

CheckPoint: Wisconsin hospitals sign on and publish quality, safety data

Charles Shabino, MD; Dana Richardson, RN

March 30, 2004 marked the culmination of 18 months of intense effort to be among the first states to create a hospital public quality and safety reporting program. And the fact that virtually all Wisconsin hospitals volunteered to participate says a lot about what physicians, staff, and hospital executives hold as central to their professional being—high quality, safe care for their patients.

This public reporting initiative began at the 2002 Wisconsin Hospital Association (WHA) Board of Directors planning session where board members challenged themselves to identify a common purpose that all hospitals could support. That purpose was identified as the desire to be accountable for the quality and safety of care provided to all people in Wisconsin. The Board then initiated the Task Force on Quality and Accountability, which developed a comprehensive model for improvement and identified public reporting as the first step in this process. The mission of the public reporting program is to develop consumer-focused initiatives that will provide reliable, valid measures of health care in Wisconsin to facilitate the selec-

tion of quality health care and aid in quality improvement activities. The WHA Board of Directors approved the task force's work in December 2002, setting into motion a series of activities to develop the first phase of the public reporting program.

One of the first steps in the development process was the creation of three teams. The Wisconsin Quality Steering Committee is a multi-disciplinary team consisting of physicians, nurses, purchasers, hospital administrators, researchers, and consumer representatives. This team is responsible for the selection of measures that meet the broad needs of multiple stakeholders. In addition, this team oversees the operational development of the initiative.

The Measures Team is a technical measurement group with representatives from health care and industry that have expertise in quality measurement and improvement, as well as statistics and reporting. This team is responsible for the detailed, technical specifications of the measures.

The third team is the Communication and Education Team, which developed the initial marketing and public relations plan. They laid the foundation for the Web site to assure that the information in it is consumer-friendly. This team dissolved after the public launch of the Web site on March 30, 2004.

Development of this public reporting effort was significantly enhanced

through the branding of the program under the name CheckPointSM. The name CheckPoint suggests that the information is available as a “check” on hospital quality and safety at a specific “point” in time. Extensive bi-directional communication was utilized to assure that hospitals, as well as other stakeholders, understood the program and had the opportunity to provide input on its development. Communication channels included multiple face-to-face meetings and presentations; frequent articles in WHA's weekly newsletter to members, *Valued Voice*; a focus on the theme of consumerism at WHA's 2003 Annual Convention, and Quality and Safety Forum; and CheckPoint's integration into WHA's public policy agenda *Healthier Choices*.

To guide the selection of the initial measures, as well as subsequent measures, selection criteria were developed (Table 1).

The first report consists of 10 medical services measures for acute myocardial infarction, congestive heart failure and community-acquired pneumonia. These clinical areas were selected because they represent three of the most common causes of hospitalization. In addition, these measures reflect key interventions that are supported by research and communicated through multiple practice guidelines. The 10 medical services measures will be updated every 3 months and consist of the following:

Doctor Shabino is chair of the Wisconsin Hospital Association Board of Directors and the Wisconsin Quality Steering Committee, and is Chief Medical Officer at Community Health Care, Wausau. Ms Richardson is vice president of quality initiatives, Wisconsin Hospital Association.

Acute Myocardial Infarction

1. Aspirin on arrival
2. Aspirin prescribed at discharge
3. Beta-blocker given on arrival
4. Beta-blocker prescribed at discharge
5. Ace inhibitor prescribed for low ventricular systolic dysfunction

Congestive Heart Failure

6. Left ventricular function assessed
7. Ace inhibitor prescribed for low ventricular systolic dysfunction

Community-Acquired Pneumonia

8. Mean time to first antibiotic
9. Oxygenation assessed
10. Pneumococcal screen and vaccination given

This data is collected by hospital staff from the medical record and entered into a third party vendor system. The vendor then submits that data to the Center for Medicare and Medicaid Services (CMS) National Data Warehouse. The data is abstracted and aggregated by MetaStar, Wisconsin's Quality Improvement Organization, and provided to WHA for publication on the CheckPoint Web site. The data is audited at several steps along this data submission process for accuracy.

The first report also consists of five measures that relate to national safety goals as defined by the Joint Commission on Accreditation of Health Care Organizations. These measures are:

1. Marking the surgical/procedural site
2. Verification for the right patient, right procedure(s) and right site(s) prior to a procedure
3. Elimination of dangerous abbreviations
4. Removing concentrated electrolytes from the patient care area
5. Utilization of free flow protection on all IV and PCA pumps

The Measures Team developed the measurement methodology for the

Table 1. CheckPoint Selection Criteria

Attribute	Criteria
Availability	Specifications developed and in use Specifications in the public domain Some Wisconsin hospitals currently collecting
Relevance or Importance	Meaningful (at least one audience) Controllability (one or more processes can be controlled) Health importance (type of measure, prevalence of condition and/or seriousness of health outcomes) Addresses factors applicable to health care issues and/or hospitals Cost-effectiveness/reasonable cost Variance in quality (institutions or providers) Potential for improvement
Scientific soundness	Clinical evidence (links between interventions, processes and/or outcomes) Reproducibility Validity (face, construct and content validity) Case-mix or risk adjustment (valid models available where required) Comparability of data sources/benchmarks
Feasibility	Precisely specified (clear population, definition and specifications) Confidential (should not violate patient-level confidentiality) Auditability
Interpretability	Understandable and useful to stakeholders

error prevention measures. Each measure consists of four components, three of which measure the care delivery process, with the fourth component consisting of an objective count of how frequently the hospital has achieved the stated goal of the measure, called the Demonstrated Success Rate. This data is collected by hospital staff and reported directly into a secured section of the CheckPoint Web site. The error prevention measures will be updated every six months.

The public launch of CheckPoint was supported by six, same-day press conferences around the state. Each press conference delivered state-level and regional messages, which included the reasons why CheckPoint would be valuable to employers and

consumers. In addition, a statewide news release issued by the WHA reinforced local efforts by hospitals to apprise the press of the value and usefulness of CheckPoint to their respective audiences.

The primary distribution vehicle for CheckPoint is a public Web site, www.wicheckpoint.org. Using the Web as the primary medium for publicizing the information allows for periodic updates to the measures that assure the information is current. The Web site also contains information that will help consumers begin to understand why the interventions in CheckPoint are important to their health. CheckPoint gives consumers a tool they can use to partner with their physician and other health care providers to ask questions about their

care. Over time, it is anticipated that this type of information will create a new environment of sharing that will be helpful to patients, physicians, and hospitals. A survey is available on the Web site to obtain feedback on the usability of the site as well as to provide input into what to include as future measures in CheckPoint.

Emerging Themes

Although we are only weeks beyond the public launch of CheckPoint, several themes have already emerged. First, it is not easy to identify and measure the quality of hospital processes due to the complex nature of the patient and the health care system. Current quality measures are more accurate than they were a few years ago, but still are not perfect. Many areas of care do not have consistent measurement methodologies at all. This is a new science that will no doubt evolve over the next several years. Second, the technical infrastructure to collect data in a systematic fashion from multiple hospitals is very fragmented.

On the other hand, CheckPoint led to the development of a statewide agenda for quality and safety improvement. One of the strengths of CheckPoint is the fact that it provides a common platform for reporting and measuring quality and error prevention data that all Wisconsin hospitals, regardless of size, can participate in. For many hospitals, CheckPoint will provide a focus and reason to dedicate resources to improving the quality of care provided to Wisconsin's citizens. Hospitals are now able to compare their progress to similar hospitals in the state and benchmark their improvement efforts. Several hospitals have already indicated that the process of collecting this information has given them insight into where they can focus to further improve their care processes and reduce the likelihood of errors. Working together to develop CheckPoint has opened the dialogue between physicians and other hospital staff that can lead to the sharing of best practices and accelerate the rate of improvement across the state.

What is the physician's role in hospital public reporting? The continued success of CheckPoint depends on physician leadership to develop and implement consistent processes that reflect the most current standards of care. This will require evaluation of working methods within the hospital and implementation of revised processes that assure the right care is provided and the chance of unexpected errors is significantly minimized. Streamlining care processes will also make the working environment more predictable and efficient for physicians and staff.

We're pleased that CheckPoint has allowed Wisconsin to emerge as a proactive national leader that has seized the opportunity to be responsive to a public that is eager to have patient quality and safety indicators measured and reported. Perhaps more important is our commitment to be accountable to continuously improving the care that we provide to the citizens of Wisconsin.

Wisconsin Medical Journal

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