HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

ACCREDITATION • CREDENTIALING • DISCHARGE PLANNING • MEDICARE COMPLIANCE • PATIENT SAFETY • QI/UR • REIMBURSEMENT

INSIDE

Necessary skill set: What does it take to succeed in quality? 16

AHRQ report touts safety gains: What's behind the numbers is a mystery . 17

Patient safety vs patient experience 19

Managers and quality: Study looks at what involvement works best... page 20

The least safe time in the hospital: Physicians think the wee hours are the scariest 21

Behavioral health and hospital costs: Study finds huge relationship 22

A new study suggests that Hospital Compare may slow the rate of price increases for certain procedures 23

AHC Media

FEBRUARY 2015 Vol. 40, No. 2; p. 13-24

Quality professionals in demand post-health reform

Help is wanted – desperately

On the National Association for Healthcare Quality (NAHQ) website, there are 770 current job listings for quality professionals. Move over to a more general job board, like LinkedIn, and a search for hospital and healthcare quality jobs in the United States can give you more than 17,000 listings — a couple thousand in the "mid-senior level" and a cool 800 from senior to executive level. There are 8,000 entry-level jobs listed. They are available in hospitals, health systems, and third-party payers. You can find quality jobs in pharmaceutical and medical device companies, large multispeciality clinics, and the smallest of rural hospitals.

"THERE ARE TONS OF OPEN POSITIONS FOR EVERY LEVEL OF QUALITY PROFESSIONAL."

This is not news to anyone working in the industry. It is taking months to fill positions, especially the more senior ones. **L. Dale Harvey**, MS, RN, a patient safety fellow and director of performance improvement at VCU Health System in Richmond, VA, says that she's had some positions open for months.

"There's a lot of work out there, and we have a very hard time filling positions," she says. "Some of that is because of the shift of focus to patient safety and quality, and some of that is because the pool of candidates has varying skills and competency."

Two positions have been open for six months, and one for two, she says. That's a little anomalous because the two longer-open positions are newly created ones. "But we prefer to wait for great, not settle," she says.

Financial Disclosure: Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Nancy Schanz report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

Hospital Peer Review®
ISSN 0149-2632, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST registration number R128870672.

POSTMASTER: Send address changes to:
Hospital Peer Review
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $469
Outside U.S.A.: Add $30 per year. Total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each.

ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.
Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.
This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

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

EDITOR: Lisa Hubbell
EXECUTIVE EDITOR: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).
ASSOCIATE MANAGING EDITOR: Jill Drachenberg, (404) 262-5508
(jill.drachenberg@ahcmedia.com).
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

EDITORIAL QUESTIONS
For questions or comments, call **Russ Underwood** at (404) 262-5521.

She runs into the problem of there being little standardization in skills in the profession. NAHQ has its certification program, but Harvey says that it is for the basics of quality. And the profession has changed so much in the last five years that a great mid-level candidate will need to demonstrate more than the CPHQ basics.

"The certification is based on a job analysis [survey] of currently practicing Healthcare Quality Professionals, so it reflects the current state of competencies needed," says **Mary Huddleston**, RN, MHSE, CPHQ, FNAHQ, president of the National Association for Healthcare Quality and a quality professional working at a large health system hospital in St. Petersburg, FL. "The Competency Project we are currently working on is for competencies of the future, although admittedly the future is rapidly approaching."

"We want a department with both a novice and experience mix, and are willing to look outside healthcare," Harvey says. "We have hired from the finance and engineering industries to get people with the right values and culture."

They cull applications and network — Harvey says networking usually gains the best recruits, although the ones who are clinicians sometimes have a misconception of the job. "Clinicians seem to think we work 8-4, Monday to Friday, and that we are off holidays. But we work 50 hours a week." Harvey was talking to *HPR* on the day after Christmas from her office, where she was putting in a full day of work. "Quality works weekends and holidays. It's not as easy as some people think."

One of the big changes that has made hiring more difficult is the shift to more specialized skills needed in the typical quality department at a medium or large hospital. If it is not a small facility with just a couple of people, then there will be a division of labor, Harvey says. Some people will focus on data abstraction and analysis, some on project management, some on root cause analyses. "In nursing, everyone may be an RN, but some work in pediatrics, some in oncology. It's the same with quality professionals."

Different skill sets are required for each. "Most quality managers, a decade ago, were nurses who didn't want to work at the bedside anymore," Harvey says. "Now, the importance of the work means that this is a career choice. It's a job people seek out from the beginning of their career, including physicians, which is new. They see quality as a career track. It's different every season; the work constantly evolves. That makes it of interest to people who are afraid of being bored."

Specific requirements

Some quality improvement efforts have specific requirements, says **Claire Davis**, RN, CPHQ, director of quality at Middlesex Hospital in Middletown, CT. The National Surgical Quality Improvement Project (NSQIP) requires dedicated personnel. Other specializations that are new to quality include people who are specialists in high-reliability, core measures, risk management, patient experience, and primary disease certification.

"There are tons of open positions for every level of quality professional," Davis says. "But the problem is, what they are looking for is a soup to nuts professional."

That's a step back in time to when the department handled Joint Commission surveys, safety, patient complaints, core measures, data abstraction, and risk management. Davis has nine people in her office, including 1.5 for NSQIP, one person for all quality and core measures for obstetrics and psychiatry, one person handling CMS and Joint Commission core measures, one person handling quality studies for medical staff, one handling external regulatory readiness — think surveys — and one doing safety and high reliability. Patient satisfaction and risk management are in other departments.

"You used to have a general surgeon who did everything," Davis says. "Now surgery is specialized. So are we."

The problem is that each of these specialists becomes limited by his or her experience. "There are few quality improvement managers who are full A-Z professionals now who can step into the director-level jobs and know all the pieces," Davis says. She worries about succession planning in this kind of environment. "There are so many people looking for directors, but not a lot of people with the full scope of skills out there, and for those of us who came into the field in the 1980s, we are aging and thinking about retiring. Who will fill our shoes?"

Davis says she has one of her staff who has the requisite background, and although she tries to mentor as many of her staff as she can, "I can't mentor all nine."

The importance of integration

With specialization, integration becomes more important, says Huddleston. "You have to learn to collaborate and cooperate. People get sick and have babies and go on vacations, so understanding the other programs is a necessity." Just because the skill sets of your data analytics person are different from those of your patient satisfaction staffer doesn't mean they can't work together on a project and learn from each other, she explains.

Davis' method has been to rotate people among their main assignments. Everyone learns root-cause analysis, to respond to complaints, to deal with Medicare and Medicaid guidelines. This year, there was a special opportunity for learning that Davis appreciates, at least in hindsight. "We had six surveys this year — Magnet, Joint Commission, CMS and three specialty surveys," she says. "I trained a subteam and put different people in different places for each survey. For one, a person might work with me on mitigating findings, for the next, that person might be the gopher. Everyone had a lot of really good experience in many areas."

CPHQ certification is required, and she encourages staff to attain fellowship status, but she would, like Harvey, appreciate seeing more, expanded certifications.

Huddleston says NAHQ is working on that. This is the 40th anniversary of the organization, and the exam for the CPHQ credential is likely to change. It's already undergone some transformation, Huddleston says, with the addition of patient safety questions when that topic became a big issue. But in the future the credential will be based on mastering concepts in six core competencies: health data analytics; population health and care transitions; patient safety; regulatory and accreditation; quality review and accountability; and performance and process improvement. The ones that excite her most are forward-looking, not responsive, predictive of future needs, Huddleston says: population health and care transitions, and data analytics. "We see them as a screaming need," she says. "In my work personally, I see the data analytics piece as a particular need."

In the end, Davis says, the goal is always to train someone who can take her job, and to encourage the people she trains to go out and climb the ladder like she did. But she worries about a middle gap at the director level.

"Those who have gone forward, who might have been doing this for 40 years, in a normal progression, would have become a vice president or something higher, but until 2000, after the Institute of Medicine report and the move tying quality to value, no one was really interested. No one outside quality wanted those mid-level jobs," Davis says.

Positions are open

Now, quality is a major driver for healthcare and the financial well-being of hospitals. Positions at the higher level are open. The problem is that people who do not have experience in the quality trenches are applying for — and sometimes getting — those jobs. C-suite level positions for quality are going to physicians who may or may not have experience in quality, she says, and the people who have been doing this work for decades are being left out. She worries it may be demoralizing. "That's why there is a shortage of directors. There is a lot of capability to move up, but there hasn't, before now, been a lot of opportunity to move beyond a certain point. Lateral moves, particularly with relocation,

aren't worth it."

That is changing, Huddleston says. Part of it is "making yourself indispensable." She herself sits in the C-suite with the chief medical officer, chief financial officer, and chief human resources officer. "You have to prove your worth. You need to learn to lead and to influence people and make the business case for quality. I see my role as to see what's coming, to keep the facility out of trouble by finding problems and fixing them. I have to keep us out of the bear trap." Do that, she says, and quality will find its way to the top.

For more information on this story contact:

• *L. Dale Harvey, M.S., RN, Patient Safety Fellow, Director, Performance Improvement, VCU Health System, Richmond, VA. Telephone: (804) 628-1131.*

• *Claire Davis, RN, CPHQ, Director of Quality, Middlesex Hospital, Middletown, Ct. Telephone: (860) 358-6337.*

• *Mary Huddleston, RN, MHSE, CPHQ, FNAHQ, President, National Association for Healthcare Quality, St. Petersburg, FL. Telephone: (847) 375-4720.* ■

Skills for success as a quality professional

What does it take to be a good quality professional? Leadership skills, says **L. Dale Harvey**, MS, RN, a patient safety fellow and director of performance improvement at VCU Health System in Richmond, VA. Even at the entry level, someone has to have demonstrated the ability to lead in at least an informal way.

They need "superb critical thinking skills." Harvey says the ability to solve problems, riddles, puzzles — that's the kind of thinking she looks for. Someone who likes detective work will like this kind of work.

One hard skill to find is someone who can see the forest and the trees at the same time. The ability to both drill down to detail and never lose sight of the systems-level goals at the heart of a good quality project is vital for someone who will one day run a quality department. "They need to understand the problem or process in the context of the entire system," she says. "They have to understand how both patients and staff will be impacted by what is changed."

At VCU hospitals, candidates for quality positions are given a self-assessment that helps the hiring manager determine how comfortable a potential employee is with the skills they will use — such as writing a formula in a spreadsheet document, or giving a presentation to a large group. This also helps the health system customize the orientation process to the new hire's needs.

During the interviewing process, the hiring manager is watching how a candidate reacts to the questions, judging answers to questions on how they would handle a hypothetical problem or what they would do during specific situations. Hiring managers also ask for examples from the candidate's experience when certain things happened and how they handled the situation.

People who express interest in quality jobs — whether internal or external — are pointed to self-learning opportunities through the Institute for Healthcare Improvement. "Then we tell them to take on a small improvement project in their current work area and see what they like about that," Harvey says. "People who think they are interested in this often find it's not for them."

VCU is a high-reliability organization and embraces Lean Six Sigma, "which takes years to learn in a meaningful way," Harvey says. "Project management skills, likewise, take years to master. Data analysis, how to design measures, facilitation — all these skills are required to be successful, and a good quality professional will have them all. That requires more than a couple years of sabbatical time in the quality department. If that's all you are looking for, we can leverage you to work on some projects in your department, but it's not what we want full time in our department."

"I want to see that lightbulb go off when you talk about quality," says **Claire Davis**, RN, CPHQ, director of quality at Middlesex Hospital in Middletown, CT. "I want to see a true passion to change things and see what can be better."

Davis always asks prospective employees how they would go about a particular task — who would be at the table, what they would discuss. As with Harvey, there's an element of riddle-solving she's looking for. "I want to see an ability to lay out puzzle pieces, as well as the usual ability to think critically and some good common sense. If they have 10 problems, I want to know which they would tackle first and why. And they need to have a good grasp of statistics."

Systems thinking — the ability

to see things at the macro level rather than getting caught up in the micro — is a key to success in this industry, Davis says. Other people have those micro skills, and you need to be able to find and harness those abilities, "but you do not have to be that person," she says. "There is an intuitive ability to know when you need to drill down to detail, but the overarching mission has to be present in your mind always. You can't lose that. You can't think just about lower length of stay, but also readmissions and quality and safety and how impacting length of stay may impact those other things. You have to understand this all at once."

Being able to juggle is a good skill — at least figuratively, because there will be "hundreds of items, topics and initiatives on your plate at the same time, and you will never see the end of your to-do list at the end of the day," she says. If someone is tied to a sense of accomplishment by completing a list, he or she may be discouraged in the quality department. There is no end to the journey. A project you thought you finished last year is not over, it just moved to a different place on the list, she says, and someone who doesn't understand that it's not like "a patient who gets sick and you discharge them when they are better" may not be a good fit.

> "I WANT TO SEE A TRUE PASSION TO CHANGE THINGS AND SEE WHAT CAN BE BETTER."

Playing well with others is important, as is "getting along with difficult personalities," Davis says. "You have to be able to form collegial relationships with people who will get mad at you. You have to have strength and courage and know when not to settle, when to stand up and say something is not right," she says. A person who can't stand her ground, state the evidence in the name of patient safety, and take the flack that comes back at her won't last. "You have to be gutsy and courageous," Davis says. "Sometimes it is just one person who stands up in the name of quality for large populations of people."

"Gutsy" is a word also used by **Mary Huddleston**, RN, MHSE, CPHQ, FNAHQ, president of the National Association for Healthcare Quality and a quality professional working at a large health system hospital in St. Petersburg, FL. "We have to have a safe environment for reporting things that aren't right, but there may be cases where reporting quality or safety problems will have a negative impact on the bottom line. There may be pressure to not report because of that." Huddleston says she has heard of people being pressured or even fired in such cases. So courage to speak up is vital.

Along with all the technical skills, critical and analytical thinking skills, Huddleston has one more recommendation for people looking to hire someone great for their department. "Do not be afraid to hire someone smarter than you." ■

Less harm done in 2013, says AHRQ

But does report tell the whole story?

The data look so good for the headlines: in 2012-2013, hospital-acquired conditions such as urinary tract infections and falls fell by 9%, saving about $8 billion. Stretching back another year, to 2011, the total cost savings reached an estimated $12 billion, with about 1.3 million cases of harm and 50,000 deaths prevented. All this good news came in a December report released by the Agency for Healthcare Research and Quality (AHRQ).

Tens of thousands of medical records are reviewed for evidence of eight kinds of events, additional costs of which have been estimated as follows:

- adverse drug events — $5,000;
- catheter-associated urinary tract infections — $1,000;
- central line-associated bloodstream infections — $17,000;
- falls — $7,234;
- obstetric adverse events — $3,000;
- pressure ulcers — $17,000;
- surgical-site infections — $21,000;
- ventilator-associated pneumonia — $21,000;
- postoperative venous thromboembolism — $8,000.

The report doesn't explain why the declines are happening, other

than to tout the government's efforts at rewarding successful efforts and punishing malingerers through value-based purchasing programs, as well as the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients (http://partnershipforpatients.cms.gov/) program, which tries to spread good ideas to attack some of these problems.

A call to action?

There are many organizations that have done great work on quality and safety, says **Mark Graban**, an author and healthcare quality consultant based in San Antonio. For them, these numbers aren't a surprise. And there are other organizations that have not been as successful. These numbers may be a call to action — a notice that others are able to make changes that make a difference, so they can, too.

"The hospitals that have been on this bandwagon all along? They know that all of the celebration about good numbers in one report doesn't mean anything, that the journey is continuous and that one person harmed is too much," says Graban. "You can't use this kind of success as an excuse to relax, but rather a way to move forward and build on a good start."

He worries, though, that some hospitals will take these numbers and use them to tout their achievements to the general public, which is not as invested in digging down into the numbers as a data jockey at CMS might be. For them to imply that the care they provide is wonderful because some lives that never should have been at risk in the first place were, indeed, not put at risk, seems disingenuous, Graban says. Similarly, it's just as unfair for the media to latch on to numbers and report headlines that scream, "Twice as many reported incidents!" without noting that it doesn't mean there are twice as many occurrences of something.

Data is complicated, he says. "It's easier to know how many people are killed by a kind of car than are killed by medical errors, which can be easily explained away by something else or covered up — either maliciously or not."

Still, these data look like we are moving in the right direction, Graban notes. What's important now is to dig down further. What actions are hospitals taking that make that movement possible, and how do we spread that around the national healthcare system? "The report doesn't go into that. What we can be sure of is that the percentages they report are not uniform. That 9% is not true in every hospital or even every unit. Some have gotten safer, and some haven't. And within the report, the various conditions have had various levels of success."

Ventilator-associated pneumonia had only a 3% reduction over its 2010 baseline rate, falls just 8%, while bloodstream infections fell by just under half.

Setting a goal of no harm

Graban suggests that hospitals take this report and compare the national benchmarks to internal performance levels. But do not let your performance against that national benchmark make you feel complacent. "We do not want any quality leader to say, 'Oh, we're better than average,' or 'We're in the top decile,'" he notes. "The top tenth is still a lot of harm and death. While it's great to do better than those numbers, it's better to compare yourself to zero harm and see what you need to get there."

That may be one of the biggest issues that those who preach quality have with national benchmarks and goals: They rarely set goals of no harm, but only of harm reduction. "If you compare badly against the norm, it should be a wake-up call, because leading hospitals spend less on benchmarking and more on striving towards zero harm, towards perfection. It's the only ethical goal. You can't have an ethical goal of two pressure ulcers. What do you tell those two patients? They were ethically okay to be harmed?"

Graban acknowledges some hospital conditions like falls will be nearly impossible to forever keep at a zero. But to those who think that having a goal of zero is demoralizing when it's often nearly impossible to meet, he says no. "The goals are only demoralizing if you just pay lip service to them, and then it doesn't matter what they are," he says. "Good leadership, that doesn't punish you for not getting to zero when you are actively and honestly pursuing that aim, will make sure that it is not demoralizing. To say that is just an excuse not to aim for perfection."

The entire Agency for Healthcare Research and Quality report can be seen at http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html#Summary.

For more information on this topic, contact Mark Graban, Lean and Kaizen Consultant, San Antonio, TX. Telephone: (817) 993-0630. ■

The conflict between quality and patient experience

Can both be good?

Imagine you are trying desperately to reduce your fall rate and you have instituted a program with bed alarms for patients who meet certain criteria. You may find yourself really pleased to note a reduction in falls, but at the same time you are noticing your patient satisfaction scores are taking a hit. Patients are talking about the noise of alarms, of feeling infantilized, of their sense of control being taken away. Is there a link? Maybe, according to an editorial in the *American Journal of Medical Quality*.[1]

Author **Sue Moffatt-Bruce**, MD, PhD, chief quality and patient safety officer at Wexner Medical Center of Ohio State University in Columbus, and a thoracic surgeon in practice there, writes with her colleagues that there has been a shift over time of the competing pressures.

In 2013, it was just process measures (70%) and patient experience (30%) as described through HCAHPS results that informed the rewards of value-based purchasing from the Centers for Medicare & Medicaid Services (CMS) to hospitals. Last year, a new piece was added to the pie: outcomes measures, taking up a quarter of the circle and reducing process measures to 45%. This year, the wedges change again: HCAHPS and outcomes are each 30%, process measures are 20%, as is the newest slice, efficiency. Next year, process shrinks to 10%, HCAHPS and efficiency are each a quarter, and outcomes are 40%.

What does this mean? It means that the balancing act just gets trickier, Moffatt-Bruce says. "People do not want to recognize this tension, even though they know in their hearts it is there," she says. "We have to be sure that we are putting the emphasis in the right place this year and next."

The issue of falls is a good one to take as an example. Explaining your efforts can change the way a patient sees them, she says. Saying that you are most concerned about the safety of the patient and ensuring that he or she doesn't fall could make a bed alarm or other fall reduction effort more palatable.

> "THE PATIENT MUST BE THE TRUE NORTH METRIC FOR US. THEY MUST BE THE CENTER OF EVERYTHING WE DO."

"Right now, we aren't even empathetic about the situation," she says. "They do not know what we are thinking when we alarm their beds or restrain them. Then when we ask them to rank their experience, we are surprised that they view it as negative. We have to do a much better job explaining our thinking to patients and their families."

In the editorial, Moffatt-Bruce and her peers note that patient-centered care — a term of a decade's provenance — may be the savior for all. Making sure you make the patient the focus of everything you do — and thinking about how what you do might be perceived by the patient — is key.

Quality professionals have two jobs, Moffatt-Bruce says. First is to help administrators understand the link between quality and the bottom line. This will help them understand that they have to "fund the mission," she says. "The patient must be the true north metric for us. They must be the center of everything we do."

Even more important, you must explain to the physicians the competing tensions in the value-based purchasing pie, Moffatt-Bruce says. "They do not understand the concept, and that they have to now balance patient experience with outcomes is a completely foreign concept to them. They need to be educated about it, be accountable for it, and recognize that they must develop a level of empathy to the tension between care processes and outcomes."

Doctors — and nurses — should also be aware of how they are doing, both as individuals, and as units and hospitals, in terms of these value-based purchasing data points. "They could go look at Hospital Compare, but what tired doctor or nurse does that?" she asks. Make it easy for them to see where they stand, and where your

facility stands.

Sometimes, Moffatt-Bruce says, "physicians and administrators think that we can define value. But the patient is the one who defines it for us, and we keep forgetting that."

Which brings her to the final point: Engage your patients. If they are at the center of all you do, you probably already do this. But make sure they are in the loop with every single process happening to them. Information is power, and one of the biggest reasons people hate being in the hospital is that they are no longer in control of their life, she says. By keeping patients in the loop about what you are doing and, importantly, that you are doing it to keep them safe and get them well, you are more likely to help the patient feel good about the experience in the hospital. That 25% of your value-based purchasing pie will be secured. "Make what you do at the bedside clear, transparent, and practical," Moffatt-Bruce says. "If you ever have need to have more explanation, it's when you are sick. It gives patients something to focus on."

Moffatt-Bruce is publishing a paper in *Management Science* this year that is a study of different hospitals and this tension. She hopes to put it in the medical literature, too.

For more information on this story, contact: Sue Moffatt-Bruce, MD, PhD, Chief Quality and Patient Safety Officer, Wexner Medical Center, Ohio State University, Columbus, OH. Email: susan.moffatt-bruce@osumc.edu. ■

REFERENCE

1. Moffatt-Bruce S, Hefner JL, McAlearney AS. Facing the tension between quality measures and patient satisfaction. *Am J Med Qual*. 2014 Nov 3. pii: 1062860614557352.

New research suggests leadership involvement improves quality

Review study finds culture really does matter

Quality can't work in a vacuum. That's the message of a review study conducted by **Anam Parand**, PhD, and associates, out of the Imperial College London, who looked at 19 studies on the role of managers, leaders, and boards in quality improvement and patient safety and how that trickled down to actual quality of care and outcomes.

The findings are probably not hugely surprising — the programs that are the best at providing dedicated personnel, leadership/managerial time, and resources for quality work get the best results; those that give quality lip service do not. But Parand and his colleagues were interested in finding empirical proof of intuitive thought.

"You may well have a good idea of what hospital boards are, or should be, doing for quality partly because there are so many anecdotal commentaries postulating on it," he says. "But this review presents only those study findings that report empirical evidence for these, and there aren't many of them. In fact, one of the most surprising findings was the scarcity of such articles available globally to help advise managers at varying organizational levels."

He's had a lot of interest because of that, Parand says. "Managers and quality professionals want to know what the evidence says is currently happening and what is worth doing."

The group of researchers was surprised to see some studies couldn't prove a benefit between quality and safety and managerial actions — you'd like to think that any action thought out enough to merit a study would have some good impact. However, "there were a couple of studies that showed managers' involvement to have a negative effect on quality-related matters, while others found no effect at all," he says, noting that those particular studies may be anomalies, or they could represent bad ideas of intervention. "Of course it's difficult to make such judgments with so little data to go on."

The cool thing is that for those studies that have been validated, quality professionals now have some proven work to mimic. Among the best ideas, according to Parand: having a board quality committee; making sure the board has a quality report every meeting; keeping a dashboard that has national benchmarks noted on it; and rewarding staff for quality achievements.

"In our article, we present a quality management input-process-output model to show the conditions and actions that affect quality performance," Parand says. "Basically it shows what managers are presently

doing for quality and safety and where they can make an impact. More research would strengthen this model, so at the moment I would say that recommended approaches should be taken with an understanding of their limited substantiation."

He'd like to see better research on what managers should be doing to have a positive impact on quality of care. "Our review has identified many gaps in the present research literature," he says. "The ideal research study would address these weaknesses by including objective quality and safety clinical outcomes that are linked to actions performed by managers. The emphasis should be on actual actions rather than contextual factors alone, as has been the case in many of the previous studies. The over-reliance on participant reports could also be strengthened by supplementary methods such as observations."

He'd like to consider reports from outside the English-speaking world, too, and to look beyond the boardroom, which seems to be the focus of most of the research.

> "THE PROGRAMS THAT ARE THE BEST AT PROVIDING DEDICATED PERSONNEL, LEADERSHIP/ MANAGERIAL TIME, AND RESOURCES FOR QUALITY WORK GET THE BEST RESULTS."

He'd like to see researchers look at frontline and middle management, "who are rarely considered by researchers, despite the large number of them." Still, he acknowledges that "because of the complicated nature of managerial work and quality of care, it's not an easy topic to research scientifically."

The study can be found online at http://bmjopen.bmj.com/content/4/9/e005055.full.pdf+html

For more information, contact Anam Parand, BSc, MSc, PhD, Research Associate in Psychology, NIHR Imperial Patient Safety Translational Research Centre, Imperial College London. Email: a.parand@imperial.ac.uk. ■

REFERENCE

1. Parand A, Dopson S,Renz A, et al. The role of hospital managers in quality and patient safety: a systematic review. *BMJOpen* 2014;4:e005055. doi:10.1136bmjopen-2014-005055.

Patient safety on the night shift

Docs say 4-7 am is the most dangerous time in a hospital

The floors are quiet, patients are asleep, and residents are trying to either catch some shut-eye or catch up on paperwork. The rush of the evening hours in the emergency department has ended. Yet the wee hours of the morning — 4 a.m. to 7 a.m. — are when doctors think the hospital is at its least safe, according to a new study.[1]

Jed Gonzalo, MD, and his colleagues surveyed physicians and nurses and looked at reports of adverse events and misses during overnight hours at a university-affiliated hospital in Pennsylvania. Results were published in the December issue of the *Journal of Hospital Medicine*.[1] They wanted to know what providers thought was the least safe time of day and why, particularly since there had been changes made to ensure that there was adequate oversight and nurse-patient ratios in the recent past that might make many think that issues previously brought up — not enough people to deal with problems, no senior doctors on site to deal with decompensating patients — had been adequately solved.

They looked at issues of quality of care delivery, communication and coordination, staffing and supervision, patient transfers, and consulting services issues. Perceived mismanagement of patient care and personal/relational tensions were also measured. The most common of the seven parameters questioned was mismanagement of patient care, with 97 of the 332 survey responses including issues with this. Next most frequent was quality of delivery, with 63 responses; communication and coordination, with 50; staffing and supervision with 39; patient transfers with 38; consulting services with 18; and professionalism/relational tension with 17.

Among the lowest-rated items

were timeliness and safety issues with patients from the emergency department, timeliness of consults, and physician staffing levels. There seemed to be much less issue with things like medication ordering and processing, getting lab results, and communications between physicians.

The authors think the issues surrounding ED admissions are the most concerning, particularly since when the study was conducted, the hospital in question had a nocturnist on staff who was supposed to make such transitions smoother. Another issue was how differently people with no night shift experience viewed the quality of care delivered at night from the people who did have such experience, and the authors note that many of those who have those negative perceptions are making decisions that directly affect care delivered at night. Figuring out what they view as "wrong" and why could be important to future delivery of care.

Lastly, they found that everyone agreed that the last part of the shift was the most dangerous — that period from 4 a.m. to 7 a.m., which does not coincide with the busiest time at the hospital (usually between 6 p.m. and 9 p.m.) when most admissions are happening. Gonzalo and his peers note they have no idea why this is so — fatigue, getting ready for shift transition — only that it is a nearly universal feeling among nurses and physicians that those hours are the most dangerous.

This study came out of a larger work on nocturnists and outcomes, Gonzalo told *HPR*. "I spent a lot of times on night shifts as a fellow and wanted to look at those hours when half the patients come into the hospital."

> "THE AUTHORS THINK THE ISSUES SURROUNDING ED ADMISSIONS ARE THE MOST CONCERNING..."

The idea is not to compare day to night, and it's hard to frame it so that it is not such a comparison. The first thing people will say is that staffing is down and that's why it's unsafe, he says, or there is less supervision. But those things have been improved. Now, with nocturnists to supervise and better nurse-patient staffing ratios, it should be the same. Yet it is not.

Most, if not all, quality staff work during the day, Gonzalo says, and may not think of the hospital in terms of how it works at night. Beyond the increase in admissions, there are things that are just different — such as communications coordination, how things move from one place to another.

It might be a good idea to come to the hospital late one evening to see what's different, or in the wee hours of the morning, he says. "The things you come up with for daytime may not apply at night. There are nuances you just may not think of. I just want to ask you to think about what you are doing and how it might impact the people who are working at night."

For more information on this topic, contact Jed Gonzalo, MD, Director of General Internal Medicine, Penn State Hershey Medical Center, Hershey, PA. Email: jgonazlo@hmc.psu.edu. ■

REFERENCE

1. Gonzalo J, Moser E, Lehman E, Kuperman E. Quality and safety during the off hours in medical units: a mixed methods study of front-line provider perspectives. *J Hosp Med*. 2014 Dec;9(12):756-63.

Behavioral health and hospital costs

Study finds huge relationship

When you think about it, it's not the fact that's surprising, but the extent. In 13 New Jersey hospitals, a third of all hospital costs were associated with behavioral health issues, such as substance abuse or mental illness. Even more alarming, the report by the Rutgers University Center for State Health Policy noted that three-fourths of the highest users of hospital services were afflicted with behavioral health conditions, compared to about a third of those who were not considered high users of services.

Lead author **Sujoy Chakravarty** says the large number affected by behavioral health problems surprised the researchers, too, and while they were specific to the 13 hospitals located in impoverished areas of New Jersey, he thinks the results would be fairly consistent with numbers in other like areas.

"I do not think it's a stretch to believe that behavioral health can impact physical health and vice versa," he says. "If you do not treat behavioral health in the community, it can hamper how well you manage physical health problems and lead to the hospital." He pointed to an example of someone with diabetes and a substance abuse problem, who ends up in the hospital because that person is not capable of monitoring his or her blood sugar consistently or eating properly in an altered state or when all of the patient's money is going to drugs.

In the hospital, too, they might be treated for both, but what happens back in the community may be fragmented. The emphasis may be on the addiction because that is what is having the most impact on the people around the patient, who may not have a primary care physician.

What this study points to is the need for integrating care and the potential benefits of accountable care organizations that truly connect the care both in and out of hospitals, Chakravarty says. "There is no concept of a behavioral health home like there is for a healthcare home," he notes.

The report is part of a series that aims to find opportunities for improving care; others in the series can be found at www.cshp.rutgers.edu/content/medicaid-acos. It concludes that many hospitalizations among this group of people could be prevented with real coordinated care, if only they had access to it.

The entire report is available at http://www.cshp.rutgers.edu/Downloads/10530.pdf.

For more information on this topic, contact Sujoy Chakravarty, PhD, Assistant Research Professor, Rutgers University, New Brunswick, NJ. Email: schakravarty@ifh.rutgers.edu. ■

Hospital Compare may slow price increases

QI impact questions remain

While previous studies have failed to prove that access to quality information from public reporting sites such as Hospital Compare can be an impetus for hospitals to improve quality of care, a study published in the January issue of *Health Affairs* indicates it may have an impact on prices.[1]

The study, by Avi Dor and colleagues, found that the Centers for Medicare & Medicaid Services (CMS) public reporting on two procedures — coronary artery bypass graft (CABG) or bypass surgeries; and percutaneous coronary interventions (PCI) — correlated to a decline in the rate of growth in prices for those procedures.

Using data from procedures between 2005 and 2010, a period that covered pre-Hospital Compare and after it had been in place for some time, the authors suggest that insurance companies are using the data from the site as a bargaining chip with hospitals.

Hospital Peer Review will delve further into the study for an upcoming issue, exploring what this information means to hospitals and quality professionals. ■

REFERENCE

1. Dor A, Encinosa WE, Carey K. Medicare's Hospital Compare Quality Reports Appear To Have Slowed Price Increases For Two Major Procedures. *Health Aff* January 2015 vol. 34 no. 1 71-77

COMING IN FUTURE MONTHS

- ICD 10 and you
- The latest on the National Patient Safety Goals
- Playing nice with risk management

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or, until Jan. 4, 2015, log on to cmecity.com to take a post-test. First-time users must register on the site using the 8-digit subscriber number printed on your mailing label, invoice or renewal notice. On and after Jan. 5, 2015, when logging onto the new AHCMedia.com, go to "MyAHC" and then "My Courses" to view your available continuing education activities.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE QUESTIONS

1. **NAHQ is creating six core competencies for quality professionals. Which one of these isn't one:**
   a. patient safety
   b. quality review and accountability
   c. leadership
   d. performance and process improvement

2. **Mary Huddleston says that QI staff have to have courage. Why?**
   a. They may work with unfriendly people.
   b. They have to learn many tasks.
   c. They may face pressure to put finances before quality.
   d. They may have trouble moving beyond director level.

3. **AHRQ says that patient harm was reduced in 2013. Which had the least decline?**
   a. CAUTI
   b. CLABSI
   c. Pneumonia
   d. Falls

4. **How much do outcomes and patient satisfaction count for in value based purchasing in 2016?**
   a. 50%
   b. 45%
   c. 65%
   d. 80%

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.