

# Healthcare Benchmarks and Quality Improvement

The  
Newsletter  
of Best  
Practices



## IN THIS ISSUE

■ If you track results, will you run afoul of the OHRP? A quality controversy may be brewing in the wake of recent actions taken by HHS' Office for Human Research Protections to halt a research project in Michigan . . . . cover

■ 'Magnet' health system says coordination is the key: Only a small percentage of U.S. health systems have achieved 'magnet' status, so when they speak, quality managers might want to listen . . . . . 28

■ What should I bid for this shift? For two health care facilities, the decision to open up unfilled shifts to bidding doesn't just help the winning bidder. . . . . 31

■ Who says VAP is a good benchmark? Not this infectious disease specialist . . . . . 32

■ Using hospitalists can yield 'modest' benefits: A new study shows the use of hospitalists can decrease the average LOS by nearly half a day . . . . . 34

■ News briefs . . . . . 35

**MARCH 2008**

**VOL. 15, NO. 3 • (pages 25-36)**

## OHRP action shuts down quality improvement research in Michigan

*Conflict raises confusion about the need for informed consent*

Recent actions taken by the U.S. Department of Health and Human Services' Office for Human Research Protections (OHRP) have resulted in the temporary suspension of collaborative research of Johns Hopkins University and Michigan hospitals involving a checklist for reducing the incidence of infection in intensive care units. Far beyond the ongoing back and forth between OHRP and Hopkins as they seek resolution, the OHRP action has unleashed a storm of protest in the quality community and has, at the least, raised questions about whether the vast majority of QI projects might be in danger of similar actions.

Here are the basic issues, as outlined by OHRP, in a statement issued Jan. 15:

"The purpose of the study was to find out whether that intervention [i.e., the checklist] decreased the rate of certain infections, which had not previously been proven. In research studies where the regulations apply, an institutional review board [IRB] must review the study before it begins to ensure that the appropriate protections for the prospective subjects are in place. For example, the IRB looks to see whether the risks to the subjects participating in the research study have been minimized, and whether the informed consent of the subjects must be obtained before partici-

## Key Points

- Government agency indicates QI projects tracking results need to obtain informed consent.
- Experts say regulations provide exceptions which project in question meets.
- Checklist had already demonstrated effectiveness in earlier research.

**NOW AVAILABLE ON-LINE! Go to [www.ahcmedia.com/online.html](http://www.ahcmedia.com/online.html).  
Call (800) 688-2421 for details.**

pation or whether the proposed research satisfies the regulatory criteria for waiver of informed consent (see 45 CFR 46.116[d]). OHRP received a complaint about the research study and determined that no such IRB review had taken place before the research study began.”

Part of the issue was that the checklist had been the subject of earlier research, published in the *New England Journal of Medicine*,<sup>1</sup> and that it already was a proven intervention. The checklist address key behaviors such as hand-washing, cleaning the skin with chlorhexidine, avoiding the femoral site, removing unnecessary lines, and using barrier precautions.

In a Jan. 2 letter to Michael Leavitt, secretary of the U.S. Department of Health and Human Services (HHS), **Karen Linscott**, PT, MA, who at

the time was acting CEO of The Leapfrog Group (see “*Leapfrog Group names Leah Binder new CEO*,” pg. 35), wrote:

“The checklist program consists of five steps that are proven to reduce the incidence of infection in intensive care units. While it can be argued that the program does not adhere to the specific language in the informed consent regulations, it cannot be argued that the checklist poses a danger to ‘subjects.’ On the contrary, the checklist has been proven to save scores of lives quickly and efficiently. The checklist is a far cry from an experimental drug for which informed consent is crucial. It is in fact consistent with your efforts related to the Four Cornerstones, with [the Centers for Medicaid & Medicare Services’] progress toward true value-based purchasing, and with the significant progress led by [the Centers for Disease Control and Prevention] to reduce hospital-acquired infections.”

And, in a widely read Op-Ed piece in the *New York Times*,<sup>2</sup> **Atul Gawande**, a surgeon at Brigham and Women’s Hospital in Boston, argued:

“The agency issued notice to the researchers and the Michigan Health and Hospital Association that, by introducing a checklist and *tracking the results* [our emphasis] without written, informed consent from each patient and health care provider, they had violated scientific ethics regulations. Johns Hopkins had to halt not only the program in Michigan but also its plans to extend it to hospitals in New Jersey and Rhode Island.”

To which OHRP responded:

“While some expressed concern that OHRP has prohibited hospitals in Michigan and elsewhere from implementing a program intervention consisting of a checklist and other measures to prevent certain hospital-acquired infections, OHRP has taken no such action. On the contrary, if any hospital or intensive care unit decides to implement the use of checklists or other measures only for the reason that they believe those measures will improve the quality of care provided, they may do so without consideration of the requirements of the Department of Health and Human Services regulations . . .”

In response to inquiries from *Healthcare Benchmarks and Quality Improvement*, **Joann Rodgers**, a spokeswoman for Johns Hopkins, adds: “OHRP has stated that its regulations do not apply when institutions are only implementing practices to improve the quality of care, but *do apply* [our emphasis] if institutions are planning research activities that look at the effectiveness of interventions to improve quality.”

The issue that remains unclear (and hopefully

**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 \$17.95 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.)

**Photocopying:** No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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

Copyright © 2008 by AHC Media LLC. **Healthcare Benchmarks and Quality Improvement** is a trademark of AHC Media LLC. The trademark **Healthcare Benchmarks and Quality Improvement** is used herein under license. All rights reserved.



### Editorial Questions

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

will be further explained) is this: Do *all* QI projects that involve the tracking of results potentially put them in the crosshairs of OHRP? If so, how many QI projects would *not* be subject to their oversight?

“The regulations do not apply when institutions are only implementing practices to improve the quality of care, even when this includes collecting information to track/monitor/confirm the results of that implementation,” says **Patricia C. El-Hinnawy**, public affairs coordinator for OHRP. “But, if institutions are planning research activities examining the effectiveness of interventions to improve the quality of care, then the regulatory protections apply and they are important to protect the rights and welfare of human research subjects.”

**Peter Pronovost**, MD, PhD, medical director of the Center for Innovation in Quality Patient Care, an assistant professor in the department of anesthesiology/critical care medicine at Johns Hopkins School of Medicine, and lead author of the *NEJM* paper, says, “I was shocked to see [OHRP’s] statement. My reading is exactly what you said: If you at all try to collect data, it will fall under the regulations, and that’s just wrong.”

“I believe very strongly that the science of quality improvement and health care has been very sloppy — more marketing rather than true evidence — and we have shown it is valid to collect evidence on a large scale, which is the whole idea of benchmarking. [The OHRP statement] shows an almost complete lack of understanding of what quality management is, or quality in general,” Pronovost adds.

### ***Is this a first?***

In any event, this may in fact be the first time OHRP has intervened in a QI project. “They’ve shut down Hopkins before, among others; they have the power, and they exercised it,” notes **Ezekiel J. Emanuel**, MD, PhD, chair, department of bioethics, NIH Clinical Center, National Institutes of Health. “In this area of quality improvement, I do believe, yes, this may in fact be unusual, although I don’t know for sure if it is the first.”

Emanuel adds that the study was being done with “five proven interventions in more than 100 hospitals.” The Agency for Healthcare Research and Quality, he notes, supported the study.

How does he see the informed consent issue? “Part of what we have argued, and what is important to recognize, is that there is not an ethical requirement or a regulatory requirement for *every*

research project to get informed consent,” says Emanuel. “If you look at the regulation, there is permission for emergency research and large epidemiology studies, and this fits it like a glove.”

There was no risk involved in the study, he continues. As for why OHRP took the action it did, Emanuel confesses, “I’m not sure what the motivation was. The regulations provide for this kind of exception; there is a specific list of rules you need to fulfill and this fits them perfectly.”

“We don’t mean to argue that informed consent is not critically important — it is — but this just does not seem like the same type of research,” adds Linscott.

“I still don’t think they’ve answered why this is different than any other population-based research, which does not require informed consent.”

Linscott goes on to say the move was shortsighted. “The larger problem in our health care system is that we are not aligning our regulatory and research activities and prioritizing to reach the greater good,” she says.

In seeking an explanation for the OHRP action, Linscott posits, “I have to say my guess is that this was a mistake. I can only surmise this and that they are now standing behind it.”

### ***What are the implications?***

For Linscott, one of the most important ramifications of the OHRP action is that work she considers vitally important has been delayed. The work that resulted in the checklist, designed by Pronovost, “has been some of the most important lifesaving work being done in health care; it is tremendously powerful and important and will save thousands and thousands of lives; but like any advance, we have to have extremely strong evidence — and he has,” Linscott asserts. “It’s not just the checklist. This was just one piece; my understanding is he was seeking to build an incredibly broad base around this subset. The fact that he was unable to make this case slows down the progress we are all trying to make.”

Pronovost notes that “the implications for QI are profound, because for far too long health care has not focused on QI. Now we seem to have momentum, where people seek data-driven efforts from which they can make valid inferences. Most importantly, the risks are much more on the side of not doing it than doing it. If we ask docs to wash their hands, what is the risk-benefit ratio? If we put up barriers, the net result will almost certainly be worse patient harm.”

As for where things go from here, OHRP's Rodgers notes: "Moving forward, we're continuing to discuss and work with OHRP to determine whether or not organizational QA/QI studies and projects similar to Dr. Pronovost's do in fact constitute human subject research subject to IRB approval; and if it is determined by OHRP that these studies do constitute such research, whether or not review and consent waiver is an acceptable IRB procedure."

"A lot of this will be slugged out in the court of public opinion," predicts Emanuel. "My real hope is that someone, hopefully within the Health and Human Services agency, says we really need to examine what we are doing in terms of oversight of human research, so we don't again have what was clearly a mistake. We can do better than this."

Pronovost is even blunter. If OHRP holds fast to its position, he asserts, "Any kind of QI effort in a hospital would essentially be void of data."

## References

1. Pronovost P, Needham D, Berenholtz S, Sinopoli et al. An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU. *N Engl J Med* 2006;355:2,725-2,732. (Correction published: *N Engl J Med* 2007;356(25):2,660.)
2. Gawande A. A Lifesaving Checklist. *New York Times*, Dec. 30, 2007.

[For more information, contact:

**Ezekiel J. Emanuel, MD, PhD, Chair, Department of Bioethics, NIH Clinical Center, National Institutes of Health, Bethesda, MD. Phone: (301) 435-8706.**

**Karen Linscott, PT, MA, The Leapfrog Group. Phone: (202) 292-6709, Fax: (202) 292-6809.**

**Peter Pronovost, MD, PhD, Medical Director, Center for Innovation in Quality Patient Care, Assistant Professor, Department of Anesthesiology/Critical Care Medicine, Johns Hopkins University School of Medicine, Baltimore, MD. Phone: (410) 502-3231. E-mail: ppronovo@jhmi.edu.] ■**

# Magnet facility credits communication for success

*Designation result of sharing of best practices*

**B**aptist Health System of Jacksonville, FL, has become one of only 13 health care systems nationwide to achieve recognition from the

American Nurses Credentialing Center (ANCC) as a Magnet health care system, an international quality designation considered the "gold standard" for nursing and clinical care. According to researchers, Magnet facilities have lower mortality rates and higher patient satisfaction, and also outperform other facilities in recruiting and retaining nurses.

The application and appraisal process extended over a four-year period and included reviews of Baptist Medical Centers (Downtown, South, Beaches, and Nassau), Wolfson Children's Hospital, and Baptist Home Health Care.

Baptist Health leaders believe their unique communications strategies were a key to successfully implementing QI processes across the system. "Over and above our meeting their standards, [the appraisers'] comments focused on the engagement of the entire organization and the innovation around communication," says **Diane Raines, RN, MSN**, senior vice president and chief nursing officer.

"One of the things that makes this award unique is that we applied as a health system — so we had to have the same [quality] across all five hospitals, including home health," adds **Kristin Vondrak, MSN, ARNP-BC, AOCN, CNA**, system director of clinical quality and Magnet program coordinator. "We acculturated quality into the system and we were able to demonstrate that."

This approach is not something that was just developed for the Magnet process, adds **Keith Stein, MD, FCCM, FCCP**, senior vice president and chief medical officer. "It's not like we had to start from a blank slate; this honor recognizes a 50-year-plus history of our culture characterized by excellent communications and inter-disciplinary cooperation for which we have been recognized in other ways," he says.

## Dashboards: A vital tool

In addition to the historic culture of quality, however, Baptist Health did introduce some important innovations during the four-year period. "Three years ago we called together a clinical quality and technology committee formed by representatives from each of the facilities," recalls **John Wilbanks, FACHE**, chief operating officer. "One of the first bits of work sanctioned and authorized by that committee was quality dashboards for each hospital, which we use as a method for evaluating parameters the committee deems significant." The committee recommended the most pertinent and valuable parameters, and reports to each hospital board on a quarterly basis.

“The dashboards look like Excel spread sheets presented in tabular form,” explains Stein. “Color coding reflects how close we are to achieving targets or benchmarks.”

Stein says that of a total of 800 parameters used by the system, two dozen of the more “overarching” parameters have been selected for board review. “Most recently we have talked about putting them on our internal portal for staff and physicians,” he adds.

The dashboards are used on multiple levels, adds Vondrak. “In addition to system-wide reports that go to the board, they are also facility-specific and unit-specific,” she explains.

### **Numerous vehicles developed**

Through the Magnet process, Vondrak says, an internal infrastructure was developed, made up of several high-level committees — system and facilities, education, research, process improvement, community and family partnership, and clinical practice. “We developed a bi-directional approach to reporting — up to the executive level and down to the bedside,” she says. “We communicate quickly and often, through our *CNO Newsletter*, [see excerpted sample, pg. 30] ‘Care Connection,’ ‘Vital Signs,’ the ‘Baptist Health Blitz,’ and the ‘Pharmacy Tablet’ — many tools to communicate to many disciplines.”

## **Key Points**

- Task forces include ancillary departments, so key messages can be spread to the entire facility.
- Dashboards display performance information on system, facility, and unit levels.
- Multiple publications reinforce education on key quality improvement goals.

As the dashboards are facility-specific, the process improvement council can readily learn the different hospitals’ internal best practices and then share them with the rest of the system, adds Vondrak. “In the context of the PI council, we have issues in common across all facilities, so we benchmark internally and externally,” she explains. “So, we move not only knowledge but processes around the system, by moving internal process experts to places that need their help.”

“Within the five hospitals there will be someone who exhibits best practices, and they become our internal expert,” adds Raines. “Their expertise can also be shared in writing, or put on-line. Or, they could become the faculty for the next education session.”

This works on a team level as well, says Raines. “Take fast-track [units] in the ED,” she says. “We have a team that perfected that approach, and this internal team moves around

## **Clinical Measures: Key Performance Indicators**

1. Coronary artery bypass graft patients — mortality rate (with and without cardiac catheterization)
2. Acute myocardial infarction (AMI) — mortality rate
3. Death in low-mortality surgical DRGs
4. Death in low-mortality gynecologic / obstetric DRGs
5. Congestive heart failure (CHF) — readmission rate
6. Community-acquired pneumonia — readmission rate
7. Acute myocardial infarction (AMI) — readmission rate
8. Knee replacement — readmission rate
9. Neurosurgical intervertebral disc excision complication rate
10. Percent of surveyed patients with hospital-acquired pressure ulcers — critical care units
11. Percent of surveyed patients with hospital-acquired pressure ulcers — combined med/surg units
12. Unplanned returns to the OR per 1,000 OR patients (inpatients and outpatients)
13. Code 15s
14. Patient falls with injuries per 1,000 adjusted patient days
15. Medication variances per 100,000 medications dispensed
16. Foreign body left in patient per 1,000 OR patients (inpatients and outpatients)
17. Hospital-acquired bloodstream infections per 1,000 patient days
18. Post-operative surgical infection rate per 100 inpatients having surgical procedures
19. Post-operative pulmonary embolism (PE) or deep vein thrombosis (DVT) rate per 1,000 patients at risk

Source: Baptist Health System, Jacksonville, FL.

to help us refine the approach, measure the impact, and continue to improve.”

“One of the key things is that the information is driven down,” adds Vondrak. “Since all councils are interdisciplinary, they communicate to the ancillary departments as well.”

Raines explains how specific QI initiatives unfold at Baptist Health. “One of our quality goals is the prevention of pressure ulcers,” she shares. “So, we bring together our nursing leadership and conduct an extensive review of best practices (both internal and external) around that goal, and the tools needed to audit their own work units. So, each of them learns the best practices, takes that back and works with their staff. In addition to that, we have specific programs for staff members on the topic; they can go on-line

and access information relative to best practices.”

The leaders agree the Magnet process itself actually led to further innovation. “I think the Magnet process allowed us to make great strides, and sometimes forced us to have conversations about where we needed to go,” says Wilbanks.

“The connection here was that striving for Magnet designation as a system gave us a platform, and helped create the vehicles to improve communication,” adds Raines.

*[For more information, contact:*

*Keith Stein, MD, FCCM, FCCP, Senior Vice President and Chief Medical Officer; Kristin Vondrak, MSN, ARNP-BC, AOCN, CNA, System Director of Clinical Quality and Magnet Program Coordinator; John Wilbanks, FACHE, Chief Operating Officer. Baptist Health, 1325 San Marco Boulevard, Suite 601,*

## Critical Success Factor of Quality

Critical Success Factor	Strategic Focus Area	Nursing Leadership Goals	Why This is Important
<b>QUALITY</b>	Deliver superior patient care by relentlessly driving to improve clinical quality	<p><b>Goal 1:</b> Improve CMS Indicators for CHF to target: <b>98% compliance with indicators (there are four).</b></p> <p><b>ONE:</b> Patients must have an assessment of the left ventricular function on the chart (either an echocardiogram or a cardiac cath).</p> <p><b>TWO:</b> Patients need to be on ACE or ARBS medications for CHF.</p> <p>While these two are medically driven, nurses can check the charts and remind the physicians if they are not present.</p> <p><b>THREE:</b> Adult smoking cessation counseling done and documented</p> <p><b>FOUR:</b> Discharge instruction must address <b>ALL of the following:</b></p> <ol style="list-style-type: none"> <li>1. Diet</li> <li>2. Activity</li> <li>3. Follow-up appointment</li> <li>4. Medications</li> <li>5. Weight monitoring</li> <li>6. What to do if symptoms worsen</li> </ol>	<p><b>Goal 1:</b> In all of our adult settings, patients with congestive heart failure are prevalent. They may be admitted with other diagnoses but have underlying CHF. Our management of CHF is reviewed by the Centers for Medicare &amp; Medicaid Services to determine if we use evidence-based practice to maximize the patient's outcome and minimize their return to the hospital.</p> <p>The nursing actions that will be measured are well within the realm of professional nursing practice and are critical for the patient's continued health. These are not arbitrary indicators but rather ones that we know will make a difference in a patient's clinical course.</p> <p>Please make sure to focus on these indicators with our CHF patients and make sure to <u>chart</u> your actions appropriately.</p>

Source: Baptist Health System, Jacksonville, FL.

## Bidding systems address U.S. nursing shortage

*Leaders realize significant savings, boost safety*

While nursing shortages are seen in nearly every market in the United States, the state of Louisiana has been hit with a double-whammy, following Hurricane Katrina and the attendant loss of health care professionals through relocation. To help address this shortage — while at the same time cutting costs and enhancing patient safety — two hospitals have introduced bidding systems that enable existing staff to vie for open shifts.

With the systems, nurses are given schedules that cover the next four to six weeks, and then are allowed to bid 1.1 to 1.5 times their current salary, with the lowest bidder the winner. Nurses who are particularly anxious to win a shift will bid low at the outset, in hopes of beating out the competition.

Interestingly enough, the same nursing leader was responsible for the implementation at both hospitals. **Debbie Ford**, RN, MSN, vice president of patient care and chief nursing officer at Our Lady of the Lake Hospital in Baton Rouge, introduced the first bidding system in May 2006 when she was at Lafayette General Medical Center. She subsequently introduced another system at Our Lady of the Lake late last year.

In both cases the systems were developed internally. “We had heard of a company called BidShifts [which provides web-based shift scheduling technology] and they gave us a demonstration,” recalls Ford. “But it would have cost \$9,000 a month to maintain the system.”

But, she says, she really liked the idea, and thought it could be used as a tool for recruitment

and retention. So she had Firefly Digital, a local firm, design a system for the facility.

### **Filling needs**

The system, called I-bid, has addressed several important needs, says **Ginger Broussard**, RN, director of nursing administration at Lafayette General.

“We had unfilled shifts throughout the hospital and we were using contract labor to fill those needs, but even with that help — which was very expensive — we still had shifts that needed to be filled,” she explains. Since contract labor was usually several times as costly as regular staff (on average \$55-\$65 an hour), “we wanted to replace the contract labor,” she says.

The system works like this: When the nurse manager makes out her staffing schedule for the next four weeks and there are unfilled shifts, the information is sent to the staffing coordinator. “They put it into the I-bid program, which is only open to our nurses,” says Broussard, adding that nurses can enter the password-protected system from any computer. “They look at what shifts are available, either on their unit or on another one, and actually bid on the shift.”

Depending on the day of the week and time of day, the shift is posted with a monetary value. “It basically works like eBay,” Broussard explains. “If the job is posted at 1.5 and a nurse makes \$10 an hour, they can bid up to \$15 an hour.”

The system, Broussard says, “has allowed us to totally eliminate the use of per diem agency nurses,” which, she says, has saved several million dollars.

“In addition, having our staff working those shifts — nurses who are familiar with our policies, know our patients and our physicians — gives us a consistency in the delivery of patient care, which is absolutely a patient safety benefit,” she continues. “We know that it has decreased patient and physician complaints, because those things are measurable in our [Press Ganey] satisfaction surveys.”

The nurses, she adds, have responded very well to the system. “It allows them to plan and pre-book their hours,” she notes.

### **‘Tweaking’ existing system**

When Ford got to Our Lady of the Lake, she realized that the system already in place — from Vastech Inc. — already had a bidding component.

### **Key Points**

- Allowing nurses to bid on shifts gives them greater control over their schedules, personal lives.
- Daunted by the high cost of ‘canned’ systems, facilities created their own programs internally.
- Bids can range from 1.1 to 1.5 times current salary; some nurses submit low bids to ensure getting the shift they want.

"We just tweaked it and educated people to generate excitement around it," she says.

In fact, she notes, the existing system was a bit more sophisticated than what had been created at LaFayette General. "You can put in the skill mix and competency of nurses; it's sophisticated enough that if you do not have the skills to do cardiovascular shifts, for example, it won't let you bid for those shifts," Ford explains.

When a nurse keys in her identification number, Ford continues, she will see only the shifts for which she is qualified. "Previously [at LaFayette General] you had to attest you would not sign up for a shift if you were not qualified," notes Ford.

Testing began on the new system in November 2007. "I wanted it to be a recruitment and retention tool," notes Ford. "Vastech already showed that if you pick up additional shifts, you could get additional incentive pay, but I tweaked it based on base pay so that it rewarded someone with more experience. So basically, the message was that the longer you stay with us and the more you participate in the program, the more you tend to make."

The marketing message to those nurses who were not working at Our Lady of the Lake, says Ford, was: "This is something new and different; come try us, come check us out." A marketing mailer was sent out around Thanksgiving, and it seems to have been effective, she says.

"We set up a phone number and put it in the flier, so if people called specifically about Vastech, there was one person who managed and logged the calls," Ford explains. "And between nine and 12 people have come on staff as a result of the flier."

A telethon was held to generate additional interest, Ford says, and those people who were contacted are now being tracked.

The staff, says Ford, have been very receptive to the new program. "The premise was that if this was their personal time off and it was worth it to us [to have them work] we needed to make it worth it to them," she says. "We can ensure we give qualified patient care, and if we get one shift filled, it's a success because nobody has to give up free time off."

At Our Lady of the Lake, a six-week schedule is published. "The whole premise behind it is that it allows you as a nurse to plan your life ahead of time," says Ford. "People can check their calendar and plan their shifts. For younger gen-x'ers, their social life is planned around it. For older nurses, the shifts can be planned around family events. It appeals across generations."

The timing couldn't be better for the hospital,

which recently signed a major contract that shifted business in the city and gave it a large number of new patients, Ford concludes.

[For more information, contact:

**Ginger Broussard, RN, Director of Nursing Administration, Lafayette General Medical Center, 1214 Coolidge Blvd., Lafayette, LA 70503. Phone: (337) 289-7792.**

**Debbie Ford, RN, MSN, Vice President of Patient Care and Chief Nursing Officer, Our Lady of the Lake Hospital, 5000 Hennessy Blvd., Baton Rouge, LA 70808. Phone: (225) 247-7980.] ■**

## VAP: Just how good a benchmark *is it really?*

*VAP hard to measure in 'concrete, reproducible terms'*

The headline pulls no punches. It reads: "Ventilator-associated pneumonia — the wrong quality measure for benchmarking."<sup>1</sup> This stunning headline, which heralded a "Perspective" article in a recent edition of *Annals of Internal Medicine*, will no doubt grab the attention of quality improvement experts.

After all, no lesser organization than the Institute for Healthcare Improvement included VAP, or ventilator-associated pneumonia, as a key objective in its "100,000 Lives Campaign," and VAP is also being considered by the Centers for Medicare & Medicaid Services and The Joint Commission. Any number of hospitals have pursued and then trumpeted their successful reduction of VAP rates.

Nonetheless, the authors of the paper are confident in their stance, and cite numerous studies to support their assertions. They point out, first of all, just how difficult it is to accurately diagnose VAP, given the fact that it shares clinical signs with so many pulmonary complications seen in the ICU. They note, for example, evaluations of ventilated patients with fever, pulmonary infiltrates, purulent sputum (or some combination of those symptoms) that indicate only 30% to 40% of them actually had VAP.

### ***No concrete measures?***

The authors note that most quality indicators are readily measurable in concrete and reproducible terms — but VAP is not. "When you use the term 'concrete' that means you know exactly

what you are measuring,” explains **Michael Klompas**, MD, an infectious disease physician and instructor in the department of ambulatory care and prevention at Harvard Medical School and Harvard Pilgrim Health Care in Boston. “If you say a person has VAP, just how confident are you?” The evidence, he continues, suggests clinical diagnoses have poor correlation with data.

The term “reproducible,” he explains, means that if different observers look at the same patient, they will come to the same conclusion — which, again, is not true with VAP. “Each one of the signs has very broad [meaning],” he asserts. “For example, fever could be infection, a blood clot in the brain, or a poor drug reaction. The presence of infiltrates could be dead lung, bruising of the lung, bleeding, collapsed lung, or fluid on the lung.”

Examples of much more concrete hospital measures, he offers, would include such things as the use of beta-blockers after heart attack, mortality rates after heart surgery, and bloodstream infections in the ICU.

### **Why use VAP?**

If VAP is such a poor measure, why are so many people using it? “They are driven by high-minded motives — to improve quality of care, and to get some sense of what normal practice should be,” says Klompas. “At first glance, VAP seems like a good choice; it’s a common problem in ICUs, and a major problem because it causes people to die.”

For someone who is not deeply involved in medical diagnosis of these patients, he continues, VAP would appear to be a good measure. “It’s more reliable in an outpatient setting, when you go to a doctor with fever, coughing green sputum, and so forth; but unfortunately that same logic does not translate into the ICU, where patients are much more complicated,” Klompas explains.

“Measures selected for quality assessment or benchmarking ought to yield consistent results regardless of where or to whom they are applied,” the authors write. “They should also closely reflect processes of care that hospitals can modify to improve their outcomes. The current definition of ventilator-associated pneumonia does not meet these standards.”

### **New measures needed**

The authors call for the development of new outcome measures to meet the standards that other measures currently meet — they are objec-

## **Key Points**

- VAP shares symptoms with several conditions common to the ICU.
- Diagnosis is considered to be more reliable in the outpatient setting.
- New measures should reflect the totality of complications that can affect ventilated patients in addition to pneumonia.

tively measurable, they indicate serious complications, and they can “reliably reflect quality of care.” These new measures, they argue, should reflect the totality of complications that can affect ventilated patients in addition to pneumonia. Such measures, they add, “should also be relatively straightforward for hospitals to collect.”

Until then, suggest the authors, quality managers and others should track evidence-based processes of care measures, including “daily cessation of sedation and appropriate patient positioning.”

Quality managers, says Klompas, should also recognize that “there is a real need to involve physicians and research experts in your course of measurement and surveillance. With some other quality measures that had been proposed we ran into exactly that same problem we have with VAP — they were difficult to measure or interpret, or there were unintended consequences.”

For example, he notes, the rule developed for community-acquired pneumonia that required patients to receive an antibiotic within four hours “led to a big upswing in people without CAP getting antibiotics; anyone with the possibility of pneumonia got it,” he notes. “What researchers found was an increase in antibiotic usage.”

The bottom line, he says, is that “you need a thoughtful clinician to be able to say what is or is not a good possibility for a measure, and a researcher to say whether it is a good idea that can translate into reality.”

### **Reference**

1. Klompas M, and Platt R. Ventilator-associated pneumonia — the wrong quality measure for benchmarking. *Ann Intern Med* 2007;147:803-805.

[For more information, contact:

**Michael Klompas**, MD, Department of Ambulatory Care and Prevention, Harvard Medical School and Harvard Pilgrim Health Care, Boston, MA. Phone: (617) 732-5775. E-mail: [mklompas@partners.org](mailto:mklompas@partners.org)] ■

# 'Modest' benefits seen with use of hospitalists

*No significant improvement in patient outcomes*

As the use of hospitalists continues to grow, the ability to demonstrate the benefits of having these professionals on staff also grows in importance. Accordingly, the findings of a new study in the *New England Journal of Medicine*<sup>1</sup> should be of particular interest to quality managers.

The study does not demonstrate the dramatic benefits many would have hoped. Compared with patients who were cared for by general internists, patients in the study had what the authors called “modestly” shorter hospital stays — specifically, about 0.4 fewer days per patient — as well as lower costs (an average of \$268 per patient).

While it's true that both of these figures appear “modest,” there were 76,926 patients in the study, so a benefit of \$268 per patient would result in total savings of more than \$20 million. In addition, avoiding the cost of nearly a half-day stay in the hospital for this many patients would also save a considerable amount of money.

When compared with patients cared for by family physicians, those treated by hospitalists had a similar shorter length of stay (LOS) of 0.4 days, but the cost of savings per patient was only \$125. In addition, the study showed similar mortality rates and readmission rates for all patients.

## **A mixed bag?**

While noting the many potential advantages of using hospitalists (i.e., all-day availability, greater familiarity with the hospital environment, greater clinical expertise through greater experience, greater incentives to reduce LOS, and freeing up the time of primary care physicians), the authors also noted a potential downside. “The hospitalist model introduces handoffs at the time of admission and at discharge, transitions during which the risk of errors and adverse events are high,” they wrote. “These discontinuities, coupled with a lack of previous knowledge of a patient's care, may lead hospitalists to order excessive diagnostic tests, resulting in higher costs with no benefit to hospitalized patients.”

Still, **Peter K. Lindenauer**, MD, Msc, FACP, of

## Key Points

- Hospitalists shown to reduce LOS by half a day, with lower average costs as well.
- Weakness of model also noted, such as increased handoffs during admission and discharge.
- Quality managers should look to hospitalists as potential physician champions.

the Center for Quality and Safety Research, Baystate Medical Center in Springfield, MA, and lead author of the article, is supportive of the model.

“I think the major findings are that compared to traditional approaches for hospitalized patients, the hospitalist model appears to be a more efficient model, and we find their care associated with a small reduction in LOS — and potentially small cost reductions as well,” he notes.

He adds that “this efficiency does *not* come at the expense of higher mortality or readmissions.”

The differences the researchers observed were not explained by the annual number of cases, he says. “There seems to be something intrinsic to being a hospitalist that is associated with greater efficiency,” he asserts. “Even internists with similar numbers of patients [have LOS and cost figures] more in keeping with other physicians in the hospital.”

Lindenauer says that the greatest benefit in LOS that hospitalists provide lies in improving throughput. “If you shave half a day off LOS you can open up the hospital for many, many admissions each year with the same number of nurses and beds,” he explains. This improved throughput, he adds, would be particularly beneficial for the ED and elective surgical procedures.

“In our hospital they care for 15,000 patients a year,” he notes. “So, 0.4 days shorter LOS represents 6,000 bed days, or 1,200 more cases a year. That is even more significant than the cost savings.”

## **Other benefits seen**

Lindenauer says you must look beyond his study's findings to assess the true value of the hospitalist. “The LOS differences are not too far off from what some meta-analyses have shown, but we looked at a limited set of outcomes [pneumonia, heart failure, chest pain, ischemic stroke,

urinary tract infection, acute exacerbation of chronic obstructive pulmonary disease, and acute myocardial infarction],” he says. “Many facilities turn to hospitalists to solve lots of other problems; they increasingly look to them as the glue that holds the hospital together everywhere between the ED and the ICU.”

For QI personnel, he continues, they have a special value. “They are often the key clinical champion for addressing Joint Commission core measures, CMS Hospital Compare, and so forth,” Lindenauer explains. “I worked with quality officers for many years and we struggled at finding physician champions.”

The typical primary care provider, he explains, spends a limited amount of time each day in the hospital, “and is less willing to make the time and intellectual commitment to improve, say, immunization procedures. Thus, it is vital for the facility to provide a group of physicians to come to the hospital every day and have an investment in making things better.”

### **More research needed**

The authors concluded by calling for more research into how hospitalists function. “Given the large and growing presence of hospitalists, there remains a need to understand how hospitalist systems should be structured in order to improve the quality and outcomes of care,” they wrote.

“While our study is interesting, ultimately it’s sort of a very inward-looking kind of study,” Lindenauer concedes. “It’s probably more important to begin turning our attention to the fact that now that they are such a large and growing presence, how programs should be structured to achieve the best outcomes.”

If you look at the 45 hospitals in the study, he notes, there was a wide range of income. “We need to ask questions such as, ‘What are the structural changes required for rounding? What are the best performance models? How can hospitalists best collaborate with nurses and others?”

How can they best use IT to achieve improvements in care?” Lindenauer asserts. “That’s what I get excited about in looking at future research — how to structure the system and collaborate with other caregivers to be successful.”

### **Reference**

1. Lindenauer PK, Rothberg MB, Pekow PS, Kenwood C, Benjamin EM, and Auerbach AD. Outcomes of Care by Hospitalists, General Internists, and Family Physicians. *Ann Intern Med* 2007 Dec 4; 147(11): 803-805.

[For more information, contact:

**Peter K. Lindenauer, MD, Msc, FACP, The Center for Quality and Safety Research, Baystate Medical Center, 759 Chestnut St., P-5928, Springfield, MA 01199. Phone: (413) 794-5987. E-mail: peter.lindenauer@bhs.org.] ■**



## **Leapfrog Group names Leah Binder new CEO**

The Leapfrog Group has appointed **Leah Binder**, MA, MGA, CEO, effective March 10. Binder is vice president of Franklin Community Health Network based in Farmington, ME. She also serves as executive director of the Healthy Community Coalition and Franklin Health Access. Binder previously served as senior policy advisor to New York City Mayor Rudolph W. Giuliani.

“Leveraging the purchasing power of large buyers of health care to advance transparency and accountability is a solution that is powerful and long overdue,” said Binder. “The Leapfrog Group’s time has come and I intend to grow this

### **COMING IN FUTURE MONTHS**

■ The Joint Commission releases potential 2009 NPSGs for review

■ Pennsylvania hospitals address preventable errors

■ Are you using methods to adequately stop catheter infections?

■ Two insurance companies to stop paying for hospital errors

organization and continue to position it as a leading part of the solution to major challenges in health care.” ▼

## QUEST advisors named

The Premier health care alliance has named the advisory panel for its “QUEST: High Performing Hospitals” program. The panel will provide external guidance and direction to the project.

QUEST is a three-year program through which more than 100 participating hospitals will report data on a set of defined performance measures encompassing aspects of quality, efficiency, safety, and the patient experience. Premier will analyze the data, facilitate sharing of best practices, and provide incentives for top-performing hospitals.

Members of the advisory panel include:

- Agency for Healthcare Research and Quality — Carolyn Clancy, MD, director;
- Alliance for Nursing Informatics, University of Minnesota — Connie White Delaney, PhD, RN, dean and professor, school of nursing;
- American Board of Internal Medicine — Christine K. Cassel, MD, president and CEO;
- American College of Surgeons — Clifford Ko, MD, FACS, director, division of research and optimal patient care;
- American Health Information Management Association — Linda Kloss, RHIA, CEO;
- American Hospital Association — Carmella Coyle, senior vice president for policy;
- American Society for Healthcare Risk

**To reproduce any part of this newsletter for promotional purposes, please contact:**

*Stephen Vance*

**Phone:** (800) 688-2421, ext. 5511

**Fax:** (800) 284-3291

**Email:** stephen.vance@ahcmedia.com

**Address:** AHC Media LLC  
3525 Piedmont Road, Bldg. 6, Ste. 400  
Atlanta, GA 30305 USA

**To reproduce any part of AHC newsletters for educational purposes, please contact:**

*The Copyright Clearance Center* for permission

**Email:** info@copyright.com

**Website:** www.copyright.com

**Phone:** (978) 750-8400

**Fax:** (978) 646-8600

**Address:** Copyright Clearance Center  
222 Rosewood Drive  
Danvers, MA 01923 USA

### EDITORIAL ADVISORY BOARD

**Kay Beauregard, RN, MSA**  
Director of Hospital Accreditation  
and Nursing Quality  
William Beaumont Hospital  
Royal Oak, MI

**Kathleen Blandford**  
Vice President of  
Quality Improvement  
VHA-East Coast  
Cranbury, NJ

**Mary C. Bostwick**  
Social Scientist/  
Health Care Specialist  
Malcolm Baldrige  
National Quality Award  
Gaithersburg, MD

**James Espinosa**  
MD, FACEP, FFAFP  
Director of Quality Improvement  
Emergency Physician Associates  
Woodbury, NJ

**Ellen Gaucher, MPH, MSN**  
Vice President for Quality  
and Customer Satisfaction  
Wellmark Inc.  
Blue Cross/Blue Shield of Iowa  
and South Dakota  
Des Moines, IA

**Robert G. Gift**  
Practice Manager  
IMA Consulting  
Chadds Ford, PA

**Judy Homa-Lowry, RN, MS, CPHQ**  
President  
Homa-Lowry Healthcare Consulting  
Metamora, MI

**Sharon Lau**  
Consultant  
Medical Management Planning  
Los Angeles

**Philip A. Newbold, MBA**  
Chief Executive Officer  
Memorial Hospital  
and Health System  
South Bend, IN

**Duke Rohe, FHIMSS**  
Performance Improvement Specialist  
M.D. Anderson Cancer Center  
Houston

**Patrice Spath, RHIT**  
Consultant in Health Care Quality and  
Resource Management  
Brown-Spath & Associates  
Forest Grove, OR

Management — Doug Borg, president-elect;

- Blue Cross Blue Shield Association — Allan Korn, MD, senior vice president and chief medical officer;
- Centers for Disease Control and Prevention — Denise M. Cardo, MD, director, division of health care quality promotion;
- Centers for Medicare & Medicaid Services — Thomas B. Valuck, MD, MHSA, JD, medical officer and senior advisor;
- Institute for Healthcare Improvement — Donald Goldmann, MD, senior vice president;
- John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital — Susan Edgman-Levitan, PA, executive director;
- National Business Coalition on Health — Andrew Webber, president and CEO;
- National Patient Safety Foundation — Diane Pinakiewicz, MBA, president;
- National Quality Forum — Janet Corrigan, PhD, MBA, president and CEO;
- Office of the National Coordinator for Health Information Technology — David Hunt, MD, medical officer;
- Rand Corp. — Robert Brook, MD, vice president;
- The Commonwealth Fund — Stephen C. Schoenbaum, MD, executive vice president;
- The Joint Commission — Jerod M. Loeb, PhD, vice president for research and performance measurement. ■