

Quality Improvement REPORT

Data collection strategies
for The Joint Commission,
CMS, and beyond

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How to navigate the basics of the QI data terrain

Vivian Chun, RN, CPHQ, learned in business school how to look at data, understand an Excel spreadsheet, and develop a database.

But she knows full well how difficult it can be for nurses who become quality improvement (QI) directors and are suddenly deluged with data demands—something few nursing schools prepare them for.

“Personally, it was a difficult transition,” says Chun, a former nurse and senior analyst in the quality department at Cedars-Sinai Medical Center in Los Angeles. “I can definitely understand the challenge of people who come from nursing and go directly into a QI directors’ position and try to figure out how to abstract data, how to analyze data, and how to report the data.”

Chun, who is now the manager of healthcare delivery advisory services for First Consulting Group in Long Beach, CA, advises QI directors to find out early on what their hospital’s priorities are and what information it’s

looking for. “You need to understand the purpose of the data and what that information will be used for,” she says.

Don’t start from scratch

The biggest mistake QI directors make, Chun says, is trying to reinvent the wheel when it comes to collecting data. Medical records staff are an excellent resource for data, she says.

“These people look at charts all the time, and they look at every chart after the patient is dis-

charged,” Chun says. “They also code data, so they probably already have some clinical data and quality data that you’re looking for.”

The hospital’s health information network and case management department also are fonts of data.

“Case managers are out on the floor all the time, and they know their patients the best,” Chun says. “They review charts on a daily basis.”

“Prepare to defend your data, because the first reaction you’ll likely get is, ‘Oh, the data is wrong.’ ”

—Vivian Chun, RN, CPHQ



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How to look at the data

So once you have the data, what do you do with them? Use the internal resources available (e.g., the information technology department and the outcomes and management team) to help analyze the information.

QI directors may want to take a class in Excel or basic statistics at a local college to help them better analyze data, Chun says.

They also may want to consider benchmarking to give their data more meaning. However, Chun warns that the information for external benchmarking can be difficult to find and, even if it is there, might not provide truly comparative data.

QI data

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Internal benchmarking, whereby certain surgeons' complication rates are compared to others who perform similar procedures, offers more control over the data. However, QI directors need to be careful about denominators, Chun says.

For example, analyzing four complication rates for a surgeon who performs only 10 hip and knee replacements per year is quite different than for a surgeon who does 100 such operations annually.

Reporting the data

The next step is reporting the data to hospital administration and the board of directors.

"Prepare to defend your data, because the first reaction you'll likely get is, 'Oh, the data [are] wrong,'" Chun says. "You need to be able to justify and explain the data.

Anticipate some of the questions, so you will be able to speak to them, because it's important to establish your credibility."

It's also paramount to keep the presentation simple. "People don't like to see a lot of numbers," Chun says. "You may have five minutes to make your point, so a graph might be the best tool."

Chun likes line graphs, as they illustrate trended data well. Bar charts are good for showing comparison data, she says. And scatter grams show standard deviations

and help you identify outliers, so you can see where you need to drill down.

"People don't like to see a lot of numbers. You may have five minutes to make your point, so a graph might be the best tool."

—Vivian Chun, RN, CPHQ

Action plan

Chun advises QI directors to develop an action plan for data collection. "If the patient fall rate increased by 20% over the last month, you want to be able to say why and by how much and what was the cause," Chun says. "Then you'll want to look at what's being done to prevent patient falls."

Chun's last piece of advice is to periodically assess the data being collected. "Every once in a while, look at the data collection and reporting that you are doing, because a lot of times it's not necessary anymore," she says. "You want to eliminate unnecessary work." ■

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System's reduction of pressure sores leads to award

Quality improvement directors with ambitious plans to dramatically reduce hospital-acquired pressure sores may want to hold off launching those projects until they've completed one critical task: collecting the necessary data.

"I would recommend they immediately develop defined measurements and some sort of database, even if it's a primitive one," says **Yosef Dlugacz, PhD**, senior vice president and chief of clinical quality, education, and research at the Krasnoff Quality Management Institute, North Shore–Long Island Jewish Health System (NS-LIJHS) in Great Neck, NY. "[Clinicians] may not believe they have a problem, but data can convince them otherwise."

Dlugacz knows whereof he speaks. He has firsthand experience in spearheading a performance improvement project to reduce pressure sores throughout his healthcare system, the third largest in the nation. That work produced positive and dramatic results: NS-LIJHS became the first organization to earn The Joint Commission's Ernest Amory Codman award in the network category in 1999.

In late 2006, the Institute for Healthcare Improvement (IHI) shone a spotlight on the prevalence of pressure sores by making the reduction of decubiti one of the six initiatives of its new 5 Million Lives campaign.

Data showed huge variations

At NS-LIJHS, the mission to reduce pressure sores began in 1996, when Dlugacz noted huge variations in the data regarding the number and severity of pressure sores. "I initially thought the variation was due to improvement. But upon further investigation, it wasn't so," Dlugacz says.

He started participating in rounds with the nurses in various units. "We saw patients with pressure sores, and they were not receiving the best care," Dlugacz says. He and the nurses decided to conduct an in-depth analysis across the healthcare system, which includes acute-care hospitals and long-term care facilities.

In order to fully assess the scope of the issues and develop preventive and therapeutic interventions, the health system convened a systemwide task force. It

included medical and surgical specialties (e.g., plastic and vascular surgeons), nurses, physical therapists, dieticians, geriatric medicine, and wound care specialists. "It was a multidisciplinary approach," Dlugacz says.

The task force used the Plan-Do-Check-Act methodology, and the healthcare system partnered with the bed-rental company Hill-Rom, which conducted prevalence studies. The prevalence studies consisted of random reviews of all patients by objective reviewers at a single point in time. Each patient was assessed for the presence of a pressure ulcer, and its stage (i.e., degree of damage) was recorded.

'We really did have a problem'

"The review from the outside illustrated that yes, we really did have a problem," Dlugacz says. "However, it was more than a nursing issue. It was a hospital issue."

The task force developed guidelines on preventive interventions such as frequency of turning and positioning, early mobility, patient selection criteria for specialty beds, and treatment protocols for various stages of pressure sores.

Staff were educated and data collection for hospital-acquired, or nosocomial, pressure ulcers and stages was standardized. The database included information on the monitoring of guidelines and nosocomial bedsores compared to those present on admission. Dlugacz then presented the data linking pressure sores to increased lengths of stay, which piqued the interest of the healthcare system's senior leadership.

The findings of this performance improvement project focused a great deal of attention on clinician—particularly nursing—education, including orientation and ongoing efforts, Dlugacz says. The Braden scale, which assesses patients' risk for developing pressure ulcers, was utilized and ultimately incorporated into the nursing assessment.

Sensitizing staff to risk

"The basic idea is to sensitize the staff to the fact that every patient is at risk for this complication," Dlugacz says.

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Hospital reduces disparities, improves cardiac care

Back in 2003, Del Sol Medical Center in El Paso, TX, decided it needed to do something about the cardiovascular care it provided. “We had outside reviewers come in to give us a clean eye as to what kind of quality care we were providing,” says **Linda Lawson, RN**, the former administrative director of cardiovascular services. “The data really hit us in the face. It was one of those ‘a-ha’ moments.”

The population of El Paso, the largest border town in the country, is almost 80% Hispanic. However, the medical center had discharge instructions only in English. And, even worse, only 1% of all patients received proper discharge instructions. “It was like an onion,” Lawson says. “The more we peeled, the more we cried, because we kept finding things. They were things that really ought to have been obvious to us, but you get so caught up in the day-to-day that you just don’t realize.”

The hospital began putting quality initiatives in place, applied for chest-pain accreditation, and created new order sets, and by the next year it saw improvements.

Expecting Success

That’s when Del Sol was invited to apply for the Robert Wood Johnson Foundation’s Expecting Success program, an initiative aimed at reducing racial disparities in healthcare. Ten hospitals would ultimately be selected to participate and receive a \$200,000 grant.

“[Expecting Success] really sparked a lot of interest,” Lawson says. “It sparked a lot of excitement.” Even though the hospital had already made inroads in cardiac care, she says the possibility of being chosen for Expecting Success “kept us focused.”

That focus and excitement paid off. In October 2005, the facility was selected from among 30 applicants to become part of the 10-hospital program.

Lawson laughs when she recalls going to the first kick-off meeting with her colleagues.

“We didn’t know who the other grantees were,” she says. “So we get to this kickoff, and we all get up and walk over to look at the map detailing the other winners,

and we just looked at each other . . . We were all kind of intimidated by our surroundings. We were in really great company. These were all really big academic centers.”

But that didn’t stop Lawson from calling the other nine hospitals to share her experience and seek advice.

Networking opportunity

“I could pick up the phone and call people in Florida,” she says. “I could call people in New York or Chicago. There was a lot of networking going on.”

Lawson also spoke of her successes—and failures—with her program peers. “You have to be willing to share your dirty laundry,” she says.

Bruce Siegel, MD, MPH, director of Expecting Success and Vickie Sears, RN, MS, CCRN, quality improvement director for the program, also visited the hospital to provide assistance. “They were readily available,” Lawson says. “They were terrific.”

Not asking about race

One of the first things the hospital discovered after joining the Expecting Success program was that admissions staff were not asking people about their race.

As a result, Del Sol altered its computer screens, adding a prompt to direct admissions staff to ask patients about their race and ethnicity. The hospital also came up with flyers in English and Spanish to inform patients that they would be questioned about their race and the rationale behind the inquiry. Hispanics have higher rates of diabetes and cardiac conditions than Caucasians.

Del Sol also instituted a policy dictating that all heart patients receive counseling on how to quit smoking. Lawson says that even though many patients said they didn’t smoke, many merely meant they didn’t smoke that day or that week. Further, many were exposed to secondhand smoke.

Cultural issue

One cultural issue the hospital discovered is that

many Hispanic patients want to speak to a family member before going to the catheterization lab, causing potentially dangerous delays. Del Sol set about educating patients about the importance of getting to the cath lab in under 120 minutes. In fact, the hospital set an even more ambitious goal of getting patients from door to balloon in under 90 minutes. It also invited emergency medical services into the cath lab to speed up the process.

Rates greatly improve

These efforts paid off. The 323-bed facility's quality scores are now as follows:

► **Acute myocardial infarction (AMI):** Nearly 84% of patients received a beta blocker at arrival during the first quarter of 2006. Preliminary results for the fourth quarter of 2006 put that number at 100%.

In addition, 62.5% of AMI patients received an ACE inhibitor or an angiotension receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD) during the

first quarter of 2006. Preliminary estimates for the final quarter of the year are that 100% received the medications.

► **Heart failure:** During the first quarter of 2006, 76.6% of patients received proper discharge instructions. By the final quarter, 100% did, according to preliminary estimates. Nearly 70% of patients received an ACE inhibitor or ARB for LVSD during the first quarter. Preliminary estimates for the final quarter are at 90.9%.

Lawson, who has been selected by the American Heart Association in Texas for its distinguished service award, recently left Del Sol. But she feels confident that the strides the hospital has made will continue.

"Del Sol's success shows what can happen when leadership is engaged, smart, and flexible," Siegel says. "They always keep their eyes on the ball." ■

Editor's note: For more information about Expecting Success, go to www.expectingsuccess.org.

Pressure sores

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This initiative succeeded, as, across the healthcare system between 1998 and 1999, the

- severity of Stage III injuries decreased from 7% to 5%, and the severity of Stage IV pressure injuries decreased from 5% to 1%
- mean length of stay was reduced by one day
- nosocomial prevalence rate decreased to 7.9%, significantly below the national benchmark of 10.3%

"I'm very proud," Dlugacz says. "It was an unbelievable commitment from the nurses, physicians, and other healthcare team members. When you have such commitment and passion, the process of improvement really works."

Today, the healthcare system has further improved upon those initial gains, and the nosocomial rate has plummeted to 1.4%.

"What is important is that we internalized appropri-

ate care as best practice," Dlugacz states. "If you can take a guideline and internalize it as a best practice, it is the ultimate outcome. Unfortunately, this does not happen often enough."

The IHI's 5 Million Lives campaign, he believes, will go a long way toward forcing hospitals to confront the problem as a medical issue, not just a nursing one.

"I don't think they have any choice but to improve," Dlugacz says. "What is happening is that, suddenly, an age-old problem has become a main topic. It's in the public eye." CMS, he adds, also is considering decubitus ulcers as preventable events.

Although The Joint Commission opted not to list reduction of pressure ulcers as a National Patient Safety Goal for 2007, it doesn't mean that this isn't a paramount issue. Violations of patient care standards in this area found on a survey may result in citations for deficiencies, according to Dlugacz. ■

Case study

This hospital is a top patient satisfaction performer

Sacred Heart Hospital in Eau Claire, WI, ranks in the 99th percentile for patient satisfaction scores, has low turnover and high staff morale, and consistently meets its budget expectations.

But what's more important to **Faye Deich, RN**, chief nursing officer, is that the hospital's commitment to patient satisfaction—which extends well beyond discharge—has actually saved lives.

"We do call-backs for our discharged inpatients, and I know we've saved a couple of lives in that process," she says. "We've gotten people back to their surgeons because they were probably starting to develop an infection. We probably saved the life of a new mother who was a diabetic, who was deteriorating on the telephone and was home alone with her newborn."

Sacred Heart launched its campaign to improve patient satisfaction in 1999, when it began surveying patients with Press Ganey. Back then, it was in the 87th percentile, with a goal to reach the 95th percentile. The Catholic hospital has since exceeded that objective and last year won Press Ganey's prestigious Summit Award for scoring in the 99th percentile for three consecutive years.

Service excellence

"When we started, we had a strategic plan," Deich says. "One of the components in that strategic plan was to focus on service excellence, so I became the champion of that as the chief nursing officer."

The first thing the hospital did was to focus on leadership development. It brought all of its leaders, including supervisors, off-site for training on the hospital's six pillars for success: quality, service, people, cost, growth, and congruency.

"We began with a lot of education for our leaders because we understood we had to role model the behavior we were expecting others to do," Deich says. "We gave our leaders a lot of training and tools, and then we

developed an accountability system to ensure that they would follow through on what we needed them to do."

The hospital also began benchmarking both in and outside of the healthcare industry.

"We benchmarked with Ritz-Carlton and other hospitals that were doing very well, and we developed service standards that we instituted across the organization,"

she says. "We had employees of all levels help us write those standards."

Ultimately, those service standards became part of every employee's job description.

"We connected it into our mission," says Deich.

"We do call-backs for our discharged inpatients and I know we've saved a couple of lives in that process."

—Faye Deich, RN

Employee satisfaction

The 344-bed hospital then turned its attention toward its workers.

"We realized that you can't have happy patients without happy employees," Deich explains. "We began to focus on employee satisfaction and what we needed to do to make the work environment more positive."

Sacred Heart instituted peer interviews across the entire organization. Housekeeping applicants, for example, interview with other hospital housekeepers, nurses interview with other nurses, and so on.

"We engaged our employees," Deich says. "They're very astute at picking the right people, and then they're very engaged in making sure they succeed."

Deich and her CEO also take new employees out to lunch after 90 days to find out whether the job is what they expected and whether there are any reasons why they would consider leaving.

Managers meet with new employees after 90 days as well.

Challenge of consistency

The hospital's patient satisfaction scores rose from the 87th percentile to the 92nd shortly after it began working with Press Ganey, but it couldn't climb to its goal of reaching the 95th percentile.

"I think our biggest challenge was consistency," Deich says. "You focus on something and it gets better, then you focus your attention somewhere else, and it drops."

To make sure all employees stayed focused on patient satisfaction, Sacred Heart linked the service standards it developed to performance reviews hospitalwide.

"You can't just treat [patient satisfaction] as a program," Deich says. "It really has to be integrated into the culture. And that took us years to accomplish."

The hospital now sends weekly reports to every department, detailing how well it's doing on patient satisfaction surveys.

Deich can't recall exactly what year the hospital hit the 95th percentile, but she remembers that shortly after it reached its goal, the scores quickly climbed even further.

What do patients want?

"Ninety-nine is really great," Deich says. "But it's really what 99 represents. And what that 99 represents is that any patient, any day of the week, regardless of who's working, can come to this hospital and receive very good care."

One way the hospital guarantees that consistency is by asking every patient at admission what he or she needs to get very good care. Spirituality and emotional needs are usually high up on the list.

"This is where we're probably the most fortunate hospital in the world," Deich says. "We have in-house pastoral care 24/7. Our pastoral care staff pretty much see every patient. Our mission really is to be there for people in their hour of need, and even though we're a Catholic hospital, it's a very ecumenical approach."

HCAHPS trial run

Deich hopes that the hospital's success with Press Ganey surveys will translate to high performance on the Hospital-Consumer Assessment of Healthcare Providers

and Systems (HCAHPS). Starting with July through September discharges, hospitals must report HCAHPS data to CMS in order to receive their full market basket update for fiscal year 2008.

In order to submit the data, hospitals must have participated in a CMS dry run, the last of which is scheduled for March. Sacred Heart will participate in that final dry run.

"The difficulty with HCAHPS is that it's a different tool than Press Ganey's," Deich says. "We might not look the same on HCAHPS as we do on Press Ganey."

"We realized that you can't have happy patients without happy employees."

—Faye Deich, RN

Deich advises quality improvement directors who may be new to the surveys to look at the questions on the HCAHPS and start querying their patients in advance.

"Obviously, you need to be courteous and respectful to people, and timeliness is important," Deich says. "But I really think that asking patients what it is that is most important to them [and] what will make them feel as though they have received the care that they need, to me, that's where it all starts." ■

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DVT form aims to get docs to comply with SCIP

Many hospitals may be scrambling to find forms to help them comply with the new Surgical Care Improvement Project (SCIP) measures on venous thromboembolism (VTE).

Not A.O. Fox Hospital in Oneonta, NY. The facility's pharmacy department came up with a form on deep vein thrombosis (DVT) several years ago. Now the problem is getting doctors to use the form, says **Wendy Fisher, RN, BS**, patient education coordinator and leader of the hospital's medication safety team.

"Our clinical pharmacist asked for input on the form several months ago," Fisher says. "So we've started this dialogue, and at our last medication safety meeting, I said, 'Look, what are we doing with the DVT form? I don't think many docs are using it.' So we started this campaign."

CMS' new rules on SCIP may provide her with just the ammunition she needs to get her doctors on board. Starting with January 2007 discharges, hospitals must report on two new VTE measures. If they don't, they lose 2% of their Medicare reimbursement. DVT is a form of VTE.

The new VTE measures are as follows:

- **VTE 1:** Ordering the proper prophylaxis
- **VTE 2:** Making sure the proper prophylaxis was given to the patient

The Institute for Healthcare Improvement (IHI) is also encouraging hospitals to implement the care recommended by SCIP in its 5 Million Lives campaign.

Fisher says she doesn't want to ditch the form just because physicians aren't using it. Rather, she's trying to determine what they don't like about it and how it could be made easier to use.


"The first medical doctor I talked to said, 'You know, I just don't think about using the form, I think about my patient.' " Fisher says. "But he added, 'You know what, maybe I've missed a few patients.' " However, he also told her, "We don't want any more forms."

Doctors at the 128-bed facility likely are ordering the prophylaxis for at-risk patients, she says. They're just doing so with the standard order sets.

Fisher is hoping the new CMS rules and IHI campaign will spur doctors to use the form. She also may want to let her doctors know that the costs for complications for just one patient who develops VTE are \$18,000, according to renowned SCIP expert Dale Bratzler, DO, MPH.

Fisher hopes to get physicians to start using the form within the next three months, but she's not sure she'll be able to meet that goal. "In a small, rural hospital, things don't move that quickly," she says. ■

Editor's note: For more information about SCIP, go to www.tinyurl.com/2f7c2a.

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Sample deep vein thrombosis prophylaxis order form



- Risk factors:** Age over 40 Surgery Hx. DVT/PE Cancer Hx. stroke / spinal cord injury
- Additional risk factors:** Obesity Varicose veins Prolonged immobility/paralysis
- Trauma Pregnancy Sickle cell anemia
- Laparoscopy Pelvic surgery Inherited coagulation disorders
- High-dose estrogen Nephrotic syndrome Acquired coagulation disorders
- CHF Myocardial infarction disorders Multiple trauma (without risk of bleeding)

Risk stratification	Prophylactic measures
<p align="center">Low risk</p> <p><input type="checkbox"/> Age under 40 years No additional risk factors Uncomplicated elective abdominal or thoracic procedures</p>	<p align="center">Please check the order of your choice</p> <p><input type="checkbox"/> No intervention required</p>
<p><input type="checkbox"/> Age over 40 years Length of surgery more than 30 minutes No additional risk factors Uncomplicated elective abdominal or thoracic procedures</p>	<p><input type="checkbox"/> Graduated compression stockings (Knee-hi TEDS) Plus Ambulate TID and Ad Lib</p>
<p align="center">Moderate risk</p> <p><input type="checkbox"/> Age over 40 years Length of surgery more than 30 minutes</p> <p><input type="checkbox"/> One or more additional risk factors for deep vein thrombosis</p>	<p>Check all that apply</p> <p><input type="checkbox"/> Sequential stockings or <input type="checkbox"/> AV Impulse until patient is ambulatory without assistance</p> <p><input type="checkbox"/> Sequential stockings or <input type="checkbox"/> AV Impulse for _____ hours</p> <p align="center">Plus</p> <p>Low-dose unfractionated Heparin* 5000 units q12h subcutaneously to begin 12 hours postop</p>
<p align="center">High risk</p> <p><input type="checkbox"/> Prior history of deep vein thrombosis and pulmonary embolus</p> <p><input type="checkbox"/> Abdominal surgery for malignant disease</p> <p><input type="checkbox"/> Orthopedic surgery on lower extremities</p> <p><input type="checkbox"/> Ischemic stroke or spinal cord injury</p>	<p>Check all that apply</p> <p><input type="checkbox"/> Sequential stockings or</p> <p><input type="checkbox"/> AV Impulse for _____ hours</p> <p align="center">Plus</p> <p>Enoxaparin (Lovenox) 30 mg. Q12h subcutaneously to begin 12 hours postop</p> <p><input type="checkbox"/> For orthopedic surgery:</p> <p><input type="checkbox"/> May use Warfarin INR 2–3 plus intermittent pneumatic compression until patient is ambulating without assistance Dose: _____</p> <p><input type="checkbox"/> Protine daily</p>

Additional orders: _____

* If the patient has contraindications to Heparin therapy, may substitute low-molecular weight Dextran 500 ml. q24h for three to five days. (Dextran is available in materials management).

Physician signature: _____ Date: _____ Time: _____

Note: These are guidelines that can be changed or adapted to each individual patient's needs and situation as per the medical doctor's discretion.

Source: A.O. Fox Hospital, Oneonta, NY. Reprinted with permission.

Experts: CMS verbal orders change adds to burden

Although CMS' new *Conditions of Participation (COP)* rule changes are designed to ease the burden for hospitals, a new requirement for verbal order authentication creates the opposite effect, a trio of experts said during a recent HCPro audioconference.

In November 2006, CMS released four new rules that took effect on January 26. A fifth revision, made to the patient rights *COP*, took effect January 8. The majority of the rule changes will make life easier for hospitals, but the verbal orders rule just got a little more complicated, said **Todd Sagin, MD, JD**, national medical director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA

"The *COPs* are fairly static documents," said Sagin. "There have been concerns for quite some time that they don't keep up with changing clinical practice, so people have looked forward for the opportunity of the government to make these changes. [The changes] have made life better in some respects, and there are some opportunities that they failed to take in these adjustments."

According to the new rule, hospitals must comply with the following:

- Verbal orders should be used infrequently
- Only authorized staff can receive verbal orders consistent with federal and state law
- All medical record entries must be legible, complete, dated, timed, and authenticated (written or electronically) by the person responsible for providing or evaluating the service provided
- For five years, the authentication may include another practitioner who is responsible for the care of the patient and authorized by the hospital and state law to write orders
- Authentication is done according to state law or within 48 hours

The Joint Commission's National Patient Safety Goal requirement 2A also addresses verbal orders, calling on hospitals to verify verbal or telephone orders by having

the person receiving the order or test result read back the complete order or test result. The Joint Commission requirement made sense and it was hoped that CMS would revise its *COP* similarly, but that didn't happen, said **Steve Bryant**, vice president and managing director of The Greeley Company, during the audioconference.

"Now, after the point of care, we're expecting the practitioner to come back 48 hours later, well after the medication has been delivered to the patient, to authenticate it," he said. "It does seem like an onerous task."

Hospitals traditionally have struggled with verbal order authentication, and the CMS rule change doesn't help matters, said **Bud Pate**, director of clinical operations improvement for The Greeley Company. "This one is just depressing," he said. "Operationally, no one that I've ever run into has a handle on this. With these rules, [CMS has] made [verbal orders] even more prescriptive and taken a good deal of flexibility out of what we're doing."

Ultimately, the intent of the rule is to eliminate the use of verbal orders to the extent possible, added Pate. "They want to see [verbal orders] eliminated through the use of faxes, e-mails, and other [information technology] solutions."

Another key new part of the verbal orders rule involves timing, said Pate. "The big change is that all entries—the H&Ps [history and physical] and the progress notes—have to be timed, not just dated. That timing of entries is now the law of the land. That's going to be a huge challenge for people."

Currently, The Joint Commission requires only that verbal order entries be dated, but it may modify its expectations to align with the *COP*, said Bryant.

H&Ps

Unlike the verbal orders rule change, the CMS change to its H&P requirements makes things clearer for hospitals, Bryant said. "Now, H&Ps need to be completed no more than 30 days before or 24 hours after admission for each patient," he noted. "This is a significant change

for CMS. Previously there was a seven-day rule, which didn't comply with Joint Commission standards."

Another change is that the H&P must be completed by a physician, oral and maxillofacial surgeon, or other qualified individual in accordance with state law and hospital policy. "This reflects changes in medical practice," Sagin said. "The use of nonphysician providers is expanding rapidly. Rural hospitals rely more on non-physician providers. Providing this flexibility makes sense. It's good coordinated management of practice."

Those nonphysician providers still must be credentialed and privileged to do H&Ps by the hospital. In addition, a physician who is not on the medical staff can complete the initial H&P, as long as there is an update from an admitting practitioner at the hospital. The update note based on the H&P is entered into the medical record.

Bryant said there has been controversy with update notes for outpatient elective surgical procedures. The Joint Commission requires that when an H&P was done prior to the day of surgery but within the 30-day window for the outpatient procedure, there must be an update note done the day of the surgery to reflect any changes.

But CMS does not require an update note prior to surgery, as The Joint Commission does, Pate said. That is left up to the hospital. The Joint Commission is conducting a field review to examine backing off the requirement of an update note, he added.

Security of medications

The changes to the rule on security of medications require that all drugs and biologicals be kept in a secure area and locked when appropriate. Schedule II, III, IV, and V drugs must be kept locked within a secure area, and only authorized individuals may have access to locked areas.

This change is a welcome one, said Bryant. "Authorized does not mean licensed," he added. "As an organization, you've determined who is appropriate and authorized to have access to these medications."

CMS is using common sense in making these changes, Pate added. "It is very specific that [CMS'] intent was that anesthesia carts don't have to be locked between cases,"

he said. "CMS says you can authorize housekeepers or engineering to be in the presence of medications. When nobody's around or the operating room is closed for the night, either the room or cart has to be locked."

Postanesthesia evaluations

CMS also requires that anesthesia policies must include the delineation of preanesthesia and postanesthesia responsibilities. For inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery.

The old regulation was antiquated, requiring anesthesiologists to visit patients a couple of days after surgery to check whether they've had any complications, said Pate. The new rule eliminates that regulation, allowing the postanesthesia evaluation to be done during the discharge process.

Restraint and seclusion

The changes to the patient rights' COP include changes to the restraint and seclusion requirements, including new definitions, regulatory requirements, training requirements, and death reporting. One change is that if a restraint has been ordered—but not by the attending physician—the attending must be notified immediately.

The face-to-face evaluation required within one hour for violent or aggressive behavior can now be done by a registered nurse, although the nurse has to meet stringent training requirements. The attending physician must be notified.

Death-reporting requirements have been expanded to cover all restraint and seclusion situations. Hospitals must report these deaths to CMS within 24 hours after a patient is removed from a restraint or seclusion. ■

Editor's note: For information about how to purchase a recording of the HCPro audioconference "New CMS Must-haves Explained: H&P, verbal orders, medication security, and postanesthesia evaluations," call HCPro Customer Service Department at 800/650-6787.

Physicians to receive bonuses for quality reporting

The United States took a giant step forward on pay for performance in December 2006 with the approval of a new law that offers financial bonuses to doctors who voluntarily report on quality measures.

“It’s an extension of the ongoing trend to move all of Medicare’s payment systems toward a pay-for-performance model,” says **Tom Valuck, MD, JD**, director of the special program office of value-based purchasing for CMS. “We don’t have authorization from Congress to move from pay for reporting to actual pay for performance, but the idea behind pay for reporting is that it is a step along the way toward true pay for performance.”

In late December 2006, President Bush signed into law a healthcare finance and tax package that offers incentive payments to physicians who report on quality data from July 1 to December 31.

Doctors can receive a financial bonus on up to three measures that will equal up to 1.5% of their total Medicare payments during that given period. To be eligible for the incentive payment, doctors must include data on at least 80% of their patients. Valuck says physicians who are not sure whether they’ll meet that 80% threshold on all three measures may want to report on four or five measures, for example, to increase the chances that they’ll hit the mark on at least three.

The quality measures physicians will report on are listed in the Physician Voluntary Reporting Program (PVRP) for 2007. As of mid January, there were 66 measures, but CMS had until the end of the month to modify them, and it will post any changes to its Web site by April 1.

Even though the data on measures linked to the bonus payments don’t need to be submitted until July 1, Valuck says doctors may want to start reporting on them now to prepare.

“One thing physicians can do is use the current G codes and [current procedural terminology] category 2 codes that are posted for 2007,” Valuck says. “They can use those to get their office staff used to reporting before there’s a payment consequence and use them to make

sure their internal systems are set up to use those codes.”

Unlike 2006, when the PVRP program began, CMS will not be providing feedback to physicians reporting on the quality measures. Valuck says many doctors have contacted CMS about the new rewards program. “We’re getting a lot of questions as to what exactly does the statute mean, what’s it going to take to comply,” Valuck says. “Physicians are trying to figure out what it is going to entail.”

Valuck suggests doctors watch the CMS Web site and check in with their trade associations because the agency will work closely

with those groups to get the message out about how the program will ultimately be structured.

“We’ll be doing a lot of outreach and getting out education materials and tools for physicians and others to use as we start to put the pieces in place,” Valuck says.

The American Hospital Association (AHA) is waiting to see how the measures unfold before making full comment. But, says AHA spokesperson **Amy Lee**, “We’re hopeful physician reporting measures will sync up and complement the quality reporting work being done by hospitals through HospitalCompare, but it’s too early to tell. That said, more helpful quality information for patients is a good thing.” ■

Editor’s note: For more information, go to www.cms.hhs.gov/PVRP.

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—Tom Valuck, MD, JD

Questions? Comments? Ideas?

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