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INSIDE

Safety Culture Proven to Improve Quality, Must be Monitored and Measured

With more evidence continuing to show the relationship between patient safety and quality of care, hospitals are devoting more resources to developing a patient safety culture. But how does a patient safety culture influence quality, and how do you know if you have instilled that culture throughout your organization?

A recent study added to the data suggesting that a patient safety culture improves overall quality within the healthcare organization. Researchers found that an embedded patient safety culture may be as important to delivering high-quality patient care as more technical issues like the skill of a surgeon or the latest high-tech equipment. *(See the story later in this issue for more on that research.)* The research reinforces an idea that has emerged in recent years, says **Coleen Smith**, RN, MBA, CPHQ, CPPS, director of high reliability initiatives with the Joint Commission Center for Transforming Healthcare. Quality leaders have come to realize that patient safety is about more than just not harming patients; it's also about improving the quality of care overall.

> "HOWEVER, INSTILLING A PATIENT SAFETY CULTURE IS PROVING TO BE A CHALLENGE FOR HOSPITALS."

However, instilling a patient safety culture is proving to be a challenge for hospitals. Based on measurements from the Agency for Healthcare Research and Quality (AHRQ), hospitals are making slow progress in creating a culture in which patient safety is paramount, Smith says.

"Hospitals are showing good results in some areas, like trusting the others in your unit to protect patients' safety. But other areas have had a

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very low positive response," Smith says. "One of the most persistent challenges is the fear of a punitive reaction to speaking up. People consistently report that they are afraid of a negative reaction and punishment if they rock the boat in an effort to improve patient safety."

Responses to a survey question regarding fear of punitive actions have held steady around the 50% mark for years, Smith says, meaning that about half of those surveyed do not report patient safety concerns for fear of getting in trouble.

"That's kind of a relic from 15 years ago when it was true that if you reported something, you might get fired," Smith says. "It's taking us a long, long time to move the needle on that. It's almost like an urban myth. People are insistent that reporting concerns will get you in trouble, even though it doesn't."

Hospital leaders set the tone

Senior leaders in the hospital must demonstrate their commitment to a patient safety culture, says **Robin Diamond**, MSN, JD, RN, CPHRM, NEA-BC, CPHQ, senior vice president for patient safety and risk management at The Doctors Company, the largest liability carrier for physicians in the country. No matter how much managers and supervisors promote patient safety, the culture will not improve if people do not believe the C-suite executives and board members are fully on board, she says.

"They set the tone for what the organization truly believes and will stand by if push comes to shove," Diamond says. "Senior leadership must set the expectations for developing a very healthy patient safety culture, the vision and values of the organization, and the regular assessment of the culture."

Throughout the organization there also should be patient safety champions who promote the right culture and spearhead the training that can change behavior, Diamond says. This person might be a nurse manager, for instance, who can address patient safety at each staff meeting with updates on safety scores, improvements in procedures or equipment, and encourage people to voice their concerns or suggestions.

Patient safety also should be part of each employee's performance evaluation, Diamond suggests. A patient safety culture involves specific behaviors that can be measured in an objective way, along with more subjective assessments of the person's commitment to patient safety, she notes.

"Many organizations are now interviewing potential new hires with questions about how well they will integrate into the culture of that workplace," Diamond says. "A strong, healthy patient safety culture will be served best by bringing on people who are comfortable with the importance of patient safety concepts like team communication and reporting errors."

That screening can be as simple as asking the person what he or she knows about the importance of a patient safety culture, Diamond says. Someone who has worked in an organization that values patient safety will be able to talk about the need for teamwork, safe handoffs, time outs, reporting errors, or asking questions. Other questions could address how the person works in a team environment and how they communicate with team members who may be their superiors. Interviewers also can ask how the person would respond

in a particular situation, such as a nurse thinking that a surgeon is about to perform the wrong procedure. Would the applicant be comfortable calling a time out in the operating room or pulling the surgeon aside to confirm the procedure?

"The response can tell you a lot about that person's experience with a culture of safety and their personal comfort level with doing what's right for the patient even in a difficult situation," Diamond says. "You might learn that this person will enhance your efforts to create a patient safety culture, or that this person will set you back."

Be transparent in all ways

Transparency is the best way to defeat the fear of punitive action, Smith suggests. Hospital leaders should strive for complete transparency in patient safety matters, publicizing all improvement efforts and praising employees who speak up about patient safety. Unless the person wishes to remain anonymous, quality leaders can publicly validate the person's concerns and thank him or her for speaking up. Even if the person voicing a concern does not want to be named, hospital leaders still can acknowledge that someone brought up an issue about a particular topic and that the administration appreciates the heads up.

This type of recognition can come in the form of laudatory announcements during staff meetings, in newsletters, on the employee website, or any other public format, Smith notes. A personal thank you note from the employee's supervisor or a senior hospital leader also will go a long way toward showing that there is no need to fear a punitive reaction, and you can count on that employee telling coworkers about it.

Smith notes that the public acknowledgment and appreciation does not have to wait until the patient safety matter is investigated and resolved. Even if the investigation reveals that there is no issue to resolve, the employee still should be praised for speaking up, she notes.

"FOLLOW-UP IS VERY IMPORTANT, BECAUSE PEOPLE STOP REPORTING WHEN IT SEEMS THE INFORMATION GOES INTO A BLACK HOLE AND NOTHING IS DONE WITH IT."

"Follow-up is very important, because people stop reporting when it seems the information goes into a black hole and nothing is done with it," Smith says. "They need to hear back that you made a change in response to their concern, or that the needed change is more than you can do now but you're aware and planning a solution. At least tell people that you heard them, you appreciate it, and you're responding in some way."

Measurement is crucial

As with any quality improvement initiative, it is important to measure your progress so that you can gauge the effectiveness of your efforts and redirect resources as necessary. With patient safety, the most commonly used tools are the "Hospital Survey on Patient Safety Culture" provided by AHRQ and the Safety Attitudes Questionnaire (SAQ) from the Center for Healthcare Quality and Safety at the University of Texas. *(The AHRQ survey is available online at http://1.usa.gov/1TW3vG6. The SAQ is available online at http://bit.ly/231lTym.)* The AHRQ survey is the one indicating that fear of punitive reaction is still a significant hurdle for instilling a patient safety culture.

Those tools should be used to measure the patient safety culture at regular intervals, and frequently, Smith says. In the past it has been common for hospitals to use those tools at three-year intervals, but Smith now recommends measuring patient safety culture every 18 months or two years.

"Particularly if you have been moving the bar, you may want to check it more frequently than every three years," Smith says. "It's important to know how your efforts are changing the culture within your organization, and three years is too long to wait if you want to confirm your effectiveness or change what may not be having enough impact."

Smith cautions that simply handing out the surveys is not enough to get a true reading on your patient safety culture. Response rates can be very low unless administration promotes the survey and how important it is to hear the feedback from employees. Shoot for a response rate of at least 65%, Smith advises, to ensure the data will be meaningful and accurately reflect the safety culture. Also be sure to administer the surveys across the board to all employees, not just front line clinical staff. Patient safety is everyone's job, so the survey should go to physicians, housekeepers, technicians, and essentially anyone who has any contact at all with patients.

"You can increase your participation rates through some mind-

ful communication. You can't just send an email and expect everyone to fill out the survey," Smith says. "Consider strategies like meetings about the survey, full-time media campaigns, and frequent reminders about why the individual's input is so important. The higher the participation rate, the better idea you're going to get of what the culture really looks like."

Involve physicians in improving culture

Patient satisfaction assessments also can help assess the hospital's patient safety culture, Diamond notes. Gathering the data is not the end of the story, however. Too often, Smith says, hospital quality leaders do not follow up on the results and share them broadly with managers. When the data is shared with managers, there often is not enough follow-through to see that the information was used to improve the patient safety culture, she says.

Quality professionals should use the patient safety survey results to develop new strategies for improvement and to tweak existing efforts that are not producing the desired effects, Smith says. The results also should demonstrate what resources and efforts are paying off well. The survey data plans for improvement should be communicated to senior hospital leadership and the board of directors, she says.

Physicians should be directly involved in efforts to improve the patient safety culture, says **Leon J. Owens**, MD, FACS, president and CEO of Surgical Affiliates Management Group in Sacramento, CA. He and his colleagues have adopted a number of patient safety practices that they promote in their hospitals, and Owens notes that the hierarchical structure of medicine means a physician who is vocal about patient safety can encourage others.

One of the practices that Owens and his fellow surgeons follow, for example, involves a specific way to handoff a patient from one physician to another. The hand off always takes place in a quiet room with a mid-level practitioner present who has been involved with the patient's care on a daily basis. The mid-level updates both doctors on the patient's status and treatment, the goal being to avoid having one physician unaware of a change in the patient and therefore not conveying it the other.

> "WE ALSO INCENTIVIZE OUR DOCTORS TO HAVE THIS CULTURE OF SAFETY BY MEETING CERTAIN METRICS ABOUT ANTIBIOTICS GIVEN AT THE RIGHT TIME, FOR INSTANCE, AND CATHETERS STOPPED AT THE RIGHT TIME."

The surgeons strive for uniformity in processes and procedures, following best practices but also uniform decisions on issues that usually are left to the individual physician, such as which antibiotics to prescribe. The surgeons also closely track complication rates. When surgeons from Owens' group begin working at a hospital, the group requires access to the hospital's patient safety data and looks for deviations that need attention. As necessary, the surgical group helps the hospital adopt better patient safety practices.

"We also incentivize our doctors to have this culture of safety by meeting certain metrics about antibiotics given at the right time, for instance, and catheters stopped at the right time," Owens says. "Of course, the biggest part of patient safety is communicating well with each other, so we put a lot of energy into communicating."

The biggest challenge for surgeons is fully committing to the team concept, Owens notes. The old school approach was for the doctor to lead and everyone else to follow without question, but a patient safety culture requires a more communal approach, he says.

"The doctor may still be the one who is ultimately in charge, but patient safety requires our physicians to work within a team," Owens says. "They are part of a culture that says, 'yes, how can I help you?'"

SOURCES

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Study Shows Safety Culture Affects Hospital Quality

Hospitals usually focus on technical issues like surgeons' skills and operating room equipment when seeking to improve surgery outcomes and overall quality. New research, however, is reinforcing the idea that a patient safety culture may be equally important in delivering high-quality patient care.

A team of investigators report their findings in a study published online in the Journal of the American College of Surgeons. The team was led by **Martin Makary**, MD, MPH, FACS, professor of surgery and health policy & management at Johns Hopkins University School of Medicine in Baltimore. *(An abstract of the study is available online at http://bit.ly/221zNB2.)*

"The non-technical skills of care coordination, teamwork and ownership over the delivery of care are measured as safety culture," Makary says. "Anybody who cares for patients knows that a hospital's culture contributes to a patient's outcome, and this study affirmed that observation."

Makary defined safety culture as "the organizational characteristics of delivering great care" and the attitude of "how we do things around here." He added, "It's a compilation of burnout, perceptions of management, the connectedness of care and staff's willingness to speak up when they have a concern."

The study results, first presented at the annual meeting of the American Medical Research Symposium in Dallas, measured 12 different safety culture factors that influenced rates of a specific complication, surgical site infection (SSI) after colon procedures, at seven Minnesota hospitals. The hospitals' average size was 168 beds. SSI rates after surgery at the hospitals ranged from 0-30%, with an average rate of 11.3%, and surgical unit safety culture scores ranged from 16-92% positive.

> "THE STUDY IS ONE OF THE FIRST TO EVALUATE THE IMPACT OF AN ORGANIZATION'S TEAMWORK AND SAFETY CULTURE ON PATIENT OUTCOMES."

The study is one of the first to evaluate the impact of an organization's teamwork and safety culture on patient outcomes. Researchers used a cross-sectional sample from the Minnesota Hospital Association to combine safety culture survey data with SSIs after colon operations during 2013. The hospitals were surveyed using the Hospital Survey on Patient Safety Culture, a staff survey the Agency for Healthcare Research and Quality released in 2004 to help hospitals assess the culture of safety in their institutions. Of the 12 safety culture factors measured, 10 were found to influence the rates of SSI after colon operations: overall perceptions of patient safety; teamwork across units; organizational learning; feedback and communication about error; management support for patient safety; teamwork within units; communication openness; supervisor/manager expectations of actions promoting safety; non-punitive response to error; and frequency of events reported.

The two safety factors not associated with infection rates were handoffs and transitions—the transfer of care of a patient from one care team to another, such as from the recovery room to the hospital floor, or from one nursing shift to the next—and staffing.

Feedback and communication after errors (the learning hospital response) had the widest variation among surveyed hospitals, ranging from 21-79% positive, while the smallest variation was in scores for teamwork across units with a range from 24-49% positive.

Makary says the study illustrated the significance of three characteristics of good safety culture: an ability and willingness to learn from past mistakes; a high degree of interest in adopting best practices; and an ability to collaborate to benchmark performance.

"The study supports what many surgeons have known for a long time, and that is that the organizational culture matters," Makary says. "While we have traditionally only studied the incremental patient benefits of different medications and surgical interventions, it turns out that organizational culture has a big impact on patient outcomes."

One notable study limitation was that the researchers only investigated one type of surgical outcome. Makary notes that there are hundreds of outcome variables that can be measured with a safety culture.

The study findings can help shape future research into evaluating the role of organizational culture more deeply, Makary concludes. "Variation in organizational culture may be an important factor in understanding the broader endemic issue of variation in medical quality," he says. ■

Quality and Safety Promoted by Disclosing Errors to All Staff

Most hospitals have embraced the idea of disclosing medical errors to the patient and family members, but Brigham and Women's Hospital in Boston, goes a step further by informing all hospital staff about these incidents.

Brigham and Women's spreads the word about medical errors and other safety issues through its Safety Matters monthly electronic newsletter, which is part of a campaign that includes other initiatives to improve patient safety. Part of the hospital's commitment to safety includes telling the stories of its mistakes, what was learned from them, and the systems improvements that were undertaken as a result, says Senior Risk Manager **Mary White,** RN, MBA, CPHRM.

Telling patient safety stories through Safety Matters helps to support a culture in which people acknowledge mistakes, openly discuss them in a blame-free environment and take steps to prevent similar errors in the future, White says.

"Our goal is transparency," White says. "Greater transparency and discussion about patient safety events allows for communication across the hospital and promotes sharing and spreading of ideas for change."

Recent issues of Safety Matters have addressed incidents in which a newborn was harmed by a tubing connection error, and one in which a patient's CT scan suggesting lung cancer was overlooked by her physician because the radiologist did not send a critical abnormal notification. Clinicians, patients, and family members are interviewed about the incident and their comments are included in the story. The accounts often stress the emotional impact of the errors. *(Find examples from one of the most recent newsletters, in this issue.)*

Idea took some time

The effort began in 2010 with the goal of sharing important lessons learned from errors in the hospital, explains **Karen Fiumara**, PharmD, director of Patient Safety at Brigham and Women's. Prior to that, the lessons were discussed only in the particular unit or part of the campus where the error occurred, she says.

> "IF SOMETHING HAPPENS, WE NEED A WAY TO QUICKLY AND CLEARLY DISSEMINATE THE LESSONS LEARNED."

"We knew that the same mistake that occurred on one floor in a particular building could happen at another building, but we didn't have a good way to share that information," she says. "If something happens, we need a way to quickly and clearly disseminate the lessons learned. That's the immediate fix while we're correcting the problem in the system and making that problem less likely to occur again. Building awareness is the first step."

The idea of openly discussing errors with all hospital staff was discussed for almost a year before Brigham and Women's leaders were confident that any risks were outweighed by the potential benefits.

"There was a lot of internal discussion before we could launch our first issue. There were different perspectives, with my patient safety team feeling very strongly that this kind of transparency supports our core values," Fiumara says. "We brought in the risk management team also and hospital leadership. Everyone had to buy in to this."

There was concern about how telling these stories publicly would affect the clinicians, patients, and family members involved. Knowing how much clinicians are affected when a mistake leads to patient harm, the Brigham and Women's team worried that telling the whole staff about their errors would be traumatic for them. Ultimately, the team decided that they could not predict the impact on the involved clinicians.

The first issue was published in January 2011 and until October 2015, the Safety Matters newsletter was available only internally at Brigham and Women's. Now it is available to the general public on the Internet.

"That speaks to our commitment to transparency, and we do hope that other hospitals can learn from our experiences," Fiumara says.

Emotional stories get attention

The stories selected for the newsletter are almost always those in which a patient was harmed by the error, rather than near misses. Fiumara explains that, while she acknowledges the learning poten-

tial from near misses, they do not have the same emotional impact as an incident that harms someone. The stories in Safety Matters are intentionally chosen and written in such a way as to emphasize how people were affected by the error.

"When you have thousands of people on staff and you're trying to get their attention, to get them to actually read this story, you're going to have better results with a story that tugs at your heartstrings," Fiumara says.

The willingness of the clinicians and patients to discuss the experience also factors in to what stories are told. Physicians and staff are encouraged to participate, but the hospital respects the wishes of patients or family members who are not comfortable talking the error or being quoted.

White and her colleagues in risk management consider the potential for liability when a story is suggested for the newsletter, but most can be used without putting the hospital at too much risk, she says. Patient names are changed and the stories do not identify Brigham and Women's physicians or staff involved in the incidents.

> "FEARS ABOUT HOW CLINICIANS WOULD RESPOND TO SEEING THEIR MISTAKES SPREAD THROUGHOUT THE ENTIRE ORGANIZATION PROVED TO BE OVERBLOWN."

"There are no formal rules about what stories can be told. In fact, our team is often the source of the stories that are ultimately written about in Safety Matters," White says. "The risk management team is involved in the collective decision about which stories will be most impactful and multiple considerations, including the perspective of clinicians, patients and family members, are factored into that decision."

Fears about how clinicians would respond to seeing their mistakes spread throughout the entire organization proved to be overblown, Fiumara says. The response from clinicians and the patients or family members involved in the incidents has been overwhelmingly positive, she says, partly because the newsletter follows the hospital's just culture philosophy, focusing on improvements and not blaming people.

"When we first launched, the staff was initially surprised that we were openly talking about our errors," Fiumara says. "Now it's seen as part of our culture here that we talk about these things and try to learn from our mistakes."

SOURCES

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Hospital Explains Errors with Duplicate Dose, Clonidine

A recent issue of the Safety Matters newsletter from Brigham and Women's Hospital in Boston, includes stories about two errors that threatened patient safety. The incidents are typical of the errors shared publicly by the hospital.

In the first incident, a nurse administered a dose of cough suppressant to patient at 7 a.m. The medicine could be taken on an as-needed basis every eight hours, so the patient's next dose could therefore be given at 3 p.m. A second nurse was assigned to care for the patient while the first was off the unit. The second nurse administered a dose of medication because the patient was coughing. The first nurse returned and gave the patient another dose at 2:30 p.m., thinking it was only the second dose. She gave the dose early because the patient was about to leave the unit for testing. The electronic health record issued a warning that the dose was being given early: "Based on the ordered frequency, this medication is possibly being administered too close to another administration. Please review previous administrations to verify appropriateness."

The nurse dismissed the warning because she was purposefully giving the "second" dose 30 minutes early. The patient was not harmed by the additional dose but the nurse later realized the error and reported it. She also offered a potential solution: the warning box in the

electronic record could include the time the last dose was given. The hospital has made that improvement to the electronic record system.

In the second incident, a baby exposed to addictive opiate drugs during the pregnancy was prescribed clonidine to reduce withdrawal symptoms. The pharmacy prepared two doses for delivery to the neonatal intensive care unit (NICU), one for immediate administration and another for later that night. The pharmacy dispensing system printed two preparation labels but only patient label, so only the one properly labeled dose was delivered to the NICU.

"IN THE SECOND INCIDENT, A BABY EXPOSED TO ADDICTIVE OPIATE DRUGS DURING THE PREGNANCY WAS PRESCRIBED CLONIDINE TO REDUCE WITHDRAWAL SYMPTOMS."

However, both doses were recorded in the electronic record as having been properly filled and delivered to the NICU. When the nurse discovered the second dose was missing at the time it was to be administered, she had to call the pharmacy and wait for the second dose to be prepared and delivered. This cause a delay in the baby receiving the medication.

The nurse's report of the incident turned out to be just one of several reports involving the same type of delay. The hospital investigated the problem and fixed the medication dispensing system to ensure the correct number of labels are printed.

For more on these incidents and other Safety Matters information, go to *http://bwhsafetymatters.org*. ■

Strategies for Recruiting Peer Review Physicians

Getting physicians to critique their colleagues has always been a challenge, but in recent years challenged physicians have increasingly used expensive litigation and claims of antitrust violations to defend themselves. That has made some physicians even more reluctant to participate in peer review, but there are solutions.

Most physicians understand that the peer review process is crucial to ensuring quality medical care, but the system fails when they think the process is not objective, says **Ricardo Martinez**, MD, chief medical officer of North Highland, a global consulting firm based in Atlanta.

When physicians see the peer review process as biased or political, they do not want to be associated with it because of the potential ramifications to their own careers, Martinez says. They may fear retaliation that would affect their referrals or, in a growing trend, litigation that accuses them of participating in an antitrust conspiracy.

"When you have a peer review process that is poorly organized, you get poor participation," Martinez says.

Must be fair, transparent

For peer review to succeed, it must be positioned within the culture of the organization so that it is seen as objective, fair, and transparent, with the goal of improving quality rather being a weapon with which to punish physicians, he says. That means peer review should not be seen as a sort of court for misbehaving physicians, but rather a resource that provides education, training and mentoring, policy formulation, and intervention.

"The process has to be systematic. It consistently occurs, as opposed to ad hoc because an issue popped up," Martinez says. "It should be part of building a high quality culture. If you have an institution where peer review is just what happens when there's problem with a physician, that raises a red flag."

Lawsuits deter participation

Opposition to peer review can get ugly. Attorney **Michael Eisner**, JD, in New Haven, CT, has represented numerous hospitals facing claims of antitrust violations from physicians in the peer review process. In many cases the physician had serious deficiencies but used antitrust litigation as a way to derail the process and tie the hospital up in court, delaying any action against the physician, he says.

In addition, the lawsuits often target individual physicians on the peer review committee. That has a chilling effect on physician participation and makes members of the committee leery of taking any decisive action against a physician, fearing retribution in the form of a trumped-up lawsuit, he says.

"A tremendous number of physicians are very gun shy about participating in peer review," Eisner says. "Doctors will call up and say, 'This physician is applying for privileges at my hospital and he's a horrible doctor, but I'm afraid to say anything because I'll get sued.' Unfortunately, the truth is that he or she might get sued."

Part of the problem lies in how hospital bylaws provide "qualified privilege" for physicians. This part of the agreement between the hospital and physician states that the physician will not sue anyone who comments about the physician's qualifications, unless there is bad faith or fraud. That qualified privilege is meant to enable the peer review process, but in fact it falls short.

"What happens is that there always is an allegation of bad faith," Eisner says. "If the doctor is upset or threatened by the peer review process, they make the claim of bad faith and that promise not to sue just goes out the window."

One way to combat that type of lawsuit, Eisner suggests, is to require physicians to accept "unqualified privilege," also known as "absolute privilege," meaning they agree not to sue someone who provides information or an opinion of their qualifications. There is no exception for bad faith or fraud. Some will argue that unqualified privilege would allow blatant defamation of a physician, but Eisner says that is unlikely because the physicians who volunteer for peer review have good intentions. And even if a physician does lie and intentionally harm another doctor, there are other legal remedies, he says. The state medical board could take action on the physician's license, for instance.

"It's not a perfect solution, but some hospitals use unqualified privilege and it makes a dent in the problem," Eisner says. "Arbitration clauses also are becoming more common. The combination of unqualified privilege and arbitration requirements could alleviate a lot of the concern from physicians that they're going to be sued for saying a doctor is unqualified."

Ongoing improvement process

Outliers and problematic events will make their way to the peer review process, of course, but peer review should be an ongoing process aside from those issues, Martinez says. He suggests planning a peer review calendar of what the committee will focus on every month and making that calendar public.

"Peer review has become more important as healthcare focuses more on teams than individuals. You have to have a process that asks less 'How are you doing?' and more 'How are we doing?'" Martinez says. "People are more likely to participate then because the process helps build teamwork and not blame individuals. The best person can't do well in a bad system."

> "IT ALSO IS IMPORTANT TO ESTABLISH CRITERIA THAT WILL TRIGGER SENDING A CASE FOR EXTERNAL PEER REVIEW."

In that spirit, Martinez says, the peer review process should embrace root cause analyses and avoid the tendency to "proximity bias," the assumption that the person closest to the patient or error is to blame for the outcome. It also is important to establish criteria that will trigger sending a case for external peer review, he notes. Lack of expertise could be one criterion, but the process should also accommodate a physician's concerns that the hospital or members of the peer review committee are trying to constrain the physician's practice. Any factors that could create bias or even the appearance of bias should result in the physician being reviewed outside of the hospital's own peer review system, he says.

Peer review also should be positioned as a continuation of the apprenticeship model in which all physicians were trained, Martinez says. They resist being put in a position of judging and telling another physician what to do, but the mentoring approach is second nature to them, he notes.

"If you get a bunch of doctors together, they immediately start talking about who taught you that procedure and who you studied this topic under," Martinez says. "The peer review program has to be seen as part of that continuous mentoring rather than a hospital program that is out to get an individual in trouble."

SOURCES

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Senior Patients: Unique Expectations, Needs

Serving senior-aged patients can require a different approach, and hospitals won't know if they're meeting the needs of this population without a strategy that involves measuring satisfaction and quality.

Engaging these patients in the best way is a current goal for **Rodney O. Tucker**, MD, MMM, FAAHPM, director of the Center for Palliative and Supportive Care at the University of Alabama at Birmingham (UAB), and also chief experience officer with UAB Medicine. UAB uses the CAHPS Hospital Survey and other standard measurement tools, but in addition to measuring satisfaction, UAB is focusing on engaging patients more — and differently.

Senior-aged patients are not the same as millennials, baby boomers, or Generation X, and trying to engage them in the same way won't be successful, he says. A 75-year-old patient, for instance, is most likely to be a consumer of illness care, while a patient in his or her 20s is probably a consumer of wellness care. UAB is analyzing its patient survey data to determine what patients 65 and older value in the healthcare experience, and how that differs from other groups. With that knowledge, UAB can better target efforts to engage those patients.

"Every improvement project we undertake now includes a look at the older population and how they engage in the healthcare system," Tucker says. "We're paying very close attention to the idea that their experience may be very different from someone younger. They might not need as much transitions of care, being moved from one place to another. They might need more deliberate family engagement to discuss discharge plans."

Younger patients, on the other hand, may be more concerned with easy access to healthcare when they need it, and they certainly are savvier with technology. They will be more loyal to the healthcare provider when they can satisfy many of their healthcare needs online, and when they feel the cost of services is reasonable, since they likely are paying more out of pocket for copays, Tucker says.

"The traditional model of coming in for a physician visit so the doctor can sit down and go over lab results and discuss their health isn't going to go over well with those younger patients," he explains. "They're used to making dinner reservations on OpenTable and ordering everything off of Amazon.com. Coming in to the office for a five-minute conversation seems ridiculous to them."

Older patients may be comfortable with using technology and the Internet, but they are more likely to prefer the more traditional interactions of office visits and face-to-face conversations with the doctor, he says.

Those differences also can apply to how the hospital engages with physicians, Tucker says. A younger physician caring for a younger patient might work well because they have similar preferences and expectations, he notes, but that physician might not meet the expectations of an older patient who needs more time, more direct conversation, and more information than the younger patient. Conversely, a young patient may be frustrated if an older physician does not use email and other technology.

UAB is currently studying its provider mix and how their different age ranges affect their expectations and satisfaction. Tucker says he expects the data to lead to strategies in the near future.

The primary concern for older patients is for someone to help them understand the healthcare system, says **Romilla Batra**, MD, chief medical executive, SCAN Health Plan, which manages care for people 65 and over in a Medicare Advantage plan. They also are focused on having their care provided by someone credible, and they want to live in their own community for as long as possible, she says.

"Based on that information, we have started providing what we call care navigators. These are people who can guide them through the healthcare system and help them understand what their providers are doing and what they want the patient to do," Batra says.

SCAN also pairs up senior patients who have been through the system with those who don't have much experience, to serve as a guide and companion. In addition, the health plan provides a care transition coach for those recently discharged from the hospital. This person helps the patient understand the process after discharge and assists with practical considerations such as getting to the pharmacy or doctor's office, Batra explains.

"Even in this age group there are different personas, with some being very involved with email and computers, and some who completely avoid that," Batra says. "We try to meet them where they are. It's important to know the common or more likely characteristics of people in an older age group but at the same time you have to remember that individuals may not fit that profile."

SOURCES

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Quality Reporting Costs $15 Billion Annually

U.S. physician practices in four common specialties spend, on average, 785 hours per physician per year and $15.4 billion annually dealing with the reporting of quality measures, according to a new study.

While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report, the researchers say. They note that the number of quality measures directed at U.S. healthcare providers by external entities such as Medicare, Medicaid, and private health insurance plans — such as rates of mammography screening for women or of testing for cholesterol or hemoglobin A1c levels for diabetes — has increased rapidly during the past decade. There are now at least 159 measures of outpatient physician care. *(An abstract of the study is available online at http://bit.ly/1QFw2yk.)*

The authors of the study say these measures impose a considerable burden on physician practices in terms of understanding the measures, providing performance data, and understanding performance reports from payers, but the extent of that burden has not been quantified. According to the study data, on average, physicians and staff spent a total of 15.1 hours per physician per week dealing with quality measures, with the average physician spending 2.6 hours per week and other staff spending 12.5 hours.

The most time — 12.5 hours of physician and staff time per physician per week — was spent on entering information into the medical record only for the purpose of reporting quality measures. The researchers determined that the time spent by physicians and staff translates to an average cost to a practice of $40,069 per physician per year.

"There is much to gain from quality measurement, but the current system is far from being efficient and contributes to negative physician attitudes toward quality measures," the authors wrote. "Improving the system rapidly will be difficult. Obstacles include the fragmented U.S. health care system, lack of interoperability across EHRs [electronic health records], lack of EHR functionalities to facilitate retrieval of data for quality measures, the cost of change to external entities and to providers, and opposition from vested interests."

The study notes several efforts to reduce the number of measures and to standardize their use across external entities, programs from the National Quality Forum, the Institute of Medicine, and America's Health Insurance Plans, the Centers for Medicare & Medicaid Services, and the Agency for Healthcare Research and Quality.

"Our data suggest that U.S. healthcare leaders should make these efforts a priority," the researchers wrote. "While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report."

Those conclusions were supported by **Halee Fischer-Wright**, MD, president and CEO of the Medical Group Management Association (MGMA).

"On top of the obscene waste of billions of dollars each year on quality measures, the most alarming thing about this study of MGMA member practices is that nearly three-fourths of the groups reported being measured on quality measures that are not clinically relevant," she said in a statement issued after the study was released. "The vast majority also stated current measures are useless for improving patient care. This study proves that the current top-down approach has failed. It serves no purpose to have over three thousand competing measures of quality across government and private initiatives."

Although standardization is critical, it's an exercise in futility if measures don't improve patient care, she said.

"As the largest contributor to the problem, the federal government needs to get out of the business of dictating patient care through wasteful mandates and create simplified systems to support medical practices in improving quality across the country," she said. ■

COMING IN FUTURE MONTHS

- Screen time vs. patient satisfaction
- Meeting TJC's communication goal
- Tips for standardizing processes
- When to choose external peer review

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CE QUESTIONS

1. What does Smith say is a continuing challenge to establishing patient safety culture in hospitals?

A. Fear of punishment for speaking up
B. Union opposition
C. Lack of concern by physicians
D. Fear of potential litigation

2. When surveying staff regarding the organization's patient safety culture, what goal does Smith recommend for a response rate that produces meaningful results?

A. 20%
B. 35%
C. 50%
D. 65%

3. Why does the Safety Matters newsletter from Brigham and Women's Hospital usually relate stories of actual medical errors instead of near misses?

A. Actual medical errors tend to be more emotional, which gets the readers' attention.
B. Near misses are of little importance to patient safety.
C. Near misses cannot be studied as thoroughly as actual errors.
D. Revealing near misses opens the hospital up to potential litigation that could be avoided.

4. What does Eisner suggest would help alleviate physician fears of being sued for their participation in peer review?

A. Qualified privilege
B. Unqualified privilege
C. Indemnification
D. Anonymous reviews

ONLINE SURVEY

https://www.surveymonkey.com/r/HPR_READER_SURVEY_2016

CE 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, healthcare workers, hospitals, or the healthcare 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.

Hospital Peer Review

2016 Reader Survey

In an effort to learn more about the professionals who read *Hospital Peer Review(HPR)*, we are conducting this reader survey. The results will be used to enhance the content and format of *HPR*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Either fax the completed questionnaire to 678-974-5419, or return it in the enclosed postage-paid envelope, or complete it online at: https://www.surveymonkey.com/r/HPR_READER_SURVEY_2016. The deadline is **July 1, 2016.**

In future issues of *HPR*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Joint Commission standards	O A	O B	O C
2. preparing for surveys	O A	O B	O C
3. discharge planning	O A	O B	O C
4. outcomes management	O A	O B	O C
5. changes in reimbursement	O A	O B	O C
6. credentialing	O A	O B	O C
7. risk management	O A	O B	O C
8. continuum of care issues	O A	O B	O C
9. Conditions of Participation	O A	O B	O C
10. National Patient Safety Goals	O A	O B	O C

Please rate your level of satisfaction with the following items.
A. excellent B. good C. fair D. poor

11. quality of newsletter	O A	O B	O C	O D
12. article selections	O A	O B	O C	O D
13. timeliness	O A	O B	O C	O D
14. length of newsletter	O A	O B	O C	O D
15. overall value	O A	O B	O C	O D
16. customer service	O A	O B	O C	O D

17. On average, how many people read your copy of *HPR*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

18. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

19. How would you describe your satisfaction with your subscription to *HPR*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

20. What is your title?

O A. quality manager/director
O B. accreditation coordinator
O C. discharge planner
O D. utilization manager
O E. other _____

21. How large is your hospital?

O A. fewer than 100 beds
O B. 100-200 beds
O C. 201-300 beds
O D. 301-500 beds
O E. more than 500 beds

22. Do you plan to renew your subscription to *HPR*?

O A. yes
O B. no If no, why not? _____

_____

Please indicate yes or no for all of the areas for which you are responsible for case management in your facility or system.

23. quality	○ A. yes	○ B. no
24. discharge planning	○ A. yes	○ B. no
25. utilization management	○ A. yes	○ B. no
26. risk management	○ A. yes	○ B. no
27. accreditation	○ A. yes	○ B. no
28. other (please specify)	_____	

29. What is the highest degree that you hold?

- ○ A. ADN (2-year)
- ○ B. diploma (3-year)
- ○ C. bachelor's degree
- ○ D. master's degree
- ○ E. other_____

30. To what other publications or information sources related to your position do you subscribe?

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31. Including *HPR*, which publication or information source do you find most useful, and why?

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32. Which website related to your position do you use most often?

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33. Please list the top three challenges you face in your job today.

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34. What do you like most about *HPR*?

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35. What do you like least about *HPR*?

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36. What are the top three things you would add to *HPR* to make it more valuable for your money?

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