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Joint Commission 2009 scoring changes: How will they affect you?

A lot is still uncertain about how changes will affect accreditation

Effective July 1, accredited hospitals will be scored on both the 2009 accreditation standards and the additional requirements released by The Joint Commission in March to bring the accrediting body more in line with CMS Conditions of Participation (CoPs). But that's not the only thing that will be different in the scoring and surveying process.

In January, all elements of performance (EPs) were classified as direct impact or indirect impact requirements to reflect the potential impact on quality of care and patient safety as the result of non-compliance with the EP. Previously, organizations were required to provide evidence of standards compliance only for requirements for improvement (RFIs) but not supplemental findings; now they must provide evidence of standards compliance with both direct and indirect impact findings.

For direct impact findings, you'll have 45 days in which to turn in your evidence of standards compliance, and with indirect impact findings you'll have 60 days. Evidence of compliance with EPs requiring a measure of success must also be submitted. In addition, the B classification for EPs is gone and EPs are classified either as A or C. In April, changes were made in the classification of some standards and EPs.

The criteria for determining either conditional accreditation (CA) or a recommendation for preliminary denial of accreditation (PDA) have changed as well. "As you'll recall before, we had program-specific thresholds based on a count of not-compliant standards at the time of survey. If you hit a predetermined number, it would result in a recommendation to the accreditation committee for conditional accreditation," says **Phavinee Thongkhong-Park**, PhD, RN, The Joint Commission's associate director, accreditation-certification evaluation methods and education in the division of standards and survey methods.

In the new methodology, thresholds — based on a count of not-compliant direct impact standards — serve as screening points for more intensive Central Office Review of the survey findings. In the hospital accreditation program, several bands of screening points have been established to account for differences in size and complexity of surveyed organizations.

The number of surveyor days will be based on the band classification, which also will correspond with the number of non-compliant direct

impact standard findings that would result in further review. For instance, hospitals that are classified as band 1, noncompliance with seven direct impact (indirect are not figured in here) standards would trigger a "screen" for more intensive review. And surveyor days would last between one and four days. (Editor's note: See *The Joint Commission Perspectives*, December 2008.)

That means the findings for that organization would be subject to a more intensive review by The Joint Commission's Central Office — unlike before, when a certain number meant a conditional accreditation decision. Now the survey findings will be reviewed and the "severity" of the findings will help the accreditation committee determine the level of accreditation. So if an organization reaches the threshold, it *could* result in accreditation with RFIs or a recommendation for an adverse accreditation decision.

"The degree of the observations and their impact on patient safety, whether they're an isolated instance of noncompliance or a systemic problem — these factors will be used to determine whether CA is warranted after review by The Joint Commission Central Office," says Thongkhong-Park.

What can you expect to see when the surveyors leave your hospital? The report will no longer include a preliminary accreditation decision because the decision goes to The Joint Commission for review. But "The Joint Commission will continue to leave the preliminary survey report," says Thongkhong-Park.

If there is noncompliance with one or more direct impact requirements, the report would show what it traditionally has for noncompliance with the specific Joint Commission requirements. Beginning in July, the report also will include references to the associated Medicare Conditions of Participation and standards. The format of the RFI is similar to the CMS principles of documentation.

Thongkhong-Park says cross-referencing The Joint Commission standards and EPs with the associated Medicare Conditions of Participation helps organizations identify observations associated with Joint Commission requirements and the CoPs.

The Joint Commission says immediate threats to life situations are those in which patients, staff, family, etc. are put at jeopardy as the result of the situation (e.g., inoperable fire alarms or fire suppression systems). Once identified by the survey team, the president of The Joint Commission is consulted. If he, or his designee, concurs that an immediate threat exists, the organization's accreditation status will immediately change to preliminary denial of accreditation and will remain as such until the situation is resolved and a survey is conducted to validate the corrective action. The organization's accreditation status would change from preliminary denial of accreditation to conditional accreditation and would remain at that level, usually for four months, until a second survey is conducted to evaluate the sustained implementation of the corrective action.

Another change: If your hospital has home care

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and long-term care components, accreditation decisions of those specific components would not affect the accreditation status of the entire organization.

What are your peers saying?

Paul Green, MS, RN, CPHQ, director, performance improvement at Scripps Memorial Hospital La Jolla in San Diego, questions just how the scoring changes are going to impact organizations going forward.

"We don't know quite how that's going to play out. It's been a difficult year for accredited organizations to sort of judge where they're at and sort of anticipate what your outcome of the survey is going to be," he says.

"I've been doing this for over 20 years with The Joint Commission, and we've always been able to, when we did our PPRs or our mock surveys, we were always able to sort of be able to predict how scoring was going to come out. We knew what the thresholds were for conditional accreditation or provisional denials."

Does he anticipate a bigger workload as a result of the changes in scoring methodology? "It really has increased the workload" of hospitals, he says — since now accredited organizations must supply ESCs for both direct and indirect impact findings.

"We always took the supplemental findings and took them under consideration and learned from them and used them within the organization but we didn't have to go through the formality of putting together a plan that had to be submitted to The Joint Commission with approval by The Joint Commission," he says.

Juan Inurria, system executive for quality & patient safety at Memorial Hermann Healthcare System, says, "If you're falling out [of compliance], that's a lot of additional work. Obviously, you don't want to fall out. Where the challenge is, is that most hospitals do not normally pay close attention to the CoPs on a day-to-day basis. So for the hospitals typically accredited by The Joint Commission, the focus is Joint Commission standards. And so sometimes the hospitals may not be as familiar with the language of the CoPs, and more importantly with the interpretative guidelines from CMS for the CoPs."

Scoring the changes

- **Accreditation status decision criteria.**

"The theory behind the new [scoring] model The Joint Commission is following is really getting closer to CMS' CoPs," says Inurria. "And they're really looking for those that put a patient in jeopardy. And that really carries more weight than anything else. You can be non-compliant in one of those and literally your accreditation can be removed immediately [with a finding of an immediate threat to life]."

And determining CA status now "is really left to the discretion of the surveyors and eventually the headquarters of The Joint Commission on how they are going to put all of those together into a potential conditional accreditation."

- **Number of EPs.**

Green adds that The Joint Commission "did reduce the number of standards, but greatly increased the number of EPs." This increases hospitals' workload even more, he adds, as each EP requires that you show evidence of compliance and is scored, whether it's classified as a direct or indirect impact or is associated with a measure of success. The Joint Commission says EPs that before were "bundled" have now been separated out as distinct requirements for clarity. "So instead of that being one EP, now it's three," Green says.

"I'm not trying to criticize The Joint Commission because I do think they're doing the right thing. I think what I'm trying to express is that until we get used to this, it is more work and it is more confusing."

- **B classification gone. EPs labeled A or C.**

As far as the elimination of the B classification in scoring EPs, Green says, "actually that does make intuitive sense. That actually does simplify it a bit." And Inurria concurs that the B category had led to some confusion. Removing that classification "takes away some of the gray area in the long-run that I think is beneficial," he says.

Kurt Patton, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission, says, "The biggest surprise to me was there was no explanation with the [scoring changes released in April by The Joint Commission]. And I think an explanation is warranted because it helps the accredited organizations understand why things are changing.

"For example, looking at the number of issues from the life safety code and environment of care, it may be that CMS has said, 'In order for you to maintain your deemed status, you need to align with us to a greater extent.' And I think the accredited industry would say, 'OK, we understand that.' However, it may be that they're just making mistakes in the assignment of EP category and then in thinking about it later, they're looking at them and saying, 'Oh, I see that doesn't make sense. That ought to be

an A or a C.' And I think that's a greater flaw."

He says in other areas — for instance with draft standards — The Joint Commission has a public process allowing industry comment. But no such process for scoring decisions exists. Category A, he says, "means, by and large, it should be a yes-or-no situation; you have a policy or you don't have a policy. Or you do it 100% of the time or you don't do it 100% of the time. The Cs mean we're looking for you to do it 90% of the time. So the C should be performance-based issues; we even have lots of observations."

As far as the recent scoring changes, he says, with many of the environment of care-related standards, it seems the changes are most likely a result of The Joint Commission trying to be more in line with CMS. He adds that many of the scoring changes in medication management, moving from A to C, "make sense. Because when you read those, they seem to be performance-based issues. The ones in the performance improvement chapter, they went from Cs to As. And As actually seemed more appropriate for those also, because they refer to having a review and analysis process; not that you use your review and analysis process at some predetermined frequency. So that made sense that there's not going to be a numerator or denominator. You either have a process or you don't have a process."

Survey preparation

As far as survey preparation, Green says, the processes at his hospital, surveyed April 6, didn't "so much change other than increasing our stress factor about not knowing... It's one of those things about being one of the first organizations that comes out of the chute. So you're getting scored on new standards, an increased number of elements of performance, and a scoring methodology where there's no benchstep in terms of people having undergone it."

In the end, he says, the survey went fine. The surveyors were focused and collegial. What was different was that he says usually surveyors will give you an idea of how your organization fared. Not this time. And while he usually receives accreditation results within two days, this time around it took two weeks.

For his part, Inurria says 10 hospitals from the Memorial Hermann system have been surveyed this year, and all went fine.

"I found the surveyors to be pretty realistic and reasonable in reviewing the particular standards that they feel were non-compliant and really have had no problems in having the dialogue and maybe even being able to turn around their initial findings if we present to them more evidence or clarification," he says.

Asked if he thinks The Joint Commission's move to be more in line with CMS will help the organization "kill two birds with one stone," so to speak, Green says: "Yeah. Well, I do think it's good that it's more in line with CMS, especially as the industry is starting to see more CMS activity, especially here in California. From a provider standpoint, we have situations where we had Joint Commission come in and they review it and everything's fine. And then CMS comes in and takes a look and says, 'Nope. You're out of condition.' So that's sort of an unfair place for us as providers when we've been doing our due diligence and doing what we're supposed to do."

His advice to quality improvement professionals is to spend time reading the beginning of the standards manual and trying to understand the "new sort of survey methodology and the scoring methodology... And if you have problems understanding it, seek help and advice either from The Joint Commission or from other resources about how it's going to play out."

Field review on staffing effectiveness

Patton refers to The Joint Commission's ongoing field review of staffing effectiveness requirements, which will be open for comment until July 22, 2009. "Just the fact that they were tweaking the PI standards relative to staffing effectiveness caused me to be a little bit amused because the industry has thought those were rather useless for years, and there's been talk at The Joint Commission about doing away with them. And here we're sort of fine-tuning them before probably eliminating them."

Inurria says, "they're looking at dropping the traditional EPs of this kind and maybe looking at measures that are more outcomes oriented and maybe more evidence-based oriented. The challenge is that... it's very difficult to have national studies and operational definitions that are reliable and that statistically really you can correlate your staffing effectiveness and skill mix and so on and so forth to outcomes." He says there is not enough literature to correlate a particular indicator with a particular outcome.

And even though his health system does track such things as decubitus ulcers and near misses and tries to tie those to the staff on the unit at the time, "to actually make all of this a national expectation, that's going to be a challenge," he says. "I think at

the end, every hospital will have to develop its internal methodology." But even though The Joint Commission is getting pressure to drop them and despite the challenge of tying them directly to outcomes, he doesn't see them going anywhere.

It's clear that many areas of confusion for what is coming from The Joint Commission exist. Green says, "it's been a difficult year for accredited organizations to sort of judge where they're at and sort of anticipate what your outcome of the survey is going to be." Are more changes coming? Green thinks so. Laughing, he amends his previous statement: "It's always a tough year to be in health care. It's never an easy year to be in health care." ■

Raising staff awareness of patient deterioration, shock

Hospital system drops preventable codes by 70%

It's when they looked back at what they had accomplished that they realized they really had been organized. For every performance improvement project, minute details and myriad elements make it almost impossible to go from A to B to C. But in retrospect, and with stops and starts and rework, the team at Children's Healthcare of Atlanta did a good job.

Their focus was early detection of patient deterioration. **Amber Cocks**, MSHCM, senior quality and process improvement consultant, and **Christiane Levine**, RN, quality and patient safety program manager, both at the health care system, led the team. "The first thing we absolutely wanted to do was to rescue the patients from harm. We had found several points of failure within our own processes and abilities to protect patients, and so we started by addressing those failure points," Levine says.

Handoff communication

The two started by evaluating and strengthening handoff communication between providers. They standardized transfer of care using the SBAR (Situation-Background-Assessment-Recommendation) technique.

They started by asking: What's often missing in this transition? Clinicians were pulled together to discuss this from their point of view, something Cocks and Levine say is essential — getting input from those handling the transfer process day in and day out. The two assembled "transfer of care champions" in each area and identified the nurse-to-nurse, shift-to-shift transfer as the greatest area for evaluation.

The team worked to identify trends in missing areas of information, and Cocks and Levine sought to isolate the "minimum set of information, the most important things they felt needed to be communicated about their patients during transfer of care."

The list they created could be modified by any department as needed. When it was first used, many departments laminated the list and put it where personnel could see. Now that most staff are familiar with the elements, there is no form needed but the hospital system also has the ability in its electronic health system to populate the information in real-time on the computer screen.

Minimum set for transfer of care elements

Situation
- name;
- age;
- weight;
- current MD;
- chief complaint/problems.

Background
- brief and significant medical history;
- allergies;
- ID and allergy band location;
- labs performed and significant results;
- radiology performed and significant results;
- isolation requirements.

Assessment
- assessment of systems;
- neurological;
- respiratory including 0_2 and ventilator settings;
- cardiovascular - include last set of VS;
- GI/GU;
- skin;
- muscle/activity;
- pain/fever;
- PEWS;
- social;
- was there information you did not receive;
- list missing information.

Recommend
- recommendation of plan of care for next shift;
- pie note reviewed;
- consults;
- upcoming procedures;
- status of transfer or discharge orders;
- discharge needs;
- comments.

Source: Children's Healthcare of Atlanta.

"It was really neat because the way it was organized is we started with general care nurses and then, once we got them to agree on the information they felt they wanted, then we brought in different groups of nurses. The ICU nurses then came in with general care and talked about what information they all needed to get together — what the OR needed from general care, from critical care.... And so it sort of spiderwebbed out so that everybody knew what to expect when they were giving or receiving reports from one of the other areas," says Levine.

Educating staff with simulation

The recognition of shock was a different campaign. "What we ended up doing," Levine says, "we really sort of shifted our whole philosophy on educating staff. And instead of sending out a bulletin to say, 'Everybody review shock. Don't forget to watch for tachycardia,' we completely shifted our model for the way we teach staff into simulator-based and scenario-based teaching."

It's important, she says, "to bring in at the beginning of the discussion of any kind of program or improvement process your clinical learning team, the people that create learning for your organization... I think that's probably a really underutilized resource, and our patient quality and safety team is partnering very closely with our learning services."

Levine and Cocks took true case study scenarios as teaching opportunities with high-fidelity simulators. Those scenarios were programmed into computers so the on-screen patient would act like an actual one. Staff walked through the scenarios and made decisions or recommendations based on what they saw. They could actually see missed opportunities; for instance, a staff member could replay a scenario and see when the patient's heart rate went up.

Let's say the staff member says, "OK, I'm going to give an IV fluid bolus now. Now what's my heart rate?" And if the on-screen patient doesn't respond, then the staff member knows he or she has missed something else. Now the nurse might say, "I'm going to call the rapid response team." As part of the yearly review of nurse competencies, every single staff member has to go through the simulation training.

Moving toward quicker recognition of patient shock, the team used both root-cause analysis and common cause analysis. One thing it found was there often was a lack of IV access. Oftentimes, staff didn't know when the IV team was in-house, Cocks says, or they didn't have a list of where or who to go to if an IV was needed. The team wanted a 24/7 IV team, which it does not yet have, so Cocks recognized experts in the critical care and emergency department settings that should be called on if an IV was needed.

Don't be afraid to speak up

Along with staff education, Levine and Cocks say it was necessary to make it clear that they wanted staff to speak up if a patient was in danger and that staff should never fear speaking up — and most importantly, that hospital administration would always stand behind them if they did.

Levine says that before, a lot of staff were too intimidated to speak up. For instance, if one staff member says to a nurse, "I think this patient is going into shock," the nurse might respond, "Who are you to tell me she's tachycardic?" With the "Speak Up" campaign, they sought to make it safe for anyone to call a rapid response team or to ask for proper help if a patient was deteriorating.

"We also offered scripting to them, and the No. 1 thing people said was, 'I'm not going to call the rapid response team because I'm not going to have someone chew my head out for calling them.' And so what we did was we scripted [the communication]."

She notes the RRT at Children's is "driven by the staff and owned by the staff." The team comprises one nurse and one respiratory therapist, and the hospital tries not to assign them so they are free to fulfill the RRT duties.

The team, which is part of the mentor program of the Institute for Healthcare Improvement, is expected to respond within five minutes of a call. "I think one of the reasons we've been really successful is because we looked at our failure points and built a team based on our failure points, not based on a structure other hospitals used," Levine says.

PEWS used for early intervention

The pediatric early warning score system, also known as PEWS, was developed by a UK hospital. Children's Healthcare got it from Cincinnati Children's Hospital Medical Center. Levine says "it's a series of assessments, and you score a patient on those assessments every four hours or more frequently as needed. And it can help paint a clinical picture of deterioration six to eight hours before an adverse event would occur."

As soon as a patient is admitted at the system, a PEWS score is taken, and that score and every subsequent assessment is placed in the patient's

chart. An algorithm goes along with the scoring system. The entire assessment, Levine says, takes less than 30 seconds to complete.

Since the nurses were the ones using the system, Levine says physicians were just taught, "This is what it is. This is how it's scored, and please just be aware if a nurse calls you and says, 'I don't know... My gut is telling me something is wrong and the PEWS score has gone up,' then please be aware that the evidence has shown that it's a good predictor of an impending cardiac or respiratory arrest."

Preventable code rates decreased

It was after evaluating and defining the elements of handoff communication and after educating staff to recognize early signs of deterioration, that Children's Healthcare began to roll out the rapid response team.

Levine says years ago she spoke with the lead author of a seminal study at Lucile Packard Children's Hospital in Stanford, CA, which showed that rapid response teams decreased pediatric death rates. **(See *Hospital Peer Review*, July 2008, pg. 94.)** At the time, Children's Healthcare had only seen a 10% drop in code rates a year after implementing its RRT.

"She said, 'You will not see a drop until at least two years.' And you know what? At two years, we bottomed off. So there's something about that two-year mark, and I think it just takes that long to really change your hospital's culture," Levine says.

Now, the system has decreased its preventable code rate by 70%. When she looks back at the entire process — beginning with transfer communications, staff education, and introducing the PEWS system — Levine says, "we realized [our success] was because by doing all of these things, we turned our ship around when we speak about culture. Because all of a sudden, we created a culture where it was safe to speak up. It was safe for nurses to critically think about IV access because now they had a tool that told them, 'You can think through this. It's OK. Here it is.' And standardizing transfer of care, making sure that they understood when it doesn't go right, it goes wrong for everybody — the patient and the nurse."

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Reduce rehospitalizations with RED discharge plan

Three components to discharge intervention

Quality care doesn't end when a patient leaves the hospital. And with rehospitalization rates on the top of the list of concerns for the Centers for Medicare & Medicaid Services, managing the care of the patient after he or she is discharged from your facility is not a nicety, it's a necessity.

"This is really relevant now," says **Brian Jack**, MD, associate professor of family medicine, department of family medicine at Boston University Medical Center. He also is lead author of a study in the *Annals of Internal Medicine* — "A reengineered hospital discharge program to decrease hospitalization."[1]

"The Obama administration is saying that if we can cut down rehospitalization by 20% or 30%, we're going to save $14 billion... And our study shows you can decrease them by 30%," Jack says.

According to the study, the problems with discharge at present include lack of standardization with the discharge process, difficulty of ensuring patient data are transferred to the patient's primary care physician, discharge summaries lack crucial information, and patients often do not understand their medication instructions.

Citing the importance of follow-up care post-discharge, Jack says, "to send people out of the hospital when they're done with treatment or treatment hasn't even begun without a plan for ongoing care, I don't think that can be defended in any way. Nobody can say that's good care, but in fact that's what we do a large majority of the time."

The reengineered discharge (RED) intervention has three critical components: communication between the patient and the nurse discharge advocate (DA), use of an after-hospital care plan, and a follow-up phone call to patients from a hospital pharmacist to review medication use and to answer any questions.

Because it was a research study, Jack could not use the hospitals' nurses; DAs were hired. But he points out that this position can certainly be filled by existing hospital personnel and that no additional hires need be made. Ideally, he says the floor nurses would handle patient discharge, because they know the patient and his or her medications.

Jack says the discharge summary is key to the whole process of successful discharges. A recent study in the *Journal of the American Medical*

Association, he says, showed that primary care physicians or the follow-up care provider had that summary less than half the time, maybe a third of the time upon the patient's first visit. And the summary often lacked crucial information.

In changing the terminology from discharge plan to after-hospital care plan, the study authors stressed what was essential to the program — making it patient-centered. Jack says many patients don't know what a discharge summary means, but an after-hospital care plan puts it in their language.

And this was a critical part of the intervention. Each patient was sent home with a "a booklet that is designed with health literacy in mind; with graphic design so that people who are older can read it." The booklets, which can be hung on patients' refrigerators, include color-coded calendars with follow-up appointment times. All follow-up appointments were scheduled by hospital staff before a patient left the hospital.

"I think a lot of our success," Jack says, "is that [patients] weren't just told about what to do; they were given this book and the book was taught to them. So it was very clear about what medicines were to be taken, why they need to take them, what to do if a problem arises, what appointments are coming up, and when those appointments are on the calendar. And it's designed so

Components of the Re-Engineered Discharge (RED)

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and
   - Make appointments with input from the patient regarding the best time and date of the appointment.
   - Coordinate appointments with physicians, testing, and other services.
   - Discuss reason for and importance of physician appointments.
   - Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
   - Be sure patient understands the importance of such services.
   - Make appointments that the patient can keep.
   - Discuss the details about how to receive each service.
5. Confirm the Medication Plan.
   - Reconcile the discharge medication regimen with those taken before the hospitalization.
   - Explain what medications to take, emphasizing any changes in the regimen.
   - Review each medication's purpose, how to take each medication correctly, and important side effects to watch out for.
   - Be sure patient has a realistic plan about how to get the medications.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
   - Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
   - Instruct on what constitutes an emergency and what to do in cases of emergency.
8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge that includes:
   - Reason for hospitalization with specific principal diagnosis.
   - Significant findings. (When creating this document, the original source documents – e.g. laboratory, radiology, operative reports, and medication administration records – should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.)
   - Procedures performed and care, treatment, and services provided to the patient.
   - The patient's condition at discharge.
   - A comprehensive and reconciled medication list (including allergies).
   - A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
   - Information regarding input from consultative services, including rehabilitation therapy.
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan.
   - May require removal of language and literacy barriers by utilizing professional interpreters.
   - May require contacting family members who will share in the care-giving responsibilities.
10. Give the patient a written discharge plan at the time of discharge that contains:
   - Reason for hospitalization.
   - Discharge medications including what medications to take, how to take them, and how to obtain the medication.
   - Instructions on what to do if their condition changes.
   - Coordination and planning for follow-up appointments that the patient can keep.
   - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.

Source: http://www.bu.edu/fammed/projectred/index.html.

they understood it."

Staying clear of medical jargon in the after-hospital discharge plan is "a really, really important" piece of the process, Jack says. "We worked very hard at being sure that the words were words people could understand."

Using the teach-back method of education, the DA would ask a patient, for example, "Tell me when your cardiology appointment is." And the patient would have to articulate and answer the question addressed in his or her plan.

Also included in the booklet were maps showing how to get to the scheduled follow-up appointment and instructions if there were other appointments, such as a physical therapy session. Patients also were told if and when medical equipment was supposed to arrive.

Now what about the chronically ill and elderly? How much can one prevent rehospitalizations in this population with chronic illnesses and frequent exacerbations? "If 20% of elderly people get readmitted within 30 days, some percent of those are preventable. Is it 10%, 20%, 30%, or 50%? Our study shows it's 30%. Others have shown about that, too. So that's kind of the going number right now."

Components meet TJC requirements

If you follow the RED components, Jack says you will be following Joint Commission requirements. In fact, he says, you will be surpassing it. He says TJC's discharge requirements are actually "pretty vague." Project RED is a part of the National Quality Forum's safe practices of hospital discharge. "The Joint Commission was a follower of that, as well as Leapfrog Group, CMS, the Institute for Healthcare Improvement, all of those guys... Project RED is a level above what The Joint Commission requires. So if you do Project RED, then you certainly fulfill The Joint Commission requirements. No question about that," Jack says.

The financial impact

One element of the program he comes back to is the incremental cost associated with it. "I don't think you need a new cadre of health care workers to do this... There's a bill in Congress right now that's going to be passed that is a new benefit for Medicare beneficiaries that will provide for post-discharge transition coaching. Maybe that's a good thing, but it's going to be expensive," Jack says.

"But the fact is is that right now it's pretty intuitive and pretty straightforward and inexpensive and is nothing more than what everybody should get anyway, and to not do those things doesn't seem to make much sense. And the whole program doesn't cost money; it actually saves money. There's really not too many things that improve care and cost less. And this does."

Frankly, though, he says the current payment system incentivizes hospitals to fill up their beds and to discharge patients as quickly as possible. "That's the incentive. There is no incentive not to readmit them. And it won't be until the summer that there's going to be some beginning of legislation and payment reform about rehospitalization." But it is definitely coming, he says.

(Editor's note: For more information, visit http://www.bu.edu/fammed/projectred/index.html.)

Reference

1. Jack BW, Chetty VK, Anthony D, et al. "A reengineered hospital discharge program to decrease rehospitalization: a randomized trial" *Ann Intern Med.* 2009 Feb 3;150(3):178-87. ■

Q&A on proposed CMS' 2010 IPPS rule

How far does it go toward VPB?

David Harlow, a health care lawyer and consultant, is the founder of The Harlow Group LLC and a "blawger" at http://healthblawg.typepad.com.

Q: It doesn't seem with the proposed inpatient prospective payment system for 2010 that there was a huge leap toward value-based purchasing (VPB).

A: No. There's slight expansions on the quality measures that are used and how those will change in the future under the RHQDAPU [Reporting Hospital Quality Data for Annual Payment Update initiative]. So there's some interesting issues there to consider. My problem with that set of measures and those incentives is that the incentive payment that's available to hospitals is incredibly small, and in terms of VBP, that's really not value-based purchasing. It's paying for reporting more than paying for performance. And virtually all of the measures are process measures rather than outcome measures.

In my mind, in order to achieve a working VBP model, there needs to be a move both to increase the number, the proportion of measures used that are outcomes measures, and also increasing the percentage of the payment that's at risk.

Q: So the quality measure changes don't require much more work?

A: There's only one or two new measures added this year. Not a big number. But they've published about 70 additional measures that they're thinking about adding over the next couple of years. And the whole thing started with 10 measures, and the idea was to see if people would actually report on measures so they wouldn't have 2% of their payments withheld.

Virtually everyone said, "Sure we'll report on 10 measures to avoid having 2% of our payment withheld." Now we're getting up to a point where there's actually a burden involved in collecting and reporting the measures, especially if we're up to 40 or 50 now and they want to add up to another 70 possibly. That's huge.

Another question there, in addition to the expense involved in collecting and reporting those, there's some talk in this rule about whether these measures can be abstracted automatically from electronic health records. Certainly that would be an improvement.

The question is really if you're looking at 70 things to assess quality of care provided at a given institution, isn't there really a core measure set of six or eight things that can really give you the same answer? That would be predictive of the outcomes of the 70 measures?

Let's say there's 70 good measures you want to follow, but I'd say it's more likely than not there's six or eight measures you could follow that would be predictive of the outcomes on the rest.

And this is something that has been pursued in the private sector. For example, by The Leapfrog Group. And I think that's an area in which the government could learn from the private sector.

Q: CMS has said it limited the number of quality measure changes this year because soon these measures can be collected and reported on through electronic health records (EHRs) eliminating the burdensome workload on hospitals.

CNE *questions*

1. Beginning August 1, 2009, The Joint Commission's new scoring process will go in effect.
A. True
B. False

2. In recognizing and treating patient deterioration, Children's Healthcare of Atlanta used which of the following were part of the initiative?
A. scenario-based training
B. standardizing transfer of care communication
C. PEWS system
D. all of the above

3. The study by **Brian Jack**, MD, showed a __% decrease in rehospitalizations.
A. 10
B. 20
C. 30
D. 40

4. **David Patterson**, MD, says the general attitude of physicians is to find a reason patients shouldn't be put on prophylaxis.
A. True
B. False

Answer Key: 1. B; 2. D; 3. C; 4. A.

CNE instructions

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

A: We hear this number being batted around of $19 billion available in incentives for implementing an EHR. That number, if you look at the numbers that may flow to an individual or hospital, the dollars available are really dwarfed by implementation costs. So someone doing a rationale cost-benefit analysis, if they're motivated only by the incentive funds, they're not going to do it. So there has to be another reason to do it. And it has to be not a stick but some other carrot.

And that's why I think that the incentives, the bonuses that are going to be available for high-quality care should be greater than 2% because that's not really sufficient incentive to move the hospital to really spend time and resources and energy in revamping their workflow.

To many hospitals, it's not just about slapping an EHR system on top of an existing system. What I've seen as health care providers and networks are implementing EHR systems with real connectivity built into them, it ends up reinventing the workflow of those provider organizations. They're often built around inefficient paper systems and things have sort of run up organically over the years or we've done it this way because we've always done it this way and putting everything on the computer system is really an opportunity for people to rethink their workflow.

[EHRs are] expensive. If a hospital is to do it itself, that alone can run into the six figures. So it's not a simple matter to say yes this is an interoperable system so you can press a button and everything gets uploaded instantly. It doesn't really work that way. ■

Focus on VTE and truths about prophylaxis

Thought shift needed on prophylaxis

Venous thromboembolism (VTE) has hit center stage as a major and preventable cause of death in hospitals and now a core measure for The Joint Commission. As a member of a rehab department with a high-risk population, **David Patterson**, MD, medical director at Casa Colina Hospital in Pomona, CA, wants to shift the pervasive attitude he sees surrounding VTE.

"Despite the core measures that are coming, there's still a general attitude of physicians [of thinking] let me find a reason a patient shouldn't be put on appropriate prophylaxis. That is basically where I'm changing behavior," he says.

Studies that retrospectively look at charts to determine patients that should have been put on prophylaxis but weren't are remarkable, Patterson says. Often physicians forget, and this is why he promotes using a team approach to preventing VTEs. "If you have to approach these issues like anticoagulation, veno-thromboembolism prevention, then you can't rely on physicians alone. You have to put processes in place that make the physicians a team leader that is part of a team."

Todd Wittenbrock, senior district manager of Eisai Inc., says, "You can go into one hospital and they basically have no management for DVT [deep venous thrombosis] prophylaxis. Then you go into another hospital and they have a complete algorithmic layout of what to do, with all the departments involved. You have guidelines out there like SCIP [surgical care improvement project] and

CNE objectives

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- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ False claims act and quality improvement
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- ■ Cultural competency via TJC and NQF

things like that, but there is no real hospital management system working with different departments... And I think that's what The Joint Commission is trying to do. You have to have something on paper that manages this issue."

Patterson says resources on VTE prevention are plentiful — the Mayo Clinic's web site, guidelines from the American College of Clinical Pharmacy, CHEST guidelines, and the Paralyzed Veteran of America's consortium on VTE management including prophylaxis and treatment.

The first area of the core measure set developed by The Joint Commission is "basically your overall VTE/thrombo prophylaxis protocols in your hospital," Patterson says. "They'll want to see there's evidence in the medical record that you are addressing the issue."

It comes down to risk stratification, he adds. "It's going to be more of an exclusion for not giving chemical prophylaxis rather than the opposite way of trying to find the reason why I'm not going to give it. You need to find the reason why you're *not* giving chemical prophylaxis," he says.

The No. 2 core measure, he says, looks at ICU patients. "That is where the ACCP guidelines, those two additions, that's where they really hit the nail on the head... That's a specific population where generally morbidity and mortality is high but DVT prophylaxis is forgotten about maybe because of the risk of bleeding." He suggests examining the ACCP guidelines on risk stratifying those patients.

Another area The Joint Commission will be looking at is your prophylaxis protocol, Patterson says. "When do you reexamine that patient you didn't put on prophylaxis? I think that's where a lot of hospitals will fall short. They'll forget that part. Reassessment is going to be a key component of the surveyors coming to look at your protocols."

He also points to examining your overlap policy with anticoagulation therapy. You should already have in place a bridging protocol with the anticoagulation core measures that went into effect at the beginning of the year, he says.

He says one challenging area that needs more clarification is the standard concerning how discharge instructions are written out to address issues such as follow-up monitoring, compliance, dietary restrictions, and adverse drug reactions and interactions. On discharge, too, he says you must think about when the next blood draw is. That's a high-risk discharge. "So [TJC] is definitely going to look at that. Now part of the core measures in '09 for anticoagulation addressed that. Were dietary restrictions given to the patient during the hospitalization, at discharge? But the core measures didn't really hit hard about this follow-up issue. So that will be a change for hospitals." ■