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INSIDE

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Physician Assistants Help Drive Quality Improvement

More hospitals are finding that the strategic use of physician assistants (PAs) can improve quality and patient satisfaction without adding a financial burden. These physician extenders can reduce readmissions and improve ED efficiency, recent advocates say.

Hospital leaders and physicians are coming to understand the role of PAs better, says **Dawn Morton-Rias**, EdD, PA-C, president and CEO of the National Commission on Certification of Physician Assistants (NCCPA) in Johns Creek, GA. Rather than being another nurse or technician, the PA is educated and provides care much like a physician, she explains.

"PAs are educated in the medical model, which means their education, course work, their academic preparation resembles medication education very, very closely," Morton-Rias says. "They work in collaboration with physicians during their training and sit for a very rigorous certification exam before acquiring their license. They are oriented to healthcare in a very similar way to physicians, and that is important to understand when you are considering the value of PAs and what they can do for your organization."

> "THEY WORK IN COLLABORATION WITH PHYSICIANS DURING THEIR TRAINING AND SIT FOR A VERY RIGOROUS CERTIFICATION EXAM BEFORE ACQUIRING THEIR LICENSE."

In addition to being able to conduct many of the common tasks that physicians do, such as taking histories, conducting physical exams, and ordering laboratory studies, PAs also can provide continuity of care, she says. Transitions and continuity of care are increasingly important topics in healthcare lately, and Morton-Rias says PAs are ideally

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suited to managing transitions from hospital to home, for instance. That can significantly reduce admissions.

"Because hospital PAs are similar to physicians in terms of their education, they are not only well prepared with their clinical skills but they also have strong interpersonal skills," she says. "They are adept at providing patient and family education, which are crucial in managing those transitions. Readmissions often occur because there has been some breakdown in the transition from the hospital experience to the home experience."

PAs Catching on in Healthcare

PAs are among the most sought healthcare professionals now, and the demand is growing as hospitals and physician practices realize their value, Morton-Rias says. There are more than 108,000 certified PAs in the country now, and the number is growing. *(See the story later in this issue for more information on the prevalence of PAs.)* They are becoming more popular as healthcare leaders realize that PAs can help optimize both sides of the current healthcare focus on both quality and cost effectiveness. State licensing requirements vary from state to state, sometimes limiting the scope of a PA's work in the hospital.

Research is proving their value. A recent study found that home visits by PAs after hospital discharge significantly reduces the chance that a heart surgery patient will be readmitted. (*See the story later in this issue for more on that study.)*

Physicians who were trained in the past several years typically worked with PAs during their education, Morton-Rias notes, and that makes them much more knowledgeable about PAs' abilities and how to effectively work with them. She suggests that quality leaders who are interested in incorporating more PAs approach these physicians — particularly the younger ones — to get them on board and help advocate for the strategy.

"Physicians have been the greatest supporters of PAs in the last several years because they understand what they can offer," she says. "They understand that this is not a role that takes anything away from the physician, but, in fact, allows the physician to focus more on the patient and improve quality of care."

Patients Like Their PAs

Patients are receptive to PAs and usually respond well to their integration into a hospital or physician practice, Morton-Rias says. The only time the integration of PAs is not smooth is when the physicians were not consulted and educated about the move beforehand, she says. That lack of communication leads to confusion and mistrust about the role of PAs, she says.

PAs also can contribute in management positions. **Ed Lopez**, PA-C, is a PA and founder of a 110-member hospitalist group that covers five hospitals with a mix of 70% physicians and 30% PAs and nurse practitioners (NPs). He is facility medical director at St. Elizabeth Hospital/CHI Franciscan, which includes a 25-bed critical access hospital and an 80-bed nursing home in Seattle. With pay-for-performance bringing more pressure for quality, Lopez and his colleagues have focused on issues such as reducing readmissions, with PAs a key part of the strategy.

When CMS started putting pressure on hospital readmissions and threatened to reduce reimburse-

ment, Lopez realized that the hospital was on shaky ground with a 30-day readmission rate of 35%. In response, he implemented a program that made use of PAs to reduce the rate significantly. (*See the stories later in this issues for more on that effort, and for another case study.)*

High Expectations for PAs

To use PAs effectively, they and the physicians must understand how to work together, he says.

"We hire people who understand this is an integrated program, with physicians and PAs working closely and cooperatively," Lopez says. "There is virtually no difference in the level of performance, expectations, responsibility between the PA and the physician. A physician or a PA is expected to perform at the highest level possible of their licensure."

That means PAs admit patients and follow them through care at the hospital, discharge the patient, have difficult conversations about death and dying, and rounding patients in the nursing home. Most of the PAs have been trained in hospice care and palliative care as well as internal medicine, Lopez says.

"Some executives in the hospital system have called us the Special Ops of hospital medicine, we have to do so much with so little," Lopez says. "As a 25-bed critical access hospital we don't have the luxury of a large group of consultants to call on as needed, so we rely on our PAs and physicians to have a wide range of talents and abilities, and we work in a collaborative way. We have PAs with 20 years' experience who have a Greater knowledge base than physicians who have four years in medicine, and they can both learn from each other." ■

Case Study 1: PAs Central to Reducing Hospital Readmissions

With CMS warning that high readmission rates could lead to low reimbursement, **Ed Lopez**, PA-C, facility director at St. Elizabeth Hospital/CHI Franciscan in Seattle, took a look at the hospital's numbers and didn't like what he saw: 35% of patients discharged to the system's nursing home were readmitted within 30 days.

"It scared me to see that number," Lopez says. "That was completely unacceptable. Before long, the nursing home came to us and said they were tired of doing business the way they've always done it and they wanted to partner with us to assume some responsibility for the patients."

Lopez worked with the nursing home administrators to develop a plan in which hospitalists from St. Elizabeth, often PAs, would round at the nursing home on a daily basis, managing patients that had been transferred from the hospital. The PAs were available around the clock, seven days a week. Additionally, if the nursing home thought a patient needed to be readmitted to the hospital, a PA would visit the nursing home to evaluate the patient and look for other potential solutions.

The effort also required a culture change, reminding clinicians that they should care about what happens to patients after discharge and helping them get over the natural tendency to avoid nursing homes because they're not thought of as pleasant places to visit.

"A readmission is not without work. The sell for me was to show that it would be easier to just go over and see the patient when we hear that there is a potential problem and avert an admission that would take us an hour and half," Lopez says. "In 20 minutes at the nursing home we've avoided that hour and half of readmission work, not to mention the costs and the fact that people don't want to be readmitted to the hospital."

Patients respond very well to the idea that their treating physician or PA will see them in the hospital, with many amazed because they feel neglected and forgotten in the nursing home, Lopez says. Nurse recruitment also improves when nurses see that they will have the necessary support from physicians and PAs, he says.

"Within six months we saw the readmission rate drop to 15% and the readmission rate across all our facilities is now 4%," Lopez says. "The message that has sent to our facilities and the CHI mother ship is that when the hospitalist group connects with a large cohort of potential readmissions and controls them, it makes a tremendous difference."

The hospital built on that success by adding more discharge professionals to work with patients discharged into the community rather than the nursing home. ■

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Case Study 2: LWBS Rates Drop

Bay Area Hospital in Coos Bay, OR, had an ED struggling to keep up with demand for years. The ED had so many patients that its left without being seen (LWBS) statistics were about 8%, well over the industry average of 2%. The ED overcame this problem with the strategic use of physician assistants (PAs) and nurse practitioners (NPs).

The physician had all physician staffing when it contracted with CEP America, a national physician staffing company in Emeryville, CA, to manage the Bay Area Hospital ED. The staffing company suspected that a mix of physicians and PAs or NPs would make the ED more efficient, says **Nancy Carlson**, RN, BSN, MBA, senior practice management consultant with CEP America. The company employs more than a thousand PAs and NPs nationwide.

"They had a good number of low-acuity patients in the ED, about 40%, but every one of them was seen by a physician, and we know physicians should spend most of their time with very sick patients," Carlson says. "We had seen from other hospital experiences that PAs are entirely capable of handling these less serious cases, as well as more complex issues."


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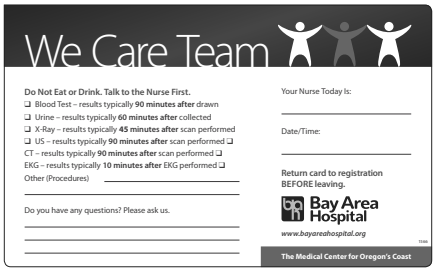
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❑ Urine – results typically **60 minutes after** collected
❑ X-Ray – results typically **45 minutes after** scan performed
❑ US – results typically **90 minutes after** scan performed ❑ CT – results typically **90 minutes after** scan performed ❑ EKG – results typically **10 minutes after** EKG performed ❑ Other (Procedures) _____

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Up to that point the hospital had been following a basic triage procedure that ensured the sickest patients were treated first and those with minor issues had to wait — sometimes long enough that they gave up and left the ED. Even very sick patients often waited an hour to see a physician, and other patients waited much longer.

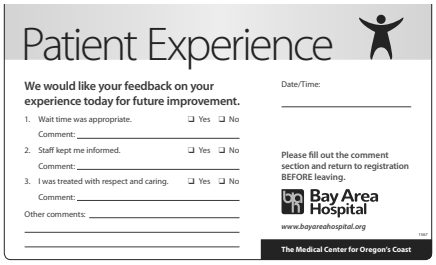
The hospital instituted several changes, including the designation of two exam rooms as "hot rooms," each staffed with a PA, nurse, and technician. When the triage nurse determines that a patient is low acuity (at level 4 or 5 on the Emergency Services Index [ESI]), that patient was is sent directly to a hot room to be seen by the staff there. The time to provider dropped sharply, Carlson says, as did turnaround time to discharge — the time from arrival at the ED to departure after waiting for test results.

"Those low-acuity patients were being seen by the PAs very quickly and their time to provider was 13 minutes rather than an hour or more," she says. "The time to discharge also dropped about 30 minutes."

Patient satisfaction rises

Moving all patients through the ED quickly is not the goal, Carlson notes. The focus is on identifying those who can be moved through quickly and getting them treated without delay, which can leave clinicians more time to spend with the higher-acuity patients.

The LWBS ratio also has gone down significantly, to less than 1%, and patient satisfaction has improved by double digits, Carlson says. The hospital helps educate patients about PAs and NPs by handing out "We Care Team" cards during registration, and then asks for their feedback with


Patient Experience

We would like your feedback on your experience today for future improvement.

Date/Time: _____

1. Wait time was appropriate. ❑ Yes ❑ No
   Comment: _____
2. Staff kept me informed. ❑ Yes ❑ No
   Comment: _____
3. I was treated with respect and caring. ❑ Yes ❑ No
   Comment: _____

Other comments: _____

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"Patient Experience" cards afterward. *(See the cards on this page.)*

The hospital also implemented a rapid medical evaluation (RME) process, which emphasizes having ED patients seen quickly and tests started even if no bed is available. The process also uses a quick registration process and triage.

Such strategic use of PAs requires commitment from the hospital administration, medical staff, and nursing staff, says **David Birdsall**, MD, a practicing emergency physician and vice president for operations and PA/NP practice with CEP.

"We're seeing more use of PAs but there are still hospitals that are holdouts because one or more of these groups is suspicious of the concept, and that's the case only when they really haven't been educated about who PAs are and what they can do," Birdsall says. "There is a reasonable concern for patient safety and quality, but those worries can be addressed by educating people." ■

SOURCES

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PA Home Visits Sharply Reduce Hospital Readmissions After Heart Surgery

A recent study concluded that just two home visits by a physician assistant (PA) during the week after hospital discharge significantly reduces the chance a heart surgery patient will be readmitted. The reduced readmissions also reduce overall costs associated with the heart surgery — a $39 savings for each dollar spent on PAs.

In a presentation recently at the 52nd Annual Meeting of The Society of Thoracic Surgeons, **John P. Nabagiez**, MD, from Staten Island University Hospital in New York City, noted that adult cardiac surgery has one of the highest readmission rates for all hospitalized patients.

Nabagiez and colleagues analyzed hospital readmission rates of 1,185 patients who underwent cardiac surgery from September 2008 through August 2012 at Staten Island University Hospital.

Patients who received visits from PAs on days 2 and 5 following hospital discharge had a significantly lower rate of readmission (10%) compared with those who did not receive home visits (17%), Nabagiez reported. This represents a 41% reduction in the rate of readmission within the first 30 days following cardiac surgery.

"The physician assistants who made the house calls in our study were fully trained cardiac surgery PAs who were actively involved in the preoperative, intraoperative, and postoperative care of our patients," Nabagiez said in his presentation, which was provided to *Hospital Peer Review* by the society.

"Unlike standard visiting nurses, our PAs knew each patient personally and understood all of the pertinent issues of the patient's medical history. They also knew the patient's individual postoperative course prior to discharge, so they entered the patient's home already knowing the concerns, if any, of the surgeon and the patient."

Healthcare expenditures fell in conjunction with the reduced readmissions, even when the additional cost of PA visits was included. It cost $23,500 to make house calls to 363 patients, which saved $977,500 in readmission costs, Nabagiez said, which translated to $39 in healthcare savings for every dollar spent.

Nabagiez attributed the lowered readmissions partly to the PAs helping patients comply with all prescribed medications and physical rehabilitation after heart surgery.

"Complications can arise in the first week after surgery, and these initial home visits can help diagnose problems earlier, which can keep patients out of the emergency department," Nabagiez said. "We found that making these two visits is cost effective and keeps patients on the road to recovery, while also reducing hospital readmissions." ■

PAs Rapidly Growing in Number and Influence

Physician assistants (PAs) are rapidly increasing their presence in healthcare, according to a recent report from the National Commission on Certification of Physician Assistants (NCCPA) in Johns Creek, GA.

The 2015 Statistical Profile of Certified Physician Assistants indicates rapid growth in the profession, which currently has almost 109,000 certified PAs practicing across every state, specialty, and clinical setting. The following are some findings in the report:

- More than 70% of certified PAs work in specialties outside of primary care, including 18% percent in surgical subspecialties and 13% in emergency medicine.
- The states with the largest number of PAs per capita are Alaska, South Dakota, Pennsylvania, Maine, and New York, suggesting they are in high demand in both populous and rural areas.
- The median age of certified PAs is 38.
- More than 22% of PAs communicate with patients in a second language. Of those PAs, 81% are speaking to patients in Spanish.
- Full-time PAs treat an average of 75 patients a week in their principal clinical position. All PAs cumulatively care for more than 7 million patients weekly.
- More than 13% of certified PAs work in a second clinical position, averaging 10 hours a week and treating 22 patients in that position.

The report is available online at http://bit.ly/292XOnI. ■

TJC Denies Accreditation for Deficiencies

TJC denied accreditation to Virginia Mason Medical Center in Seattle after a surprise review in May revealed noncompliance with 29 standards. A subsequent survey resulted in contingent accreditation.

After the unannounced visit May 20, surveyors concluded that a condition existed "that posed a threat to patients or other individuals served," and TJC issued a preliminary denial of accreditation. The 29 TJC standards Virginia Mason failed to meet are available online at http://bit.ly/298mflJ. Many of the standards involve the most basic obligations of the hospital, such as educating the patient about his or her follow-up care at discharge; labeling all medications, medication containers, and other solutions; resuscitation services are available throughout the hospital; and the hospital conducts fire drills. A spokesman for the hospital told *The Seattle Times* that most of the failures involved detailed aspects of the standard. The hospital conducts regular fire drills, for instance, but TJC wanted to see more variation in scheduling the drills, he said.

Following another visit on June 1, TJC issued a contingent accreditation to Virginia Mason. The accrediting agency will conduct another unannounced follow-up survey at Virginia Mason soon to make sure the hospital has corrected the deficiencies identified in the original survey. The hospital released a statement saying hospital officials are "confident we will address [the issues] to TJC's satisfaction in the coming weeks."

The accreditation problem comes on the heels of a possible hepatitis B exposure at the hospital. Virginia Mason announced in June that a lapse in hepatitis B screening procedures may have put dialysis patients at risk for the blood infection. The hospital is contacting about 650 patients treated in the hospital's dialysis unit over the past six years, recommending they be tested for hepatitis B infections. ■

Copy-and-Paste Should Be Used Carefully

Anyone who uses a computer or other device routinely takes advantage of the copy-and-paste feature to save time and effort, but how appropriate is that when you're working in an electronic medical record (EMR)? It can be done safely, but only if you are aware of the potential risks and use the feature wisely, experts say.

The use of copy-and-paste in EMRs was the focus of a recent work group at ECRI Institute in Plymouth Meeting, PA. Experts from healthcare organizations studied how copy-and-paste is used and the potential effects on quality, patient safety, and legal risks. The group determined that there are significant risks, says **Lorraine Possanza**, DPM, JD, MBE, senior patient safety, risk, and quality analyst for ECRI.

"One of the biggest problems is when you are copying incorrect, outdated, or inappropriate information into a chart," Possanza says. "Even if you're going back into the patient's record and pulling information that was valid at that time, you have to ask if the information is still accurate and relevant. It's one thing to copy the past surgical history — a fairly static list — but quite another to copy an assessment from when the patient presented with a similar condition two years ago."

Copying an assessment or similar material creates a cognitive bias in all clinicians using that record afterward, presenting the information as current when in fact it may be from years ago, Possanza explains.

Both Risks and Benefits

The ECRI task force identified several risks and benefits of copy-and-paste. The risks included producing notes with internal inconsistencies; creating more queries or work to determine if information is correct; erosion of confidence in the documentation either for provider or the health record in general due to outdated, inaccurate, or misleading information; interfering with effective communication among providers because important findings and problems are intertwined with normal patient information; producing overwhelmingly long charts and notes; and the perceived need to "fill" the note for billing and regulatory requirements. *(The ECRI report is available online at http://bit.ly/28YYlnU.)* The ECRI work group developed four recommendations for the safe use of copy-and-paste. *(See the recommendations in the story later in this issue.)*

But as serious as those problems are, copy-and-paste should not be eliminated because it offers valuable benefits as well. ECRI points to these positive results from the prudent use of copy-and-paste, saving time by allowing for information that does not readily change to be easily transferred,

efficiently capturing complex information, improving tracking of multiple problems for complex patients by providing an easy way to continually document care, improving continuity of care by allowing a simple way to transfer important information to other providers, reducing transcription errors, and reducing the risk of neglecting important issues.

Possanza points out that copy-and-paste is different from cut-and-paste. Copying text can be efficient and safe when done properly, but cutting text in a medical record is never acceptable because it amounts to altering the record, she explains. That is not only bad medicine but also exposes the hospital and clinician to legal liability, she says.

"That is an important distinction the work group made," Possanza says. "There is a big difference and the work group was clear in saying that cut-and-paste has no place in working with a medical record."

Special Recommendations

The work group studying the risks and benefits of copy-and-paste for the ECRI Institute in Plymouth Meeting, PA, developed these four recommendations:

- **Recommendation A: Provide a mechanism to make copy-and-paste material easily identifiable.** The group noted that copy-and-paste can help ensure completeness of encounter documentation and generally produces fewer transcription errors, but copied material should readily identifiable so that it can be confirmed and validated.
- **Recommendation B: Ensure that the provenance of copy-and-paste material is readily available.** Knowing where the copied information came from is important in ensuring the accuracy and appropriateness of information that will be used to make clinical decisions. The provenance can help alert clinicians to information that is inaccurate, out of date, or from an inappropriate source, such as information mistakenly copied and pasted from the wrong patient record.
- **Recommendation C: Ensure adequate staff training and education regarding the appropriate and safe use of copy-and-paste**. Hospitals should outline proper procedures for copying and pasting information to standardize the process. This also will facilitate regulatory compliance and ensure that the record will be useful in the litigation setting.
- **Recommendation D: Ensure that copy-and-paste practices are regularly monitored, measured, and assessed.** An audit policy will allow hospitals to monitor how copy-and-paste is used so that potential problems can be identified. ■

Most Lack Policy

Another significant risk from copy-and-paste is that the medical record can be cluttered with repetitive or unneeded information, Possanza says. Lab results, for instance, may be lengthy and detailed when just a few values are important for the patient's care. If the clinician copies and pastes the entire lab report instead of entering just the pertinent data, the next person using the record will have to wade through the entire lab results. That increases the chances that vital information will be overlooked, she says.

"It makes the note exceptionally long, and you cause the reader to lose the train of thought, and maybe forget what you opened the record to look for in the first place," Possanza says. "It makes decision-making more difficult and clogs the communication between providers."

Possanza notes that a recent survey by the HHS OIG found that only 23% of hospitals had a policy on cut-and-paste, so the issue has still mostly overlooked.

"Individuals who have grown up in an electronic environment expect to use copy-and-paste and they don't understand why it can be such a problem," she says. "Copy-and-paste also leads to a bloated medical record because you very easily take a big chunk of text and duplicate it elsewhere, whereas the doctor probably wouldn't have taken the time to write that much if it had to be entered manually. The longer and more complex the chart is, the more likely that something will be overlooked."

Educating people about the risks and safe ways to copy-and-paste is the first step in addressing the issue, Possanza says.

"There are inherent risks and we have seen incidents where copy-and-paste led to patient harm," she says. "In one case, the record incorrectly indicated that the person had received anticoagulant prophylaxis and that got carried forward for several days. The person ended up getting deep vein thrombosis, and that probably would not have happened if the error wasn't copied and pasted into the record over and over." ■

SOURCE

- Lorraine Possanza, DPM, JD, MBE, Senior Patient Safety, Risk and Quality Analyst, ECRI, Plymouth Meeting, PA. Email: hit@ecri.org.

Assess Anesthesia Patient Satisfaction Correctly

Measuring patient satisfaction is important in all aspects of healthcare, but anesthesia can pose a particular challenge. There is a lack of standardized tools and anesthesia does not fall easily into the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) categories.

That means hospitals usually do not provide HCAHPS to anesthesiologists the way they do with other physicians, notes **Emily Richardson**, MD, an anesthesiologist and chief quality officer with Encompass Medical Partners in Fort Collins, CO. Hospital quality leaders may have to find other ways to assess quality in this specialty, she says.

"With the financial implications with reimbursement and quality, hospitals are seeing anesthesiologists coming to them and asking for quality data, but the hospitals are saying they don't have anything for them," Richardson says. "Hospitals will start to see even more interest as physicians realize the impact on their Medicare reimbursement."

Hospitals will need to start assessing patient satisfaction in anesthesia on an individual level because it will be tied to the hospital's reimbursement. Under the Physician Quality Reporting System (PQRS), patient satisfaction counts as an outcome measure when reporting to the registry, Richardson notes. The move toward more shared accountability and concepts like perioperative surgical homes will make anesthesia satisfaction more important, she says.

Also, postoperative pain control is highly correlated with overall patient satisfaction, she notes. That is more incentive for hospitals to work with anesthesiologists to measure satisfaction, she says.

"Post-op nausea and vomiting are very strong dissatisfiers for patients, so those are very important," Richardson says. "There also are benefits like patients adhering better to post-op instructions when they are satisfied, which in turn leads to better outcomes."

Measurement Tools are Scarce

The Anesthesia Quality Institute (AQI) in Schaumburg, IL, noted in a recent white paper that, despite the implementation of CAHPS and HCAHPS, "there is a persistent gap in the ability to adequately measure patient experience, as identified by the Measure Applications Partnership (MAP)," which provides input to HHS on the selection of performance measures for performance-based payment programs. There is a "significant lack of validated satisfaction tools" for anesthesiologists, the report states. *(The report is available online at http://bit.ly/292VONY.)*

> "POST-OP NAUSEA AND VOMITING ARE VERY STRONG DISSATISFIERS FOR PATIENTS, SO THOSE ARE VERY IMPORTANT."

"Many practices are currently using proprietary vendor products or are being assessed by surveys implemented by the institutions to which they provide anesthesia services," the AQI report says. "For example, the majority of free-standing surgical facilities assess patient satisfaction, and many of these assessment instruments include questions that pertain to the patient's perception of anesthetic care. At this time, no standard for anesthesia-related questions exist, and this makes comparison of satisfaction results across facilities or practices very difficult."

Hospitals can develop their own patient satisfaction measurement tools, but the usefulness of the data will be limited because the lack of standardization means it is difficult to compare anesthesia patient satisfaction from one facility to another, Richardson says. *(See the story later in this issue for suggested questions.)*

Anesthesia satisfaction can be improved through better education of patients, Richardson says. They often do not understand anesthesia well, and their anxiety is a major influence on their post-op satisfaction, she says. Patients also often are confused about the role of their anesthesia providers, a common problem when using a care team model with a physician and nurse anesthetist, Richardson notes.

"There is an opportunity at the preoperative clinic, with handouts and other information, but at the point of care the provider needs to explain and answer questions," Richardson says. "Communication skills are important, and anesthesia providers need to be compassionate in their education."

Privacy is a Major Concern for Patients

Setting appropriate expectations also is important and can improve patient satisfaction scores, and pri-

vacy is a particular concern. Privacy and respect for patients are important throughout the hospitals, but Richardson notes how patients are especially concerned with regard to anesthesia. Patients may already be anxious about being anesthetized, and worries about how the clinical team will treat them when they are vulnerable can make that worse. Those fears are increased after recent high-profile cases in which patients secretly recorded their anesthesia providers and other surgical team members insulting them and otherwise being disrespectful during the procedure.

The timing of surveys is important. The longer you wait to ask about patient satisfaction with anesthesia, the more likely the patient is to correlate it with the outcome of the procedure, skewing the results, Richardson says. Two weeks is often cited as the optimal time to survey anesthesia patients, she says.

The anesthesia group that Richardson previously was part of contracted with a third-party vendor to measure patient satisfaction, and she says a hospital could do the same for its anesthesia providers. That comes with considerable expense, of course, so a hospital would not be able to use a third-party vendor to study the patient satisfaction of every specialty. But it could be worthwhile for a specialty like anesthesia that is particularly difficult to measure with more common and less costly methods, she says.

Assessing patient satisfaction by specialty also runs the risk of patients suffering survey fatigue. When Richardson's anesthesia group sought to contact patients, some of the ambulatory surgery centers the group worked with balked at providing access to the patients because they conducted their own surveys and did not want patients to feel overwhelmed and stop responding.

> "WE NEED THAT INFORMATION IF WE ARE GOING TO IMPROVE, SO IF IT IS NOT BEING GATHERED BY THE USUAL METHODS WE MIGHT HAVE TO GO OUT ON OUR OWN TO GATHER IT."

"I'm sympathetic to that, but I would want that facility to understand that anesthesia providers are at a real disadvantage when it comes to feedback, so it's not like we are repeating what you've already asked them," Richardson says. "We need that information if we are going to improve, so if it is not being gathered by the usual methods we might have to go out on our own to gather it."

Patient satisfaction tends to be high with anesthesia, Richardson notes, but that can make it difficult to show improvement. Providers sometimes are frustrated when they employ quality initiatives but see little movement on their quality scores, she says.

When working with anesthesia providers to measure patient satisfaction, Richardson suggests keeping the tone positive and supportive. Many anesthesia providers do not like participating in patient satisfaction measurement because they see it as an audit to find their mistakes and weaknesses, she says. A hospital seeking to address patient satisfaction in anesthesia should strive to present the effort in a positive way, making it an opportunity for the anesthesiologists to confirm their quality rather than a witch hunt.

"Approach it from a global perspective, stressing that we're all in this together and we're not trying to single out bad providers," Richardson says. "The anesthesia group will be interested in what works and how they can improve their satisfaction scores, but they will want to know that the hospital is supporting that goal and that everyone benefits in the end."

Additional resources on measuring patient satisfaction are available from Somnia Anesthesia in New Rochelle, NY, at http://bit.ly/295CEFJ. ■

SOURCE

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Recommended Questions from the American Society of Anesthesiologists

The American Society of Anesthesiologists (ASA) has many recommendations for questions to ask in assessing anesthesia patient satisfaction. First, it provides the following list of

Surgery-CAHPS questions that are relevant to anesthesia:

- Q17: Were you given something so you would not feel pain during surgery? (y/n)
- Q18. Who gave you something so you would not feel pain during your surgery? An anesthesiologist did this? The surgeon did this? Don't Know?
- Q19. Did this anesthesiologist encourage you to ask questions? Yes, definitely? Yes, somewhat? No?
- Q20. Did you ask this anesthesiologist any questions? (y/n)
- Q21. Did this anesthesiologist answer your questions clearly? Yes, definitely? Yes, somewhat? No?
- Q22. After you arrived at the hospital or surgical facility, did this anesthesiologist visit you before your surgery? (y/n)
- Q23. Did talking with this anesthesiologist during this visit make you feel more calm and relaxed? Yes, definitely? Yes, somewhat? No?
- Q24. Using any number from 0 to 10, where 0 is the worst anesthesiologist possible and 10 is the best anesthesiologist possible, what number would you used to rate this anesthesiologist?

In addition, a 2014 ASA white paper suggested 25 questions that hospitals can use to help assess patient satisfaction with anesthesia. To illustrate the type of questions the ASA recommends, here are the first 12:

- Q1. During the visit with the anesthesia practitioner before the surgery, I was able to ask the questions I wanted (disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q2. The information given to me by the anesthesia practitioners was understandable (disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q3. How satisfied were you with treatment of nausea and vomiting after the operation? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)
- Q4. How satisfied were you with pain therapy after surgery? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)
- Q5. I was satisfied with my anesthetic care (disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q6. I would recommend the anesthesia team to others in my family. (disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q7. To what degree did you have confidence in your anesthesia practitioners? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)
- Q8. To what degree was the anesthesia team willing to listen to your questions? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)
- Q9. Based on this experience, I have a good understanding of the role the anesthesiologist played in my surgery? (Disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q10. How would you rate the quality of care by the anesthesia practitioners? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)
- Q11. During the visit with the anesthesia team before the surgery I was able to ask the questions I wanted. (disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, agree very much)
- Q12. To what degree were you satisfied with the amount of information given from the anesthesia practitioners? (Very dissatisfied, dissatisfied, slightly dissatisfied, slightly satisfied, satisfied, very satisfied)

The white paper and the rest of the questions are available online at http://bit.ly/292VONY. ■

CANDOR Toolkit Helps After Adverse Events

Prompt and honest communication with the patient and family members after an adverse event has become the best practice in healthcare over the past decade, and the federal government is supporting that effort with a new toolkit from the Agency for Healthcare Research and Quality(AHRQ).

The Communication and Optimal Resolution (CANDOR) toolkit provides a process that healthcare institutions and practitioners can use to respond in a timely, thorough, and just way when unex-

pected events cause patient harm. Based on expert input and lessons learned from AHRQ's $23 million Patient Safety and Medical Liability grant initiative launched in 2009, the CANDOR toolkit was tested and applied in 14 hospitals across three U.S. health systems.

The CANDOR toolkit contains eight different modules, each containing PowerPoint slides with facilitator notes. Some modules also contain tools, resources, or videos. Generally, the CANDOR process begins with identification of an event that involves harm. This activates initiation of coordinated post-event processes.

The CANDOR toolkit is intended to help hospitals save money on malpractice litigation while encouraging more robust scrutiny of what went wrong, and a full disclosure to the patient or family. In addition to supporting patients families, CANDOR also acknowledges that an adverse event can be traumatic for clinicians and provides ways to assist them.

CANDOR calls for a prompt response after an adverse event, with specific actions to take. When a case involving patient harm is identified, trained hospital staff tell victims or their families what happened within one hour. They also contact the clinicians involved and offer assistance. The hospital also puts an immediate hold on the billing process so the patient or family is not stressed by a bill for the very services that may have injured or killed the patient. Hospital leaders stay in touch with patients and relatives during the investigation, which should be completed within two months. The results of the investigation are shared with the patient or family, along with a discussion of how to prevent such adverse events in the future.

When the investigation concludes that harm resulted from a breach in the standard of care, CANDOR calls for the hospital to negotiate financial compensation. The CANDOR toolkit is available online at http://1.usa.gov/1P2A17C. ■

TJC to Survey Fire Life Safety Code

TJC announced recently that it is now including the 2012 version of the National Fire Protection Association's 101 Life Safety (LS) Code in surveys, following the lead of CMS. The rule covers hospitals, critical access hospitals, inpatient hospices, long-term care facilities, intermediate care facilities, and ambulatory surgical centers.

CMS recently published the final rule on Fire Safety Requirements for Certain Health Care Facilities to amend the fire safety standards for certain Medicaid and Medicare participating healthcare facilities. It now requires hospitals to follow the 2012 versions of both the LS Code and the NFPA 99 Health Care Facilities Code referenced in the LS Code.

The rule adopts most of the proposals that CMS made in 2014 with one significant exception. CMS removed a proposed requirement for hospitals to install smoke-purging systems in operating rooms, which would have been a costly and disruptive requirement. Categorical waivers for the 2012 Life Safety Code are now available, provided the organization complies with that code's requirements.

TJC provides this sampling of the provisions in the final rule:

- Doors with roller latches will be limited only to "doors to corridors, and to rooms containing flammable or combustible materials."
- Facilities will be required to have a fire watch and evacuate if a fire sprinkler system is out of order for more than 10 hours.
- For new construction only, window sills must not be higher than 36 inches above the floor.
- Wheeled transport and patient handling may take place in the egress corridor, including the use of transport gurneys, wheel chairs, and patient lifts.
- Fixed furnishings, such as seating, are allowed in the egress corridor, with certain restrictions. ■

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CE QUESTIONS

1. According to Dawn Morton-Rias, EdD, PA-C, what is the trend with physician assistants (PAs) in healthcare?

a. PAs are among the most sought healthcare professionals now, and the demand is growing.
b. PAs are not as popular as in previous years, due to increased regulation.
c. PAs are increasingly popular in nursing homes, but not other healthcare settings.
d. PAs are sought mostly in rural settings with few physicians available.

2. How did Ed Lopez, PA-C, use PAs to reduce the percentage of patients discharged to the system's nursing home who were readmitted within 30 days?

a. Nurses at the nursing home were replaced with PAs.
b. All discharge decisions have to be approved by a PA.
c. If the nursing home thought a patient needed to be readmitted to the hospital, a PA would visit the nursing home to evaluate the patient and look for other potential solutions.
d. All patients readmitted to the hospital were assigned a PA to oversee their care and work toward avoiding another readmission.

3. What did the work group at ECRI Institute in Plymouth Meeting, PA, conclude about the use of copy-and-paste in electronic medical records?

a. It offers some benefits but still should be prohibited.
b. It offers some benefits and should be allowed, but only with precautions and oversight.
c. It offers no benefits but should be allowed for convenience.
d. It offers no benefits and should be prohibited.

4. Why is the timing of post-op anesthesia satisfaction surveys important?

a. The longer you wait, the more likely the patient is to correlate it with the outcome of the procedure, skewing the results.
b. The longer you wait; the less likely patients are to remember problems or concerns.
c. Surveying too soon will result in fewer patients responding.
d. Surveying too soon will result in an overly positive assessment.