and techniques and safety standards used.
- Broward's initiative eliminated rescheduled exams and failed procedures by 98%.

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ate a child-friendly, welcoming atmosphere to ease apprehension among young children as they prepare for exams. A decision was made to invite parents to participate in the quality initiative.

First, protocols from nationally recognized children's hospitals were examined. A root cause analysis was conducted to determine underlying factors for failed sedations, and parents were surveyed to obtain input for needed changes.

The assessment, root cause analysis, and parent survey revealed these areas in need of improvement:

- Chloral hydrate and nembutal were ineffective sedatives with a high rate of undesirable side effects, such as delirium and failed sedations.
- Scheduling was not taking into consideration parents' work hours and the length of time children went without eating or drinking.
- The sedation area, located in the radiology department, was not child-friendly.
- Continuity of care was fragmented.
- Staff education was needed.
- Procedures required process improvement methodologies.

The following performance improvement changes were implemented between October 2003 and April 2006:

- Sedation privileges were created. These defined minimum education and training

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requirements for staff performing pre-sedation assessments.

- Staff received certification in advanced cardiac life support and pediatric advanced life support.
- The organization's sedation policy and procedure criteria were revised to comply with Joint Commission standards and guidelines from the ASA and the American Academy of Pediatrics.
- A standalone eight-bed sedation unit was created to accommodate the registration process, pre-assessment, and post-procedure monitoring.
- A pediatric physician champion was designated.
- An a2-adrenergic agonist, dexmedetomidine, was selected to decrease the need for opioids and eliminate sedative narcotics.
- A requirement was established for all children to receive 4% topical lidocaine analgesia before intravenous insertion.

Overall, the initiative eliminated rescheduled exams and failed procedures by 98%. After the new protocol was implemented in 2003, the failed pediatric sedation rate decreased to 1.63% in 2004, 0.19% in 2005, and 0.28% in 2006. "In 2007, our rate was 0.72%, still well below the national benchmark of 2%," says Sattler.

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