HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

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

INSIDE

RELIAS
Formerly AHC Media

JANUARY 2018 Vol. 43, No. 1; p. 1-12

Obstetrics Offers Many Opportunities for Quality Improvement

Maternal and fetal morbidity are ongoing concerns, and hospitals are using an array of evidence-based strategies to improve quality of care, from simple process changes to high-tech virtual reality simulations of obstetric emergencies.

Hospital leaders are under increased pressure to improve patient care in maternal and fetal medicine now in part because of government and public responses to mortality data, says **Michael R. Foley**, MD, professor and chair of the Department of Obstetrics and Gynecology at the University of Arizona College of Medicine in Phoenix, and chairman of obstetrics and gynecology at Banner — University Medical Center Phoenix. U.S. maternal mortality data from the CDC show room for improvement when compared to other industrialized countries, though there are factors that explain some of the metrics, including the increasing age of pregnant women, Foley says.

HOSPITAL LEADERS ARE UNDER INCREASED PRESSURE TO IMPROVE PATIENT CARE IN MATERNAL AND FETAL MEDICINE.

"There also is the excellent cardiac care that babies now receive. Whereas in recent years they might not have survived to the reproductive age group, they now have complex cardiac surgeries as neonates and reach the age of having babies themselves," Foley says. "That brings an increased risk to the pregnancy and increases infant mortality, so a lot of hospitals are recognizing this and looking at what they can do to address infant mortality with

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

Hospital Peer Review®
ISSN 0149-2632, is published monthly by
AHC Media, a Relias Learning company,
111 Corning Road, Suite 250,
Cary, NC 27518-9238.

Periodicals Postage Paid at Cary, NC, and at additional mailing offices.

GST registration number R128870672.

POSTMASTER: Send address changes to:
Hospital Peer Review
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518-9238

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
CustomerService@AHCMedia.com
AHCMedia.com

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling. Canada: Add $30 per year. Total prepaid in U.S. funds.

Printed back issues are $50 each
Online only: 1 year (Single user): $467

Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

AUTHOR: Greg Freeman

EDITOR: Jesse Saffron
(919) 377-9427 (jsaffron@reliaslearning.com).

EDITOR: Jill Drachenberg
(404) 262-5508 (jdrachenberg@reliaslearning.com).

EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

more resources and the development of new programs."

The first step, Foley says, is to determine where the hospital currently stands with quality metrics and mortality, identifying potential targets for improvement. Then hospital leaders must be recruited and given a sense of urgency on the issue, he says.

"Develop a vision of where you want to go and then empower these leaders to implement the right programs in their units," Foley says. "As they begin to see small wins and improvements, you have to encourage them to make those changes stick and take on additional goals. That's how you change the culture."

Maternal and fetal care is one of the most popular quality initiatives among hospitals today, says **Diane Doherty**, senior vice president of Chubb Healthcare in New York City. Many of the efforts focus on communication and teamwork.

Hospitals are looking to improve the process of communication among clinicians, and also the transfer of information, she says. Two of the most popular strategies are Situation, Background, Assessment, Recommendation (SBAR) and TeamStepps. *(More information about SBAR is available online at: http://bit.ly/2iZNwMg, and information on TeamStepps is available at: http://bit.ly/2p0Ysd2.)*

"A strategy that has been quite successful is for hospitals to conduct team huddles at least once a day, when the team gets together to review the patient list for half an hour. It's a short meeting that lets people talk face to face about their patients and any challenges that might arise," she says.

"Huddles increase situational awareness among the team, and that means not just nurses. The huddle should include team members from obstetrics, anesthesia, neonatology, and anyone else involved in caring for mothers and neonatal patients," says Doherty.

A hospital's adverse event reporting system is crucial to improving maternal and fetal care, Doherty notes. Near misses should always be reported and debriefed so that lessons can be learned, she says. *(See the stories on page 4 and page 6 for examples of how two hospitals have improved quality with maternal and fetal medicine.)*

Hospitalists Improve Care

Foley advises aligning the four Ps of OB/GYN safety: People, Place, Programs, and Practice. For people, Foley notes that hospitals are utilizing hospitalists or laborists who can provide consistency in the coverage of emergencies and triage, and the implementation of guidelines and protocols.

This professional is in the OB unit continuously to interact with internal medicine, maternal/fetal medicine, anesthesia, and the ICU, and to look at tracings and possibly intervene with the early deterioration of a patient — key interactions that typically require conveying information to a doctor over the phone, Foley says.

Place is addressed by creating an OB triage, which functions as an ED for OB patients and a 24-hour staffed medical ICU. The OB triage facilitates more oversight and monitoring of mothers and babies, Foley says.

"You have a professional there

in the OB triage who can look at that tracing immediately, rather than having a physician in the ED try to figure out what's going on or waiting until you can reach a doctor at home," Foley says.

Programs come into play as many hospitals are adopting bundles for OB emergencies and checklists for high-risk issues such as postpartum hemorrhage, hypertension, shoulder dystocia, amniotic fluid embolism, and perimortem cesarean section, Foley notes.

"Making them checklists, as opposed to just guidelines, is a real success measure. We found that with advanced cardiac life support years ago, when we used to have guidelines but now most of those have evolved to checklists and protocols," Foley says. "A guideline can have too much room for interpretation."

Virtual Reality Education

Hospitals also are creating OB virtual ICUs, which are multidisciplinary teams that care for patients in the most appropriate resourced area of the hospital.

An expectant mother who has hypertension, heart disease, or septic shock may not be cared for in the labor and delivery unit, but rather in a location that is best equipped and staffed for rapidly responding to any deterioration in that patient's condition, Foley says.

"We've now delivered more toward delivering the baby and caring for the mother in those units, rather than trying to create a brick-and-mortar unit that can be all things for all patients," Foley says. "We can move all the equipment we need for delivering the baby into that cardiac care room and set up a bassinet for monitoring the newborn, for instance, rather than taking the patient away from the location that is best for addressing that critical illness. This has also made a world of difference in fostering camaraderie and communication around critically ill pregnant patients."

OB rapid response teams also are growing in popularity, Foley says, along with OB Code Blue.

"A rapid response team brings together a number of highly trained professionals for a critical patient situation, but that does not always include people who are trained in maternal and fetal care," Foley explains. "An OB rapid response team or an OB Code Blue team brings the right people to care for the mother and baby no matter where they are in the hospital."

Hospitals also use Code Stork to bring the right professionals to a maternal or neonatal emergency. Foley also strongly recommends drills and simulation practice for fellows, residents, nurses, and others.

"Being able to work together and care for the manikin on a computer, right on the floor with the same team that would care for a patient, is invaluable in helping team communication," Foley says. "It helps you look for breakdowns in teamwork that can be noted before they affect a patient's care, and addressed properly."

Foley's hospital also employs virtual reality experiential training in postpartum hemorrhage and perimortem cesarean section. Clinicians don Oculus virtual reality goggles to view educational videos that place them in the middle of a room watching a well-oiled team care for an obstetrical emergency. "They can watch how the drugs are used, the timing, how different team members interact and communicate, all with a bird's-eye view as this happens around them," Foley says.

"Our new millennials love this because it's a new educational modality for them. They hate the old 'sage on a stage' model where somebody teaches them something and they have to go read a chapter," adds Foley.

Certification in Fetal Monitoring

The hospital also has a fetal monitoring strip certification program based on the program offered by the Society of Maternal and Fetal Medicine.

The interpretation of maternal and fetal monitoring tracings is a dominant factor in patient safety and can drive the course of care, Foley notes, and disputes over how a tracing should have been interpreted are the foundation of many malpractice lawsuits.

Nurses and physicians take the same certification course so that they all communicate about monitoring strips in the same way, use the same standards and protocols, and hopefully make the same judgment calls.

The University of Arizona College of Medicine has instituted those strategies along with quality programs to measure outcomes on metrics such as postpartum hemorrhage and ICU admissions.

The labor and delivery area uses its own quality program and quality scorecard, and it uses outside scores such as a state mortality review,

Foley says. "Having these outside reviews and checks are always good for any hospital, no matter how good your internal measures are," he says.

The challenges with these quality improvement strategies often involve financing, Foley notes. Hospitals can find it difficult to finance the hiring of hospitalists who will be present at all times, for instance.

The University of Arizona College of Medicine justified those costs, in part, by balancing them against the potential costs of two or three severe malpractice cases per year resulting from poor OB care, along with the emotional and life costs of injured patients.

The risk management department funds the strip monitoring certification program because the potential savings from lawsuits outweigh the costs.

"It almost always comes down to a cost/benefit analysis. Everyone wants the best quality, but the reality is that people want the best value, too — the best quality at the lowest cost," Foley says.

"Finding out what that is in an arena like maternal and fetal care can be tricky. We ended up funding some of these projects, like the filming for the virtual reality training, by holding seminars for clinicians from around the country and the money we made on those was used to pay for some of these things that otherwise would be hard to fund through our regular budget process." ■

SOURCES

- **Diane Doherty**, Senior Vice President, Chubb Healthcare, New York City. Phone: (212) 703-7120. Email: diane.doherty@chubb.com.
- **Michael R. Foley**, MD, Professor and Chair, Department of Obstetrics and Gynecology, University of Arizona College of Medicine, Phoenix, and Chairman of Obstetrics and Gynecology, Banner — University Medical Center Phoenix. Email: mike.foley@bannerhealth.com.

Hospital Standardizes Debriefing After Critical Events

The maternal and fetal medicine team at Sharp Grossmont Women's Health Center, affiliated with Sharp Grossmont Hospital in La Mesa, CA, improved quality of care recently by implementing a standardized debriefing process for critical events.

Mia Taa-White, BSN, RN, and **Jennifer Turney**, MSN, RN, CNS, CPN, clinical leads in OB/GYN at the hospital, were part of a team that determined there was no standardized debriefing process that could help the clinical teams learn from patient experiences. They addressed the issue as part of their participation in the Clinical Scene Investigator (CSI) Academy sponsored by the American Association of Critical-Care Nurses.

The Women's Health Center has 24 labor suites and 24 single-occupancy rooms for couplet and women's surgical care. Physicians are in-house day and night, and there is an operating room and post-anesthesia care unit dedicated to women's services.

Hemorrhage Incidents Reduced

They theorized that improved debriefing could help lower the incidence of a serious complication of postpartum hemorrhage resulting in a massive transfusion, defined as more than four units of blood. They developed a program with the goal of reducing the incidence below a rate of 1.5/1,000 women.

From June 2015 to June 2016, there were four cases of postpartum hemorrhage resulting in massive transfusion. In the year since implementing debriefing education and standardizing the process, there have been no events of massive transfusion and the goal to decrease the rate below 1.5 has been achieved.

The incidents avoided in that period resulted in a cost savings of $101,212. *(More data and the standardized debriefing form are available online at: http://bit.ly/2AfCVDn.)*

"We standardized a debriefing form that evaluates our timeliness in recognition and timeliness in responding to a critical event," Taa-White says. "It also helps us evaluate our team dynamics. It aligned us with our journey to become a high reliability organization, heightened our awareness, and helped us create a mindset to think critically about work and performance."

Prior to the standardized form and process, critical events were loosely defined but included anything the nurse thought required a rapid response.

Debriefing after these events was

inconsistent, Turney says. "Nurses felt like they needed to weigh and discuss those events, but there was no process. Nurses would go home and think about what happened, recognize things that might have been done better or that suggested some potential for improvement, but they didn't have any formal way to pass that on to leadership," Turney says. "There might have been delays or supplies were missing, concrete things that could be addressed, but the information was not utilized."

An interdepartmental team addressed the issue, with representatives from labor and delivery, OB/GYN, the surgical post-anesthesia care unit, as well as frontline nurses.

"In addition to developing a way to send this information to leadership, we wanted to be able to communicate with staff also so that we all can learn from these experiences," Taa-White says. "We started with introducing the idea of debriefing itself — the importance of debriefing, what it means to debrief, and what would be done with the information."

Pushback on Time, Leadership

There was some skepticism and resistance, as can be expected with any initiative, Taa-White says. Time was the biggest concern, with clinicians pushing back on the idea of a new step they would have to work into their already busy schedules. The debriefing team emphasized that the process could be quite brief, as little as five minutes.

Leading the debriefing session was another source of concern. "Everyone was shy about leading the debrief, especially with doctors involved. After a critical event, everyone is still stressed out about the situation and catching up on charting, so debriefing was the last thing they wanted to do," Taa-White says. "The idea of leading it was even less popular, because nobody wanted to take that responsibility and be the one to criticize the team's work. We explained that leading doesn't mean criticizing or grading your co-workers on their performance, but rather it's about facilitating the discussion."

Turney notes that physician participation improved when Taa-White and another member of the debriefing team visited with OB and anesthesia leadership to explain the process and the benefits.

"It was a big step forward when we got physicians to stay after the event and discuss with the nurses what went well and what didn't," Turney says.

"It's not 100% participation, but it gets better and better with each event. The physicians are starting to see that this is an opportunity for them to educate others, and also to convey any concerns they had about the equipment they needed or changes that would have helped them do their jobs better."

Problems Revealed and Addressed

In addition to overall improvements in communication and teamwork, several specific improvements have come from the debriefings, Taa-White says. Comments from debriefings led to the refinement of the hemorrhage cart that is brought to a room during a bleeding emergency. Some necessary items were missing and new items were added.

The debriefings also revealed that the overhead speaker in a physicians' lounge was broken, so the doctors there could not hear OB stat calls.

However, addressing those issues was not enough. The changes were communicated to the clinicians with an emphasis on how they came about directly because of the debriefings, Turney says, to reinforce the importance of the process and to validate the input from caregivers.

SOMETIMES IT IS BEST TO JUST GET STARTED RATHER THAN WAITING FOR THE PERFECT SETUP.

The debriefings also provided a way to measure the quality of critical event responses, they note. "Previously we might have thought we did pretty well, but with this process we can put our team performance on a scale of one to four and categorize it over time, looking for patterns with particular types of emergencies and any consistency in what could be improved," Turney says.

One of the lessons from the project is that sometimes it is best to just get started rather than waiting for the perfect setup, Turney says. The debriefing team initially spent a great deal of time and effort trying to design the debriefing form, which delayed the implementation of the project, she says.

In retrospect, Turney says it might have been better to go ahead with an early version of the form and modify it as the project progressed. ■

SOURCES

- **Jennifer Turney**, MSN, RN, CNS, CPN, Clinical Lead, Sharp Grossmont Hospital, La Mesa, CA. Email: jennifer.turney@sharp.com.
- **Mia Taa-White**, BSN, RN, Clinical Lead, Sharp Grossmont Hospital, La Mesa, CA. Email: mia.taa-white@sharp.com.

Site Infections Reduced for Post-op Cesarean Section Patients

Infection levels in mothers after cesarean sections were reduced at a California hospital with a remarkably simple fix: providing the right size bandage so too-large ones didn't have to be cut by hand.

The issue was recognized by a team at Sharp Mary Birch Hospital for Women & Newborns in San Diego, a freestanding women's hospital with more than 9,000 deliveries per year. Superficial surgical site infections (SSIs) were partly responsible for increasing readmissions each year, and they were becoming more common with an increasing number of cesarean sections, explains **Lauren Korrub**, RN, BSN, clinical nurse at the hospital. They also were costly for the hospital and there was no standard reimbursement. In addition, SSIs are reportable events to the California Department of Public Health.

Korrub and others at the hospital worked on the issue in the Clinical Scene Investigator (CSI) Academy sponsored by the American Association of Critical-Care Nurses. Their goal was to reduce superficial SSIs in postoperative cesarean section patients by 50% and to provide education to 100% of staff on superficial SSI prevention. They also sought to increase hand hygiene patient education to greater than 95%.

The team developed the slogan "A healthy wound is a happy wound." They provided interactive learning to staff, with monthly giveaways of gift items and spa days. Staff also received badge clips with the motto and the project's smiley face logo.

Patient education also was important. The team developed a patient handout in English and Spanish, which was available electronically in the medical record and as a handout located near discharge folders. The patient handout explains how superficial SSIs happen, why they are dangerous, and how to prevent them. It provides specific advice such as checking the incision daily, keeping the wound open to air after 48 hours, and not using any lotions, creams, powders, or ointments on the incision.

The team also introduced a container of hand sanitizing wipes to the patient's bedside table, accounting for the fact that cesarean section patients are confined to bed for days and can't easily wash or sanitize their hands in the bathroom or with the hand sanitizer on the wall.

But the most effective intervention also was the simplest. The team realized that the size of the bandage supplied for cesarean section incisions was contributing to infection rates.

"We observed our nurses and some of the habits we had when we were taking care of incisions after removing staples and applying Steri-Strips," Korrub explains. "Our OR had pre-cut Steri-Strips that were the right size for their needs, but we had to cut ours in half to make them the right size after we removed staples. We realized nurses were taking scissors and cutting them in half, which introduced bacteria on to the Steri-Strip."

The supply orders were changed so that nurses had the smaller bandages available for post-op cesarean section patients, and nurses were instructed to stop cutting bandages to fit. Hand hygiene also was emphasized more during the staple removal process.

"People were touching the bed and going back to take out a staple, not being as clean as they could when they were taking out staples and caring for the incision," Korrub says. "We also had nurses in the habit of putting a pad across the incision site, but we stopped doing that because the doctors' orders are to remove any dressing after the first 48 hours."

From June 2015 to June 2016, the hospital had 13 readmissions for superficial SSIs, with *Escherichia coli* and *Staphylococcus aureus* isolated from wounds when cultured. The average loss to the hospital was $30,197 per readmission. In the same one-year period after the intervention, there were only four readmissions for superficial SSIs. That amounted to a savings of $272,769.

Hand hygiene showed improvements, according to nurse documentation of their own habits. Patients also showed evidence of better understanding of superficial SSIs, with 97% of post-discharge patients saying the tape stayed adhered to skin and 97% saying they showered and checked the incision daily.

"Everything took a lot longer than expected, but the results were worthwhile," Korrub says. "It can take a long time to make changes in a hospital, even something as simple as getting the right size Steri-Strips. It's not enough when your manager says it's a great idea, because she has a manager, and they have a manager, and it's a whole process to go through. Stick with it." ■

SOURCE

- Lauren Korrub, RN, BSN, Clinical Nurse, Sharp Mary Birch Hospital for Women & Newborns, San Diego. Phone: (773) 931-4916. Email: lqg103@gmail.com.

Patients Threatened by Gaps in Care When They Change Settings

Patient safety and quality of care are threatened when patients move from one setting to another, but there are strategies that can address those gaps in care. A recent report in the *The Joint Commission Journal on Quality and Patient Safety* addressed the risk, specifically in the transition of care from a hospital to a skilled nursing facility (SNF), noting that these transfers often are marked by delays in executing treatment plans and poor communication among providers. In addition, SNF clinicians often have the impression that hospital clinicians are unwilling to address errors or concerns after patients leave the hospital. The study notes that 23% of patients discharged from a hospital to an SNF will be readmitted to the hospital within 30 days. *(The full study is available online at http://bit.ly/2jvn75a.)*

The report supports the fact that many hospital readmissions are driven by the SNF's inability to properly care for the transferred patient, says **Larry Burnett**, RN, a principal with KPMG Consulting in Phoenix.

"If you have a patient who's been well cared for by a hospitalist and staff who are familiar with the condition and ready to answer questions, it's no surprise that when you transfer the patient to a facility without that physician support and knowledgeable staff, readmissions will occur," Burnett says.

"We see that a lot. The solution is coordination between acute care and post-acute care, particularly with finding the appropriate place for the patient to be transferred," he says.

The study notes that hospital clinicians often are challenged to find good discharge options.

"These providers often struggled to identify a safe, appropriate care setting for patients with complicated medical and psychosocial needs. They grappled with financial policies that limited the availability of services for patients, including payer sources and reimbursement rates," according to the report.

Collaboration Is Key

"Respondents emphasized the importance of communication but encountered significant barriers when exchanging information, including hospital providers' poor knowledge about SNFs, inaccurate and incomplete documentation, and work flow challenges," the report states.

Cases involving trach and ventilator patients show how quality of care suffers in transitions, Burnett says. "The average length of stay in a hospital for trach and vent patients is about 28 days, and getting them to a skilled nursing facility is actually better for them. Studies show that if you don't take the patient off the vent in about seven days, you're not likely to get them off the vent for quite a while," Burnett says.

"So, leaving them in a hospital in the ICU is not the best thing. You want to get them to a facility that can wean them off the vent, but if you don't find the right kind of facility with the right skills and resources, they will be right back at your hospital," he adds.

The study authors say hospitals, SNFs, and research programs must work across institutional silos to improve care and transitions.

"This could include establishing direct communication channels between sending and receiving providers, working collaboratively on care plans that follow the patient from hospitalization through community discharge, instituting tours or visiting rotations through healthcare institutions, and identifying opportunities for facilities to manage costs across the continuum of care," the authors wrote.

Hospital-to-SNF transfers can be improved with strategies such as hosting an interactive demonstration of the electronic referral system, convening a multidisciplinary team to conduct root cause analyses of 30-day unplanned readmissions, administering a survey assessing SNF clinicians' experiences with hospital discharges, and implementing a telephone report between hospital and SNF clinicians before patient discharge, the study suggests.

Case Management Problems

One challenge for hospitals is how to get physicians involved in a patient's care after a transfer, Burnett says. The growing popularity of hospitalists complicates the issue, with up to 80% of patients in some acute care hospitals cared for by a hospitalist,

Burnett says. "There's a huge break in the system when you try to get the patient back under the care of a physician in the community," he says.

"It's important that the case management system include components that get the patient appointments with a doctor who understands the care they've received so far and can take over in a seamless fashion. That's where people are getting tripped up on many occasions," he adds.

In many cases, hospital physicians are skeptical of the SNFs that are available for patient transfer and with good reason, Burnett says. That doesn't mean hospitals can absolve themselves of any responsibility for the quality of care after discharge, he says. Some hospitals are working with SNFs to improve their care, and Burnett says that, ultimately, is the best solution.

"It's a long, slow, painful process for most healthcare organizations. But until we get that care redesign built up more and better physician coverage in these skilled nursing facilities, hospitals are still going to suffer with readmissions and poor outcomes," Burnett says. "It is in their best interest to work with these downstream facilities to improve transitions and reduce these gaps in care." ■

SOURCE

- **Larry Burnett**, RN, Principal, KPMG Consulting, Phoenix, AZ. Phone: (480) 254-0851. Email: larryburnett@kpmg.com.

Meaningful Recognition Reduces Burnout and Improves Satisfaction

Compassion fatigue threatens patient safety and quality of care, but it can be addressed with meaningful recognition of the contributions of nursing staff, according to a recent report.

The researchers studied 726 ICU nurses in 14 hospitals with meaningful recognition programs. They also studied 410 nurses in 10 hospitals that did not.

According to material cited in the study, younger nurses and those with less work experience are more likely to suffer.

That earlier research found ties to low levels of support from management and working in environments considered "high risk." Nurses suffering compassion fatigue are more likely to quit their jobs, the study notes. Nearly 20% of nurses leave the profession in the first year, they noted.

The researchers found that "similar levels of burnout, secondary traumatic stress, compassion satisfaction, overall satisfaction, and intent to leave were reported by nurses" regardless of whether the hospital had a meaningful recognition program.

However, "meaningful recognition was a significant predictor of decreased burnout and increased compassion satisfaction. Job satisfaction and job enjoyment were highly predictive of decreased burnout, decreased secondary traumatic stress, and increased compassion satisfaction," they reported. *(The full study is available online at: http://bit.ly/2k9gSbu.)*

Compassion Satisfaction

The research shows that meaningful recognition has a significant effect on nurses, says study author **Lesly A. Kelly**, RN, PhD, assistant professor at Arizona State University in Phoenix.

"Nurses who have been recognized have lower burnout and have higher compassion satisfaction," she says. "It's not necessarily even getting the award. It can be just getting the nomination. Either way, the key is to make it meaningful within the community of that nurse and the people he or she works with, with a recognition ceremony for the award recipient and also letting the others know that they were nominated and giving them some sign of that, like a pin they can wear on their badge."

Kelly notes that there is a connection between compassion fatigue, meaningful recognition, and quality of care.

"This is about creating a healthy work environment, and it has been shown that when nurses practice in a healthy work environment they are able to produce better outcomes for patients," Kelly says. "Meaningful recognition is one part of a healthy work environment." ■

SOURCE

- **Lesly A. Kelly**, RN, PHD, Assistant Professor, Arizona State University, Phoenix. Email: lesly.kelly@asu.edu.

Administrator Says CMS Working to Reduce Quality Requirements

CMS Administrator Seema Verma said recently at the Health Care Payment Learning and Action Network (LAN) Fall Summit that the agency is working to reduce the regulatory burden on hospitals by reducing the quality measurement requirements.

Verma announced what she called a "new comprehensive initiative on quality measures to reduce the burden of reporting called 'Meaningful Measures.'"

"Since assuming my role at CMS, we are moving the agency to focus on patients first. To do this, one of our top priorities is to ease regulatory burden that is destroying the doctor-patient relationship. We want doctors to be able to deliver the best quality care to their patients," Verma said.

"Regulations have their place and are important to ensuring quality, integrity, and safety in our healthcare system. But, if rules are misguided, outdated, or are too complex, they can have a suffocating effect on healthcare delivery by shifting the focus of providers away from the patient and toward unnecessary paperwork, and ultimately increase the cost of care."

She noted that CMS recently announced its new initiative, "Patients Over Paperwork," to address regulatory burden by assessing existing requirements and eliminating, or changing, those that do not benefit patients.

"As many of you are painfully aware, CMS is one of the leading agencies for promulgating regulations within the federal government. We publish nearly 11,000 pages of regulation every year. That's a lot of paper … and it's taking doctors away from what matters most — patients," she said.

"The American Hospital Association, last week, published a report showing that health systems, hospitals, and post-acute care providers must comply with 629 mandatory regulatory requirements … and these entities spend nearly $39 billion a year solely on the administrative activities."

> "WE PUBLISH NEARLY 11,000 PAGES OF REGULATION EVERY YEAR. THAT'S A LOT OF PAPER … AND IT'S TAKING DOCTORS AWAY FROM WHAT MATTERS MOST — PATIENTS."

The report also showed that an average-size hospital dedicates 59 full-time employees to regulatory compliance, she noted. "That's a lot of provider time, money, and resources focused on paperwork instead of patients."

Verma also discussed the Medicare Access and CHIP Reauthorization Act (MACRA), a complex new Medicare payment system for doctors that ended the Sustainable Growth Rate formula, which threatened severe Medicare payment cuts every year.

"But, in its place, our implementation of MACRA included extensive reporting requirements — more boxes for physicians to check. At this time, the only way to avoid MACRA's extensive reporting requirements is for physicians to take on risk to be part of Advanced Alternative Payment Models, or APMs, which many practices are simply not ready for. Moreover, we have few Advanced APM models available — and hardly any for specialists," she said.

"We are hearing that doctors are overwhelmed by MACRA's new requirements and confused about the steps that they need to take."

As part of efforts to minimize burden in implementation of MACRA, CMS is reexamining the process for conducting quality measurement "across the board," Verma said.

"We want to move to a system that pays for value and quality — but how we define value and quality today is a problem. We all know it: Clinicians and hospitals have to report an array of measures to different payers," she said. "The measures are often different and there are many steps involved in submitting them, taking time away from patients. Moreover, it's not clear whether all of these measures are actually improving patient outcomes."

She noted that inpatient hospitals report up to 61 quality

measures, and 12 of them are "chart abstracted," meaning that hospital staff must manually enter the values.

"Some family practitioners have to report nearly 30 measures to seven different payers, again which leads to less time focused on patients and is contributing to clinician burnout," Verma said. "We have too many measures. We are measuring process and not outcomes."

The new Meaningful Measures takes a new approach to quality measures to reduce the burden of reporting on all providers, she said.

"Meaningful Measures will involve only assessing those core issues that are the most vital to providing high-quality care and improving patient outcomes," she said. "It's better to focus on achieving results, as opposed to having CMS try to micromanage and measure processes. The ultimate goal of Meaningful Measures is to direct efforts on high-priority areas." ■

Study Finds ACA Penalties Linked to Higher Mortality

Affordable Care Act (ACA) financial penalties intended to discourage repeat hospitalizations are associated with higher mortality rates for patients with heart failure, according to a recent study.

The Hospital Readmissions Reduction Program (HRRP) penalizes hospitals with high rates of readmissions within 30 days of discharge for Medicare patients with heart failure, pneumonia, and heart attacks, and the research suggests that this strategy has been effective in one sense.

Data on 115,245 heart failure patients hospitalized from 2006 to 2014 indicated that readmission rates dropped from 20% before the ACA penalties took effect to 18.4% after.

However, that was not necessarily good for patients.

The proportion of patients who died within 30 days of going home increased from 7.2% to 8.6% in the same period.

Further, one-year mortality rates climbed from 31.3% to 36.3%, researchers from the David Geffen School of Medicine at the University of California, Los Angeles reported.

The researchers looked at three distinct time periods: before the ACA, from Jan. 1, 2006, to March 31, 2010; during an ACA implementation period from April 1, 2010, to Sept. 30, 2012; and after readmission penalties kicked in, from Oct.1, 2012, to Dec. 31, 2014.

"Among fee-for-service Medicare beneficiaries discharged after heart failure hospitalizations, implementation of the HRRP was temporally associated with a reduction in 30-day and one-year readmissions, but an increase in 30-day and one-year mortality," the researchers concluded. "If confirmed, this finding may require reconsideration of the HRRP in heart failure."

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

Thyroidectomy Measures Could Be Good Hospital Metrics

Some thyroidectomy outcome measures could be useful as national hospital quality improvement metrics, according to a recent study.

Data from a retrospective cohort study indicated that hospital performance is related to postoperative hypocalcemia and recurrent laryngeal nerve (RLN) injury, a correlation close enough to suggest that the measure could be used to assess overall hospital quality.

Thirty-day hypocalcemia and RLN injury rates were lower among the best-performing hospitals participating in the ACS National Surgical Quality Improvement Program (ACS-NSQIP), the researchers reported.

For hypocalcemia, four hospitals were considered low and seven were high outliers. For RLN injury, eight hospitals were low and 14 were high outliers.

The authors noted that more than 70,000 thyroidectomies are performed annually in the United States. The most relevant potential complications are hypocalcemia, RLN injury, and cervical hematoma, they say.

The analysis included

14,540 patients who underwent thyroidectomies at 98 hospitals. Hospital performance varied for hypocalcemia and RLN injury but not for hematoma.

"Hospital performance rankings were largely unaffected by the inclusion of thyroidectomy-specific data in risk adjustment. With regard to processes, patients undergoing thyroidectomies at the best-performing vs. worst-performing hospitals less frequently had their postoperative parathyroid hormone level measured [19.9% vs. 31.7%], and more often were prescribed oral calcium, vitamin D, or both [76.6% vs. 66.8%]," according to the report. "When profiled by RLN injury, use of energy devices [69.1% vs. 507 55.2%] and intraoperative nerve monitoring [55.7% vs. 346 37.7%] were more prevalent at the best, compared with the worst-performing hospitals."

The researchers concluded that "Postoperative hypocalcemia and RLN injury, but not hematoma, potentially could be used as thyroidectomy-specific national hospital quality improvement metrics. Strategies aimed at reducing these complications after thyroidectomy may improve the care of these patients."

An abstract of the study is available online at: http://bit.ly/2Au9U7g. ■

Choose Your Value-based Model Wisely, AHA Report Says

A report from the American Hospital Association concluded that although quality and outcomes are gaining prominence in determining revenue for healthcare organizations, determining how to apply them in new reimbursement models is not always clear.

Hospitals must remain nimble to adapt to new developments and change plans when necessary, the report says.

"Hospitals and health systems — influenced by both policy and market forces — are increasingly moving away from fee-for-service payments toward value-based arrangements," the Trendwatch report says.

"There is no single model that will work for every organization. Hospital and health system leaders should assess the personnel, infrastructure, and other capabilities required for success in each model when considering the most appropriate path for their organization."

The report offers these takeaways on transitioning to value-based payment (VBP):

- "The movement to VBP is being driven by a combination of rising healthcare expenditures, declining reimbursement for Medicare and Medicaid, federal and state policy, market competition, and payer dynamics."
- "There is no 'one-size-fits-all' approach to VBP for hospitals and health systems — leaders will need to assess the most appropriate model for their community and organization."
- "Past experience with VBP arrangements, organizational capabilities and culture, and market and policy forces influence the ability of hospitals and health systems to succeed in shared savings and population-based VBP models."

Because individual and group incentives are different from fee-for-service models, some hospitals and health systems have found that moving to VBP requires changing the organization's culture, the AHA report notes. "These efforts may include changing the organization's governance and reporting structures and ensuring that clinicians are engaged and represented in leadership roles," it says.

The report emphasizes that even when hospitals and health systems determine a value-based "destination," that may have to change over time.

"Leaders will want to frequently revisit their vision and objectives to assess which model may best help them achieve organizational goals and understand the tools, information, resources, and delivery network required to succeed in a particular model."

The full report is available online at: http://bit.ly/2jOrbh1. ■

COMING IN FUTURE MONTHS

- Peer Review Legal Trap
- Best Career Moves in Quality
- Most Effective Quality Measures

HOSPITAL PEER REVIEW
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

Most Clinicians Admit to Sharing EMR Passwords

A majority of medical staff surveyed recently said they have accessed an electronic medical record (EMR) system using a password improperly supplied by a fellow medical staffer, and explained that strict confidentiality rules can make it difficult to get the data needed to do their jobs properly.

The survey results are part of the first study to examine EMR access among medical providers. In the study, researchers gathered survey responses from 299 medical professionals, including residents, medical students, interns, and nurses. The research team included researchers from Ben-Gurion University of the Negev, Harvard Medical School, Duke University, Hadassah-Hebrew University Medical Center, and the Interdisciplinary Center in Herzliya, Israel. *(The survey results are available online at http://bit.ly/2x2tdiw.)*

Nearly three-quarters (73%) of the 299 participants claimed to have used another medical staff member's password to access an EMR at work, and more than 57% of participants (171 out of 299) estimated they have used someone else's password an average of 4.75 times.

All medical residents said they had obtained another medical staff member's password with consent. Within the student and intern groups, 77% and 83%, respectively, used someone else's access credentials because they said they "were not given a user account."

In addition, 56% of students and almost 70% of interns cited that their user access had inadequate permissions "to fulfill my duties," forcing them to ask for someone else's access credentials. Only half of the nurses surveyed (57.5%) reported using someone else's password. The researchers offer these recommendations:

- Attaining access credentials needs to be less difficult and time-consuming.
- "Understaffed hospitals, especially during on-call hours, may need to delegate administrative tasks and extend EMR system access to paramedical, junior staff, interns, and students," they wrote. "Nurses, who generally carry out more precisely defined duties, are more likely to have the EMR privileges they need."
- "Healthcare organizations should add an option for each EMR role that grants maximum privileges for one-time use only. When this option is invoked, the senior physician and a protected health information security officer would be informed," the researchers wrote. "This would allow junior staff to make urgent, lifesaving decisions under formal retrospective supervision without having to sneak onto the EMR." ■