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INSIDE

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Geriatric-Friendly EDs Improve Quality, Outcomes and Satisfaction

Hospitals are finding that EDs designated specifically for geriatric patients can improve quality of care and patient satisfaction for an aging population, but it also is possible to make existing EDs more geriatric-friendly and reap the same benefits.

The unique needs of an elderly population can affect quality of care in the ED, going far beyond mere comfort and patient satisfaction, says **Catherine Gow**, AIA, principal with health facilities planning at the architecture and design firm Francis Cauffman in Philadelphia. She has worked with several hospitals to design geriatric EDs or retrofit existing EDs to make them more accommodating to the needs of the elderly. EDs that treat the elderly more effectively can expect to see improved outcomes and reduced readmissions, Gow says.

Elderly patients have health conditions that are not common in the general population, and their limitations or sensitivities can interfere with effective treatment, she says.

> ELDERLY PATIENTS HAVE HEALTH CONDITIONS THAT ARE NOT COMMON IN THE GENERAL POPULATION, AND THEIR LIMITATIONS OR SENSITIVITIES CAN INTERFERE WITH EFFECTIVE TREATMENT.

"Some of the design issues involve the prevalence of disorientation, light and sound sensitivity, stability concerns, many factors that can affect the level of care they receive and their outcomes," Gow says. "There also is the need to make them feel relaxed, which is very difficult for the elderly and can interfere with the effectiveness of the care you provide. They tend to come in with multiple issues and polypharmy, which is not what you usually see with other ED patients."

Gow notes that much of the theories on geriatric EDs are driven

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by the work of **Mark Rosenberg**, DO, MBA, FACEP, FACOEP-D, chairman of the Department of Emergency Medicine and chief of Geriatrics and Palliative Medicine at St Joseph's Healthcare System in Paterson, NJ. Rosenberg has advocated for more geriatric-oriented EDs for years and many of his strategies are used in current designs. Gow and her firm helped design the geriatric ED at St. Joseph's. (*See the story in this issue for more on Rosenberg's ideas.)*

In designing or redesigning an ED, the goal with elderly patients is to create a calm and soothing environment so the patient can relax, Gow says. A typical ED can be loud, crowded, and frenetic, with bright lights and furniture that is not ideal for the elderly, all of which can make an already ill elderly patient more nervous and uncomfortable, she notes. When the environment allows the elderly patient to relax, he or she will more accurately convey their symptoms and concerns, and better understand the information provided, she says.

Gow notes that hospitals do not have to establish a separate geriatric ED to meet these needs, though that can be ideal if the budget allows. St. Joseph's was able to create a separate geriatric ED to maximize the effect of the strategies, but the same design changes can be applied to existing EDs either in total or in a designated portion of the ED, Gow says. *(See the story in this issue for more examples of how hospitals are accommodating the needs of the elderly in their EDs.)*

Simple Strategies, Big Effect

Some of the strategies are simple but can have a significant effect on the elderly. St. Joseph's uses exam beds with thick mattresses for the elderly, which makes them much more comfortable than the usual thin mattresses found in EDs. Some hospitals even choose to use hospital beds in a geriatric ED. The environment is designed to be quieter and less busy than a typical ED, minimizing the use of alarms, intercoms, radios, and bright lights.

Non-slip floors are important, but the floors also must be non-glare, Gow points out. Corridors should be free of hazards, with no equipment, and there should be hand rails also. The design should allow for soundproofing between rooms, so that noise in one area does not intrude into others. LED lights on the ceiling can provide adequate light without overwhelming elderly patients sensitive to light. A good idea is "cove lighting," in which small areas of a room are illuminated instead of the entire area.

"These are features that you might find more commonly in an inpatient unit, but not necessarily in an ED. For the older patient, these features are very important in the ED," Gow says.

Another concern is having enough room for family members. The elderly patient is more likely to arrive in the ED with family in tow, at least one or two and sometimes more, so it is important to have room and seating for them, Gow says. The ED also should have blankets available and easily accessible because the elderly patient is more likely to be cold while waiting.

The path to the bathroom is especially important, she notes. The path from the waiting area or exam room to the bathroom should be especially safe, with handrails, proper lighting, safe floors, and no obstacles.

"The ED staff don't tend to think about these things," Gow says. "They're busy saving lives. It's life or death and they're in a rush. You have to educate the ED teams, and you can retrofit any existing ED to make it more friendly to these patients."

Change Clinical Practices

The need for geriatric-friendly EDs is driven in part by the aging baby boom population, notes **Marcus Escobedo**, MPA, senior program officer with The John A. Hartford Foundation, a nonprofit in New York City dedicated to improving the care of older adults. Hospitals are responding more to the trend since the idea of geriatric EDs first emerged in 2008, he says. There are now more than 100 geriatric EDs in the United States, and still more EDs that are not solely geriatric but are catering more to the needs of the elderly, he says.

"We're seeing a lot of attention to emergency care in general that is important in terms of quality and cost outcomes in hospitals," Escobedo says. "Part of that is paying more attention to the needs of the geriatric population, trying to make them more accommodating and more able to effectively treat this population."

Escobedo points out that the physical design is not the only concern when making an ED geriatric-friendly. This population also is more likely to have certain illnesses and complications, such as delirium, so the ED staff must be on alert for those conditions and ready to respond appropriately.

"We know that when older adults receive age-appropriate care, we can see better quality outcomes and improve the experience of those patients," Escobedo says. "We don't advocate necessarily separate and distinct ED structures be set up for elderly adults. There are things you can do in terms of retrofitting and learning from best practices in terms of modifications, as well as training your work force."

Escobedo also advises hospitals to seek resources from the John A. Hartford Foundation, the American College of Emergency Physicians, and the Geriatric Society.

"This is vitally important now. Twenty million of the annual 60 million ED visits are older adults. More than half of elderly adults can expect to visit the ED in a year," Escobedo says. "Those older adults are consistently at risk for poorer outcomes and higher costs when their needs aren't met." ■

SOURCES

- **Marcus Escobedo**, Senior Program Officer, The John A. Hartford

Stats Show Need for Geriatric EDs

Much of the early research and advocacy for geriatric EDs comes from **Mark Rosenberg**, DO, MBA, FACEP, FACOEP-D, chairman of the Department of Emergency Medicine and chief of Geriatrics and Palliative Medicine at St Joseph's Healthcare System in Paterson, NJ.

In a study published in 2011, Rosenberg notes that the elderly make up 15-20% of all ED patients and use seven times more ED services than other patients. They account for 43% of all admissions and have a 20% longer length of stay. They also require 50% more lab work and radiology, and the rate of social service interventions is an astounding 400% higher.

When it comes to clinical care and outcomes, elderly patients are more likely to suffer delays in diagnosis and treatment, Rosenberg reports. The incidence of certain illnesses is significantly greater, including acute myocardial infarction, sepsis, appendicitis, an ischemic bowel. Some conditions are more likely to be overlooked in the elderly, including delirium, depression, cognitive impairment, drug and alcohol abuse, and elder abuse.

Rosenberg also cautions that without proper protocols and staff education, elderly patients can be harmed by overuse of sedation and Foley catheters. Adverse drug events also are more likely if staff do not adequately understand the patient's medication usage.

Physicians and staff in a geriatric-friendly ED also should keep in mind that they must interact differently with these patients, Rosenberg advises. They are more likely to have vague complaints such as, "I just don't feel well" that, if explored more in depth, can lead to serious symptoms. Their vital signs are likely to be normal and the elderly patient may seem to have no serious illness, Rosenberg cautions, but further investigation is always a good idea. He urges physicians to press for more information and pursue potential diagnoses more aggressively with elderly patients than with the typical ED patient.

A summary of Rosenberg's research and advice is available online at http://bit.ly/2fWH8kH. ■

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Hospitals Revamping EDs to Serve Elderly

Mt. Sinai Hospital in New York City opened its geriatric ED in 2012 after realizing the growing elderly patient population needed more directed attention than they could receive in the normal ED. Mt. Sinai had already responded with an expanded volunteer program aimed at assisting the elderly, says **Denise Nassisi**, MD, director of the geriatric ED.

"We tried to give them more of the human touch, someone to advocate for the patient and keep them engaged with activities. We also had someone donate reading glasses and hearing devices in case patients forgot theirs at home," Nassisi says. "These changes helped and we started looking at the possibility of making physical changes as well. We ended up deciding to create a separate physical space for our elderly patients."

Part of the impetus for the separate geriatric space was to keep elderly patients from being admitted unless absolutely necessary, Nassisi explains. Elderly patients don't want to be admitted and a hospital stay often is risky for them, so ED services that best meet their needs could improve the chances of them going home afterward, she says.

The project involved a wide range of hospital departments and services and a year of planning, she says. A space adjacent to the existing ED was scheduled for renovation already, so Mt. Sinai incorporated the geriatric ED into that plan, making the financial investment lower than it would have been if starting an entirely new construction project, Nassisi says. The hospital also received a federal grant that helped with hiring additional staff.

The geriatric ED has yielded positive results, she says. Elderly patients consistently report that they prefer it to the regular ED, she says. Social services has a particularly robust presence in the geriatric ED, focused on helping patients go home rather than being admitted and helping them with discharge and aftercare. Avoiding admission sometimes means keeping patients in the ED longer than they would be in the regular ED, Nassisi says.

"We try to avoid just admitting patients who have a lot going on, and instead we take the time to sort out what's going on so that we can send the patient home if that is at all possible to do in a safe way," she says.

Coordination with other available services is important in making the geriatric ED effective, Nassisi says, so it is important to get the buy-in of social services, pharmacy, case management and many other departments in the planning process. Staff also must be trained in the special concerns with elderly patients.

ED Affects Elderly More

MedStar Good Samaritan Hospital in Baltimore has long-term plans to put a geriatric-designated area in its ED, says Director of Geriatrics **George Hennawi**, MD, CMD, FACP. The hospital established a center for aging in response to the growing need, and now it plans to set aside part of its ED as well.

"It's not that traditional EDs don't serve the elderly well, but the experience for them is not what it could be. The reality is that the fast pace, the noise, the uncomfortable seats, the traditional approach in an ED is not usually soothing or comforting for older folks," Hennawi says. "People over 65 already account for a large proportion of ED visits and that number is only going to grow."

Elderly patients often fare poorly in a traditional ED because they have a poor reserve for dealing with stress. An experience that may be unpleasant for a younger person can trigger real problems in the older patient, he says. With patients already susceptible to delirium, the onslaught of noise, lights, strangers touching them and asking questions or giving instructions, can result in the elderly patient being overwhelmed and sliding into a state of delirium, Hennawi notes. That complicates their care and can reduce the quality of the outcome.

"That can begin a trajectory of decline," he says. "Hopefully a geriatric ED will reduce the confusion and delirium, which will reduce the other complications that come from that and lead to greater quality for older folks. We will treat them without making them confused, which will lead to better results."

The plan is to give elderly ED patients an area that is quieter and more comfortable, which Hennawi

says is about patient satisfaction — but more. The Good Samaritan ED has about 50 beds, so Hennawi is thinking of setting aside an area with about eight beds, which roughly matches the percentage of elderly patients seen in EDs. Even though it will be small in comparison to the rest of the ED, Hennawi estimates that the project will cost about $2 million because of the extent of the redesign for that area — everything from new flooring to soundproofing and all new furniture.

An Outpatient Feel

The geriatric ED may be ready in 2018, Hennawi says. The area will be physically separated to avoid the noise and bustle of the regular ED.

Hennawi says Good Samaritan is aiming more for the feel of an outpatient clinic, so it won't have the high-efficiency but low-comfort amenities of a normal ED. Rather than exam beds with thin mattresses, it will have reclining chairs. A volunteer will roam around to check on people and provide assistance. Even the curtains have been chosen carefully, with plastic rings and supports to avoid the typical noise of curtains being pulled open or closed.

Colors are chosen to be more pleasing to an elderly generation, avoiding overly bright or high-contrast colors. Artwork will be chosen similarly, perhaps depicting traditional scenes from Baltimore history.

Some of the changes, such as a quieter environment and more comfortable beds, would appeal to all ED patients and not just the elderly. But Hennawi says it would be impractical to implement them across the entire ED, which has to deal with high-acuity patients rapidly.

"You can't take someone who comes in with a heart attack and needs rapid IVs, needs to be laid flat on the bed for a central catheter, and treat them in this more comfortable ED," he says. "EDs are designed to take care of people like that in the most effective and efficient way, but we're carving out a segment of the ED population that doesn't always need that aspect."

Other Patients Could Benefit

Elderly patients are most negatively affected by the typical ED environment because they have poor reserves to begin with. However, Hennawi notes that the elderly are not the only ED patients who don't always require that high-speed, high-acuity care. He suggests that hospital EDs should work toward providing this more patient-centered approach to as many segments of the ED population as possible.

"This is critical for any hospital because in addition to the statistics, patient satisfaction scores are a big part of how hospitals are going to be reimbursed, and this type of ED has a shown a great satisfaction score right off the bat," he says. "I think it's a great strategic move for our hospital."

Good Samaritan also is hoping to reduce readmissions from the ED, which is increasingly viewed as a bad metric that penalizes hospitals, he says. The hospital plans to study the level of delirium among ED patients, readmissions, outcomes, and other factors to assess the effectiveness of the geriatric ED.

"It's a win-win situation, with the patient getting better patient-centered care and the hospital improving patient satisfaction scores, reducing complications, and reducing readmission," he says. ■

SOURCES

- **George Hennawi**, MD, CMD, FACP, Director of Geriatrics, Medstar Good Samaritan Hospital, Baltimore.
- **Denise Nassisi**, MD, Director Geriatric Emergency Department, Mt. Sinai Hospital, New York City.

Reduce Clinical Variation to Improve Quality, Resource Use

Clinical variation is the bane of many healthcare leaders, including quality leaders who realize it's not acceptable to have better processes and outcomes in some areas but not in others. Standardizing clinical resources and processes can significantly improve quality while also reducing costs and resource use.

Some analysts have suggested that unnecessary clinical variation accounts for nearly half of all wasted healthcare expenditures in the country, but that variation often is tied to a relatively small number of physicians or individual hospital units. Pressure also comes from the Medicare Access and CHIP Reauthorization Act (MACRA), quality incentives and penalties, patient safety indicators, readmissions, and now Medicare Spending per Beneficiary. With this increased

pressure to reduce costs while improving quality, hospitals are targeting clinical variation — the overuse, underuse, different use, and waste of healthcare practices and services with varying outcomes.

Acute care is still the leading frontier for cost expenditures and where reducing clinical variation is key, says **Nancy Lakier**, RN, BSN, MBA, CEO and managing principal of Novia Strategies, a consulting company based in Poway, CA. Hospitals and health systems are looking to the reduction of clinical variation to survive and thrive in their efforts to provide high-quality care while controlling costs. Lakier previously was a nursing executive and has seen what she says are meaningful improvements in the standardization of care.

"Historically, physicians were trained by different schools of medicine, and the different schools of medicine had their own philosophies and many things, both clinical and non-clinical," Lakier says. "It was very much independent practice by physicians, so the patient's care depended on their individual expertise and their particular way of doing things. One doctor might do something quite differently than another, but that was not seen as a problem necessarily."

The healthcare community has made strides in integrating those silos of delivery, but there still can be substantial variation in how the same patient might be treated by different physicians or hospitals, Lakier says. Some healthcare groups, particularly nursing, have standardized much of their care processes but organizations have not sufficiently integrated those groups or departments for greater standardization, she says.

Variation Drives Down Quality

Clinical variation and redesign are important because unwarranted clinical variation may result in poor clinical outcomes, sub-standard care, wasted resources, excessive costs, and disappointing experiences for patients and families, says **David A. Di Loreto**, MD, FACS, MBA, senior vice president of GE Healthcare Camden Group in Chicago. Hospitals and healthcare providers increasingly are reimbursed through value-based contracts that factor clinical outcomes, patient experience, and healthcare costs into the rates that are paid, he notes.

"Delivering higher-quality care at a lower cost is proving to be a competitive differentiator for health systems that have successfully reduced unwarranted clinical variation," Di Loreto says.

Reducing unwarranted clinical variation helps improve coordination and avoid redundancy, Di Loreto says. Standardization strategies also should detect gaps in care and seek previously unrecognized insights into performance. An overall goal should be to provide a framework for standardization by providing evidence-based protocols, care pathways, and clinical decision support tools, he says.

"One of the most important factors in successfully redesigning care is to design around the needs of patients and caregivers," he says. "Automating administrative tasks, delegating more clinical responsibilities to nurses, medical assistants, and pharmacists, and reducing the clerical burden so that clinicians' time with patients is increased builds trust and improves overall satisfaction."

Raise Quality, Save Money

Lakier first addressed clinical variation when she was the nursing executive for Scripps Health when managed care hit California providers, which prompted her to lead a project to improve care while reducing costs. Scripps managed to save tens of millions of dollars by improving quality outcomes in all areas, she says.

"We did that by using risk-adjusted data and bring together groups of physicians to really discuss and look at the variation across physicians," Lakier says. "That was something new because there had always been this acceptance of physicians doing what they thought best, in the way they wanted to do it. We said this isn't necessarily right or wrong, but we should talk about it and see if there is something to change."

Physicians began to learn from each other, and Scripps encouraged them to focus more on best practices. The effort yielded more clinical pathways, protocols, and practice guidelines, all intended to embed the changes in care to ensure that the patient was getting the best care process available, Lakier says. It was a switch for some physicians to look at their care decisions this way, she says.

After capitation and managed care fell by the wayside, the impetus for standardization of clinical practices also waned, Lakier says.

"Now, with the Affordable Care Act, we're looking again at how to standardize care to best practice," she says. "We have seen numerous times how it improves care for the patient and reduces costs. So many times, we are providing care 'just because.' The doctor has always ordered labs that way, or it's just routine to do a task this way, whether it's right or not."

Clinical variation easily slips under the radar in healthcare systems, Lakier notes. Not everyone welcomes increased attention to the issue, she says, because people generally do not like their professional decisions and habits to be questioned. Younger physicians tend to be more receptive because they were trained with more attention to best practices, she says.

"Some hospitals have addressed this, but I would say the majority have not," Lakier says. "If they have not addressed clinical variation, their patients are getting variable care based on the expertise of the individuals caring for their patients. Some people are more highly skilled than others, but more than that, we all have good days and bad days. Why not have protocols in place to support that care meeting optimal standards?" *(See the story in this issue for examples of how clinical variation can be discovered and addressed.)*

Must Be Interdisciplinary

The interdisciplinary component is critical to clinical standardization, Lakier says. When working on case management projects, for example, she has found that not everyone knows the expected discharge date for the patient. Without that common knowledge, the teams from different disciplines cannot optimize care to meet that goal, and one individual's non-standard care decision could throw off everyone else's plans, she explains.

Embedding standardized clinical processes into an organization helps keep everyone on the same page, she says. If the whole team knows the patient should be discharged in four days, some decisions will stem from that as part of the standardized processes, Lakier says. Discharge education and planning may begin immediately, for instance.

"It's not that people aren't trying to do their best, but everyone gets busy. If the physician forgets to order physical therapy, now the patient waits a whole day for physical therapy and that might extend the patient's stay," she explains. "That increases their risk, because every day in the hospital puts them at risk of comorbidities, falling, or other complications. We want to make sure the care they need is delivered expeditiously, and that is achieved most effectively by having standardized care processes."

Routine protocols take the burden off of physicians to remember every single detail of care, such as the physical therapy order that will delay discharge if overlooked, she says.

All About That Data

Addressing clinical variation starts with obtaining good risk-adjusted data, Lakier says. The data can include HAP scores, readmission rates, morbidity, mortality, and a range of other measures. The data should focus on quality improvement and outcomes, not just costs.

The data should be presented to medical leadership, identifying variation among physicians. It's important to have risk-adjusted data and emphasize to the physicians what that means. This will eliminate the sometimes-valid retort that a physician with poor outcomes treats sicker patients than the others.

Rather than going to physicians with a predetermined solution and telling them, "this is how you're going to practice medicine from now on," the data can prompt internal discussions that will lead to better and more standardized practices, Lakier says.

"Pretty soon they're talking to one another and saying, 'Wait a minute, how come your costs are different from mine? What are you doing to get your patients a shorter length of stay than mine?'" Lakier says. "If this isn't done in a collaborative and informative way, you're going to have resistance. Our job in quality improvement is to present information to help them understand what the data says. Then if they choose to change their practices, our job is to embed that in the organization so you get sustainability." ■

SOURCES

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Look for Variations in Data, Seek Out Causes

Studying a range of data sets at your hospital may reveal opportunities to improve outcomes and cut costs, says **Nancy Lakier**, RN, BSN, MBA, CEO and managing principal of Novia Strategies, a consulting company based in Poway, CA. The outliers and unusual numbers will point

you toward issues that need more investigation, she says.

"Why is one physician having fewer readmissions than others? Why is one service line having fewer readmissions?" she says. "There are all sorts of quality indicators to look at that can guide you toward what you can do to improve quality, not just in the hospital but also post-discharge."

In working with data sets on congestive heart failure with myocardial infarction recently, Lakier saw that one physician at the hospital had an average length of stay three days higher than other physicians, with a commensurate increase in costs. When she drilled down into the reasons for the variance in length of stay for that physician and other outlier physicians, she saw that one factor was the pharmaceuticals prescribed by those physicians.

"They were dramatically different. The high-cost physicians used drugs that varied significantly from the others," she says. "That doesn't always mean those drugs are inappropriate, but sometimes it's just a matter of asking the question. The physician might respond that he didn't realize his choice was so much different from everyone else's and he could use the other drug and get the same results."

It also is common for nurses and physician assistants to order certain drugs, lab tests, or therapies because they think that's what the physician wants. They're mistaken, but the physician doesn't object, Lakier says.

At one hospital, Lakier determined every patient received a physical therapy risk assessment for falls prior to discharge. When she asked why the risk assessment couldn't be performed by a nurse instead of physical therapy in most cases, she was told that about 10 years earlier there had been a bad patient outcome blamed on a lack of adequate fall assessment.

"Ten years later, they still had that assessment in place and it was adding a half a day to the length of stay for every patient in the hospital," Lakier says. "Plus, they had increased their physical therapy staff way beyond what any other hospital used. The chief nursing officer said there was no reason they couldn't do most of the assessments, but no one had ever questioned the policy."

Once that policy was rescinded with the approval of the physicians, the hospital's length of stay decreased, and so did overtime costs for the physical therapy department.

In another example, Lakier studied data sets and saw that a bariatric surgeon was performing 70 appendectomies per year, but the hospital was using a $381 special bariatric tray insert rather than a standard and far less expensive appendectomy tray. The surgeon's staff most likely provided the more expensive tray because the doctor previously requested it, or it might have been specified on his preference card, Lakier says. Either way, the costly tray was not necessary for an appendectomy.

In other cases, the data may show that one physician keeps patients in the ICU longer than others. A little investigation may reveal that, for whatever reason, the surgeon doesn't trust the care provided on the med-surg floor.

"Sometimes you have to fix operational problems before you can address the clinical variance. You might have to bring up the quality of the med-surg staff before your surgeon will be willing to change his ways," Lakier says. "Sometimes patients are staying in the hospital because they can't get in to the OR. So you have to find out what's going on in the OR and what you can improve in the perioperative area to get those patients in faster. ORs often are at max capacity, but that might be because their operations aren't so smooth." ■

C. Difficile Reduced 75% with Targeted Interventions

A hospital in Medford, OR, reduced its rates of *C. difficile* infections by three-fourths with a targeted approach intended to identify exactly what strategy is the most effective after previous attempts left hospital leaders wondering which of several interventions had worked.

Asante Rogue Regional Medical Center, the largest of three hospitals in the Asante system, experienced unacceptable rates of *C. difficile* infections. The trend continued upward, and hospital leaders tried to address the problem in 2013, says **Holly Nickerson**, RN, BSN, director of accreditation at the largest of three Oregon hospitals in the Asante system. They saw some success, but they implemented many different strategies in a "shotgun approach," she says, so they didn't know which affected the infection rate. Thus, the improvement was short-lived.

"We tried a ton of things all at the same, so we had no idea what worked," Nickerson says. "We

changed our cleaner, we were doing hand hygiene campaigns, all sorts of things that we thought would lower the infection rate. The rates fell some but we couldn't sustain it, and after we changed our cleaner, the infection rate actually increased."

In late 2014, the vice president of medical affairs declared the hospital's *C. difficile* rate a critical issue and sought strategies for reducing the weekly infection rate, which was about four per week at that time. The Asante system formed a "Green Team" to study recent *C. difficile* cases and develop possible interventions. Green was chosen because the Asante metrics scorecard use that color to indicate good results.

Root Causes Identified

The system-level team was multidisciplinary, bringing together nursing staff and leadership, infection prevention, pharmacy, environmental services, performance improvement, electronic charting, clinical nurse specialists, nursing professional development, and purchasing. The other two hospitals in the Asante system were outperforming Rogue Regional on *C. difficile* prevention, so the team looked to them for best practices.

The team found that the infections stemmed from three sources: inappropriate testing, healthcare worker transmission, and environmental services issues. The Green Team then developed strategies for addressing each of those sources of infection. For the inappropriate testing, the team determined that the hospital's multidrug-testing protocol could be at fault. The protocol allowed nurses to order *C. difficile* testing any time, which was intended as a good proactive step toward detecting infections. "Test early and test often" was the school of thought.

But it seemed that some positive results were classified as hospital-acquired when they were present on admission, Nickerson explains. Poor communication among nurses sometimes led to a *C. difficile* test being performed after a patient had received laxatives or medications causing diarrhea, and no *C. diff* test was performed on admission, a positive test during the hospital stay might automatically be deemed hospital-acquired.

"We know that many patients, especially patients that kind of live in the healthcare system, are colonized with *C. difficile*, so you may have someone who is shedding spores but who does not have active *C. difficile*," Nickerson explains. "By giving them laxatives, we might be just capturing some normal flora that lives in their bowel. We had to help staff understand when to test."

To address that issue, hospital leaders discontinued the policy of testing for *C. difficile* under the multidrug-resistant organism protocol at any time, instead encouraging physicians to order specimen collections only when the patient fit appropriate criteria. This was a turnaround from previous hospital policy, so it took some effort to reeducate nursing staff, says **Bella Lucas**, RN, BSN, manager of infection prevention at Asante Rogue Regional Medical Center.

"It was very much ingrained in the staff to use proactive thinking and wonder if a problem could be *C. difficile*. They were taught to test early and isolate it to prevent the spread of infection," Lucas says. "The staff were perplexed by the idea that now the testing would require a physician consult and buy-in."

Audits for Enteric Procedures

Infections originating from healthcare workers were addressed with daily enteric precaution audits that provided real-time feedback to staff regarding their compliance with procedures for entering and leaving enteric precaution rooms. In addition to immediate feedback, the compiled audit results are provided to staff on a regular basis. When a *C. difficile* infection is traced to healthcare worker transmission, frontline staff are gathered for an immediate huddle to discuss the case and what precautions may have failed.

For the environmental services issues, the Asante Green Team determined that terminal room cleans were not meeting expectations, with only a 55% passing rate. The root cause, the team discovered, was that the environmental services teams followed no protocol for terminal room cleans. Morale and commitment to the job also were lacking, Nickerson says.

"When I had one of our continuous project improvement leaders meet with that group, it was very apparent they had no standardized process for cleaning their rooms. We use the fluorescent gel dot system that is placed in key areas to test how well the room is cleaned, and it consistently showed poor performance," she says. "The environmental services team knew where the dots were placed and still were failing the room. That was a pretty big red flag for us that they did not have a process and did not know how to clean the room."

Those problems were addressed through weekly meetings with a performance improvement project leader to establish a standardized process

for terminal room cleans and retrain all staff. The leader also worked to improve their morale by emphasizing the importance of their jobs and how attention to deal can have a direct effect on individual patients.

Cleaning Staff Retrained

The chief of quality and safety met with the environmental services team to emphasize the importance of their roles in patient safety. News items in the hospital newsletter praised cleaning teams for their work and promoted them as vital to protecting patients.

"It was a big retraining process, a big commitment from our environmental services leaders in monitoring and coaching their staff," Nickerson says. "It came to the staff receiving disciplinary action if they did not clean the rooms properly. We also went to great lengths to stress that they don't just clean rooms: They help people keep from getting infections."

The effort was successful, raising terminal room cleaning performance from a 55% passing rate to 100%.

Over the course of nine months, the hospital's *C. difficile* infection rate fell from four per week to one per week.

"The effort showed us that you can't really reduce infections if you don't have a full understanding of why they're occurring, and what variables could have an influence," Lucas says. ■

SOURCES

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Physicians Unlikely to Reveal Errors to Patients, Study Says

Primary care physicians are willing to report medical errors within the healthcare organization, but are not as likely to tell the patients, according to a recent study from the School of Public Health at Georgia State University in Atlanta.

Kathleen Mazor, MD, a researcher at the Meyers Primary Care Institute in Worcester, MA, and her colleagues studied 397 primary care physicians, presenting them with two hypothetical cases involving a diagnosis of cancer. The researchers explained in the report, published recently in *BMJ Quality and Safety*, that the research was prompted by the trend in recent years to promote full disclosure of errors to patients with a statement of regret. Most healthcare professionals express support for the idea, but the researchers suspected they might not practice what they preach.

In the first scenario, the physicians recognized that breast cancer should have been diagnosed earlier than it was. In the second, a cancer patient suffered because care coordination delayed the response to the patient's symptoms. The physicians were asked to imagine that they were the physician responsible for that patient.

After studying the information, the researchers asked the physician four questions about how they would respond after realizing an error had been made with their patient. The questions sought to determine if the doctor would apologize to the patient, offer an explanation of what error occurred, provide information about what factors led to the event, and/or discuss any plans for preventing a recurrence of the error. In each option, the physician could choose nondisclosure, partial disclosure, or full disclosure.

In addition, the physician responses were assessed for factors that could affect their disclosure decisions, including the level of personal responsibility for the error, beliefs about the seriousness of the event, time constraints, and expectations about whether a malpractice lawsuit was likely. The researchers also assessed factors such as how much the physician valued patient-centered communication and how much confidence the physician had in his or her ability to communicate. The study also factored in the physician's perceived organizational-level support for open communication with patients.

The results confirmed suspicions that physicians do not disclose errors as fully as the healthcare community expects. A majority said they would not fully disclose the error in

either scenario, though some would provide limited information without an apology. Seventy-seven percent said that in the delayed diagnosis case they would offer no information at all or only make a vague reference to miscommunication. In the failure to respond to symptoms scenario, that number was 58%.

With both scenarios, more than half of the physicians said they would not apologize at all or only make a vague statement about regret.

An abstract of the study is available online at http://bit.ly/2g7lQ1s. ■

Readmission Rates for Bariatric Surgery Drop with QI

Thirty-day readmission rates for bariatric surgery patients can be reduced by implementing a series of quality improvement efforts, according to recent research. Some of the top performers in the study more than doubled the average readmission reduction.

The American Society for Metabolic and Bariatric Surgery (ASMBS) and The Obesity Society (TOS) reported recently on research presented at the groups' annual meeting and highlighted a study led by **John M. Morton**, MD, director of bariatric surgery at Stanford Hospital & Clinics in California. The study involved the Decreasing Readmissions through Opportunities Provided (DROP) program, part of the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), a joint program of the American College of Surgeons (ACS) and the ASMBS.

A significant portion of bariatric surgery readmissions are preventable, stemming from issues such as nausea and vomiting, or nutritional problems including electrolyte depletion, ASMBS reports. DROP was implemented at 128 facilities performing bariatric surgery that in the prior year had an average readmission rate of 4.79%. Six months later, the readmission rates dropped an average of 14%, but the top performers in the study saw reductions of 32%.

The DROP program focuses on quality improvement measures that address the most common causes of bariatric readmissions with improved nutrition counseling, discharge processes, psychological therapy, and other methods. ■

CORRECTION

A source was incorrectly identified in the December 2016 issue of *Hospital Peer Review*. On p. 135, the source identified as "Mathew Thomas" should be "Thomas Mathew, MD, a hospitalist for 10 years and corporate medical director of health systems for naviHealth, a post-acute care management company based in Nashville."

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CE QUESTIONS

1. According to research by Mark Rosenberg, DO, MBA, FACEP, FACOEP-D, which of the following is true of elderly patients in the ED?

a. They account for 43% of all admissions.
b. They have a 20% shorter length of stay.
c. They require 50% less lab work and radiology.
d. The rate of social service interventions is 60% lower.

2. According to George Hennawi, MD, CMD, FACP, why is it important to provide a separate ED area for elderly patients?

a. It makes the overall ED run more efficiently.
b. It reduces wait time in the ED.
c. A typical ED experience can negatively affect an elderly patient's health.
d. Typical EDs do not provide adequate clinical care to the elderly.

3. What does Nancy Lakier, RN, BSN, MBA, say is one of the most important factors in successfully redesigning care to reduce clinical variation?

a. Design around the needs of patients and caregivers.
b. Design around the long-range goals of the organization.
c. Provide opportunity for individual choice.
d. Establish a disciplinary policy for variation.

4. In the project at Asante Rogue Regional Medical Center to reduce the *C. difficile* infection rate, why did the hospital change its policy on when to test for infection?

a. They wanted to encourage nurses to test early and often, at their discretion.
b. Their lab was overwhelmed with tests.
c. Testing was too expensive.
d. Positive tests sometimes were incorrectly deemed hospital-acquired.

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.