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Focus on QAPI Helps Hospital Overcome Bad Survey

A poor accreditation survey is bad news for any hospital, but with the right approach it can be the beginning of systematic improvements that improve quality throughout the organization. That was the experience of one hospital that received an extensive list of deficiencies in a Healthcare Facilities Accreditation Program (HFAP) survey but bounced back and now receives outstanding scores.

For three years after receiving the survey report, Wilson Memorial Hospital in Sydney, OH, invested time and energy into quality improvement based on HFAP's guidance and recommendations. By the next survey, the hospital had completely corrected all the deficiencies and implemented a sustainable system for ongoing quality improvement.

Wilson switched from Joint Commission accreditation to HFAP in 2007, partly because hospital leaders had grown weary of what they saw as TJC's view that there was only one way to meet quality standards, says chief nursing officer **Linda Maurer**, RN, MSN. Having been through several HFAP surveys now, Maurer says HFAP surveyors are more educational and supportive.

> A POOR ACCREDITATION SURVEY IS BAD NEWS, BUT WITH THE RIGHT APPROACH IT CAN BE THE BEGINNING OF SYSTEMATIC IMPROVEMENTS.

"They are very communicative and allow you to share your story about how you are meeting the quality standards. There are standards that must be met, but they truly believe there is more than one way to meet the standard," Maurer says. "I also appreciate the fact that their surveyors are living

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day to day in hospitals, working in hospitals full-time, and only doing surveys in addition to their regular job. They're very supportive and will sit down to talk with you about what you're doing to meet a standard, helping you understand if you're meeting the intent of the standard."

Bad Results on QAPI

In a 2013 HFAP survey, Wilson Memorial did not fare well on many quality measures, particularly quality assessment and performance indicators (QAPIs).

"Just about anywhere you saw QAPI in the survey, we were deficient. We really didn't have effective QAPI," Maurer recalls. "We were very good at collecting data and that's what we were calling QAPI. But just collecting data is not quality. Quality is collecting data and using that data to direct the outcomes that your patients deserve."

At the exit interview with the HFAP surveyors, before receiving the final report, Wilson Memorial leaders heard "QAPI" over and over again in the summary of findings. As soon as the surveyors left, the hospital leaders discussed the implications of the deficiencies.

"The executive team was still sitting there and we looked at each other, saying this is a big deal. We decided that we as an organization need to understand that quality is more important than finances," she says.

"We had to decide if we were willing to put forth the time, energy, and resources necessary to make this change. There wasn't anyone in the room we had to convince."

Deficiency Report as Road Map

Maurer and other hospital leaders responded to the poor survey results by systematically reviewing all HFAP quality measures, particularly those involving QAPIs. They also used the HFAP deficiency report to focus on where change was needed in the organization.

An HFAP-accredited organization must have QAPI indicators that are reviewed regularly and communicated effectively to the hospital board, but Wilson's leaders realized they did not have effective systems in place for QAPI even though they were collecting data.

"We have a spreadsheet now that shows everything that has to be reported up to the board and which HFAP standard requires it to be reported," Maurer says.

"We also have a monthly QAPI committee meeting in which departments report their data, along with what they are doing to affect that data and improve the quality of care within their department. We have hospital goals and each department has goals for their own data."

A key strategy was to better educate staff and clinicians about the difference between merely collecting data and actually using it to implement changes, she says. Every department has a key process indicator (KPI) board displaying its quality indicators, some of them updated daily.

The executive team also visits a department every weekday morning to review the indicators.

"We're there to support them and ensure there are no roadblocks

in the way to improving their data. We want to know if there is anything we, as the executive team, can do to help them succeed and improve," Maurer says.

"Each department's data also is compiled on a monthly basis and reviewed by the QAPI committee, which then passes it on to the board," she adds.

Board Is Now on Board

The board now is far more involved in quality issues than at the time of the 2013 survey, Maurer says. At that time, board meetings usually focused every month on finances and quality was on the agenda four times a year. Now, the board reviews a quality report every month just as it reviews a financial report, Maurer says.

"Getting the board in that mindset was not as big a challenge as I thought it might be. One of the board members had a background in quality, and we had that person chair our quality committee," she says. "When we went to them with the HFAP deficiency report, they became invested in that. It wasn't a matter of telling us that's our job and we should go fix it."

The hospital also adopted Lean process improvement methods to address specific issues. One problem involved the delays in getting patients from the ED to an inpatient bed. Once admitted by a physician, it sometimes took hours to get a patient to his or her room.

A Lean process improvement committee was formed with emergency and med-surg staff, the frontline people actually involved in the issue, along with senior leaders.

The committee mapped out the current process for moving patients from the ED to inpatient beds, then applied Lean process improvement. The committee looked for patterns and behavioral issues that were affecting patients moving from the ED to inpatient care.

"By the end of the week, we had a completely new process in place designed by the bedside staff. That's how you gain buy-in, because they're the ones who do the work," Maurer says. "Now, we can get patients from the ED into a bed within 60 minutes the majority of the time, instead of hours. That is a key process indicator that the ED tracks."

Journey With No End

That experience became the model for how Wilson Memorial handles all quality process issues now, Maurer says. Part of the approach involves using a Kaizen event, which typically is a short-duration improvement project with a specific goal, involving those people directly involved in the process and, perhaps, representatives from support areas or hospital leadership.

"We find a problem, we create a team, we have a Kaizen event, add an indicator to our key process indicator board, and we improve it," Maurer says. "This organization has always been fabulous at collecting data for the past 20 years, but we never did anything with it. Now, we use that data to improve process."

Hospital leaders also have adopted the outlook that accreditation is a journey with no end, Maurer says. There may be points at which you realize you're not meeting a standard and need to put a team in place to address it, she says, but you don't put that off until time for a survey.

"You don't want a culture in which you scramble to comply with standards every three years," Maurer says. "This is a journey in which you're constantly measuring and assessing, and looking for opportunities to improve. Getting everyone into that way of thinking is a big step toward improving the care your patients receive, and then a survey is just a formality."

Much Improved Survey Results

The five years since the disappointing survey have brought significant improvements to the hospital, says **Sue Neumann**, RNC, MS, CPHRM, CPPS, director of quality, risk management, and corporate compliance. Wilson Memorial now has four stars on Hospital Compare, an "A" rating from Leapfrog, and excellent HFAP survey results.

HFAP surveys facilities every three years, and the 2016 surveyors told Neumann and Maurer that they were bracing for a number of deficiencies after reading the previous report. But in the end, the surveyors did not cite Wilson Memorial for any QAPI deficiencies in 2016, and there were few other deficiencies.

The HFAP surveyors were surprised that the hospital could make such significant changes in only three years.

"This should be encouraging for hospitals out there that are struggling. It is possible. You can get there," Neumann says. "You just

have to be very intentional about how you do it."

Getting the hospital board to prioritize quality improvement is crucial, Neumann says.

"It's important to get the board to recognize that this is just as important as finances and patient satisfaction, the things that the board usually can grasp more easily," she says. "We're all pulled in different directions, and the board is no different. They have to be shown that this is something to prioritize."

Neumann also points out the value of hiring high-quality assistive personnel.

"It's hard to keep all the plates spinning, and having the right support personnel can make a difference. It's important for senior leaders to understand the value of those ancillary personnel who help keep things going," she says. "That is an important part of what makes our quality program work here: the fact that we have excellent support staff who keep things from falling through the cracks."

That's not possible in some hospitals because everyone is trying to operate on such small margins, but good support staff are worth far more than whatever you have to pay for them, she says.

"We are a team of three in my office. You don't have to have 20 people doing this, but you need people who can help you organize and utilize technology to get the information out in a way that can be understood," she says. "People who live in small communities deserve high-quality care, and I believe we can do it in small community hospitals. We just have to look at how to do it creatively. We're an example of that." ■

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Patient Engagement, Net Promoter Scores Increased With Feedback

Improving patient feedback can dramatically increase engagement levels with caregivers and decrease turnover, leading to an overall improvement in the quality of care, one hospital reports.

Those results at Methodist Hospital of Southern California, in Arcadia, came from improving patient satisfaction and engagement by providing patients and family members an anonymous, real-time way to review the care received. The system also provides caregivers an opportunity to receive that feedback immediately and improve service delivery when possible.

The hospital adopted the system in June 2017, first employing it to gather baseline data on patient reviews before making that information available to staff in the form of individual scorecards in September 2017, says **Darlene Burge**, director of service excellence/volunteer services. Patient satisfaction scores spiked in October and December, she says.

"We also started getting positive letters from patients and families praising specific employees, and they started mentioning names we hadn't seen in the past, people we didn't necessarily consider our 'A' players," Burge says. "It was interesting to see how the system is transitioning employee behavior. We know our data is very young, but the numbers are sustaining and improving every month."

The same methodology at the Florida's Special Care Unit at North Broward Hospital in Ft. Lauderdale doubled the unit's engagement levels among its caregivers, showing a 39% improvement in Net Promoter Score, a proprietary metric that can be used to measure patient satisfaction. The unit also experienced a decrease of 18% in care provider turnover.

Frequent, Anonymous Feedback

Methodist Hospital uses a software system with three major portals. One is "Patient/Family," where reviews on individual providers are taken during the time of their care. Another is "Employee," with an individual dashboard, and the last is "Admin," where managers get real-time visibility into employee performance and patient satisfaction.

Volunteers ask five questions

of patients and family members, such as whether the employee was kind to them, entering those data into the system with the names of any individual hospital employees mentioned. All surveys by patients and families are anonymous unless they self-identify for follow-up.

The employee dashboard allows individual employees to see how they are performing on a per-question basis in real time so that they are empowered to make behavioral change while being recognized for their strengths. (Methodist Hospital uses a system from Wambi in Los Angeles. Other patient feedback systems are available from RL in Cambridge, MA; RepuGen in Irvine, CA; and several other companies.)

Employees receive ongoing recognition through the dashboard, where they can see their overall patient satisfaction scores, compare their performance vs. the unit (but not other individual employees), and provide encouraging feedback to their peers. Employees accumulate points called PECKs, which stands for Providers Empowered by Compassion and Kindness.

Employees work to reach Silver, Gold, Rose Gold, and then Diamond levels after earning a defined accumulation of PECKs. When they hit their first level, Silver, they receive a silver pin to wear to work to share their achievement. They receive another pin for each level achieved.

"The caregivers are now aware that the attribution is coming to them individually. They can't hide behind a score for the whole floor," Burge says. "They can't say the floor's score is because of someone else's behavior and not theirs."

Gamification Makes It Work

The system works in part because it includes a "gaming" component, notes **Bobbie McCaffrey**, RN, vice president and chief nursing officer. Also called gamification, this is an increasingly common element in many feedback systems. It applies features familiar from game playing, such as scoring points, competing with others or against your own past scores, rules of play, and trophies.

"To be perfectly honest, I was a little skeptical because I've always believed that if you work in healthcare it's almost a sacred calling for you. That may not be the case for everyone, though, so you do have to reward people for doing a good job," McCaffrey says. "Everywhere you look everyone is doing something on their phones these days, and we have a ton of millennial employees who are sometimes more comfortable texting someone than engaging them personally. So we're taking advantage of their comfort level with technology, but at the same time encouraging them to engage with people more."

Employees can sign on to the hospital's webpage for the system and see a real-time update of their reviews and the points accumulated. In addition to recognition pins and praise, employees reaching certain point levels earn gift cards, starting at $5, that can be used in the hospital cafeteria or gift shop.

The hospital determined that any monetary rewards for gamification would be taxable income, which complicates accounting and diminishes the value for recipients. So, instead of providing cash, Methodist Hospital created its own internal dollars that can be spent in-house. The dollars can be spent immediately or accumulated, Burge explains.

"It's a competitive thing, which people seem to enjoy, and there is a tangible reward as well. Praise and recognition are very important, but people also like to receive an actual gift of some sort for doing well," McCaffrey says. "This all draws on people's natural tendencies to be rewarded for working hard."

Some Initial Skepticism

However, the system was not immediately welcomed by staff. Employees saw it as a rating that could be held against them, so they were waiting to see the negative repercussions from poor scores, Burge says. She and other hospital leaders wanted to focus more on rewarding positive behavior, so they celebrate positive feedback and high scores from the reviews, and they look for other opportunities to praise employees, such as articles in the hospital newsletter.

Employees soon accepted the review system and how it created individual accountability, Burge says.

"From a caregiver's perspective, it makes sense for them to do the right thing now because it is attributable to them instead of their good work being lost in a collective score for the entire unit or floor," Burge says. "People who provide the best customer service may not be the most popular with their co-workers because they're spending more time with the patient and less time getting tasks done. It rewards the behavior we're seeking, which is

interaction with the patients."

McCaffrey notes that, though the hospital tries to focus on positive reinforcement, poor reviews from patients and families can be instructive for individual employees.

"The employee can look at the score from a patient interaction and wonder what caused the patient to give such a low score. What caused that person to have such a negative impression of my interaction with them?" McCaffrey says. "It can lead the employee to be a little more reflective and consider how they are actually engaging the patient, how they can correct some of their performance to score higher."

Coaching Opportunities Revealed

Burge, McCaffrey, and their staff monitor individual employee scores, looking for opportunities to intervene if the surveys show an employee is falling short in a particular area.

"I might see that one person is doing poorly in communication and that the concerns are all about how he or she communicates discharge instructions. We can go to that person and say, 'We want to help you get better scores in this area,'" Burge says. "That might mean asking the employee to go through the discharge process with us and help them hone their skills to get the maximum number of points. Previously, we might have known that this person wasn't considered a great communicator, but we wouldn't know where to start with coaching."

Each employee's performance dashboard breaks down the accumulated points, how close they are to getting a reward, and how they compare to other employees. The hospital originally set the threshold for rewards too high, at 2,000 points for the first gift card, and recently reduced it to 1,500, McCaffrey notes.

"We didn't want to start so low that it just seemed like a giveaway, but we found that it was a bit harder than we intended for them to reach that first $5 gift card," she says. "We lowered the points needed so that it's still a stretch and they feel like they earned it, but they get the positive reinforcement from the reward without waiting so long that it becomes counterproductive."

In addition to individual scores and rewards, the system compiles an overall score for the unit or floor, which can be rewarded for achievements like having no falls or infections during the month, Burge says. Each member of the team receives points for the unit's achievement, such as 150 points if the unit had no falls that month. The goal is to encourage a sense of teamwork and shared responsibility at the same time individuals are recognized for their particular work, she says.

Looking for HCAHPS Correlation

Administrators monitor scores for each unit or floor, looking for correlation between positive feedback Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

"If I see that 5 North historically has not done very well in HCAHPS but it's now seeing positive comments in our surveys, I expect to see that same trend in HCAHPS," Burge says. "If we see a conflict there, we have to dig deeper to find out what is registering on one but not in the other, and which is more accurate. We do a lot of analysis on the back end to make sure what we're seeing is really valid."

The first three months with the system produced positive trends, but McCaffrey notes that a six-month trend is considered necessary to be statistically valid.

The review system engages employees in a way that is different from the routine encouragement to improve HCAHPS scores, says **Jason Sydenham**, RN, BSN, MBA, 4 North Unit manager. Staff become accustomed to hearing about the importance of patient satisfaction and HCAHPS scores, he says, but a system providing feedback on a microscopic level gets them involved in a different way, he says.

"People may have the best intentions and still become numb to the constant talk about HCAHPS. With this, I have people coming up to me and actively engaged, wanting to know more about how they can earn more points, whether they're going to get points for having no falls this month," Sydenham says. "They come to me on the 29 of the month, asking about scores because they want to achieve a good score before the end of the month." ■

SOURCES

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Streamlining Metrics Helps With 'Measurement Mania'

Quality metrics should be streamlined to focus only on those that truly affect the care provided to patients, a physician group says.

The medical community is slowly realizing that an overabundance of metrics is detrimental to the cause of improving healthcare, says **Steven Green**, MD, chief medical officer at Sharp Rees-Stealy Medical Group in San Diego, and secretary of the Council of Accountable Physician Practices (CAPP), a coalition of multispecialty medical groups and health systems based in Alexandria, VA.

One physician says "measurement mania" is bogging down efforts to provide quality care.

The challenge is getting physicians and other healthcare leaders to see the big picture and not just their own slice of healthcare, Green says.

"I hear from physicians that they want the measurements to be streamlined, but I'm not sure everyone is on board yet because there are a lot of people involved and they all have good intentions. People want to add just one more metric to the list because in their particular area of medicine, it would be a laudable metric that is worth tracking," Green says. "They don't realize that in the great scheme of things it just becomes too many. A health plan adds one, state organizations add one, and if this isn't limited and coordinated, it can quickly get overwhelming."

Report Calls for Streamlining

CAPP recently released a report noting that though the country has made progress in measuring quality of care, lack of coordination has produced an overabundance of measures that are confusing to everyone. Lack of coordination among quality measurement initiatives creates multiple parallel systems with hundreds of measures, the report says. It calls the current system of measures fragmented and redundant. *(The report is available online at http://bit.ly/2nq3q0A. See the sidebar on pages 32 and 33 for excerpts from the report.)*

Green notes that research has shown physicians spend an average of 785 hours per calendar year reporting external quality initiatives — time that could be better used caring for up to nine more patients per week.

Preventive care and chronic disease management are among the most useful metrics on which to focus, Green says. His medical group focuses on quality measures for conditions such as diabetes and blood pressure because there is substantial opportunity to improve patient health and avoid complications through interventions guided by metrics, he says.

"We put a lot of emphasis on getting patients to their goals, and on issues like hospital admission rates. About two-thirds of our patients are in managed care, so it's important to us for our group's finances and to our patients to keep hospital admissions down," Green says. "We've managed to achieve a rate of 186 admissions per thousand senior patients, but that takes a lot of coordination with making sure patients have access to care in outpatient settings. It's also a matter of keeping their chronic conditions under control so they're just less likely to need hospitalization."

The medical group also looks at service metrics, devoting a good deal of time and resources to educating staff about patient relations. Over 15 years, the group has raised its service metrics from the 15th percentile to the 85th percentile nationally.

"That is useful not just from the standpoint of being able to brag about it, but if patients and physicians have a good relationship it is much more likely that patients will bring up concerns to the doctor," Green says. "Access to care

is another metric we focus on, so that when patients have a concern they get help in the way that makes the most sense. In the past year we've increased the use of patient portal messages by 25%, and we've also increased the use of phone or video visits."

Physician Leadership Needed

Streamlining metrics and getting the most use from the ones you keep will require physician leadership, Green says.

"At department meetings, it is very common for us to be talking about these and we might have physicians with good measures share their best practices. It isn't something you can impose on people," Green says. "You have to work on the culture and get buy-in for it. Physicians have to recognize that this is good for the medical group as a whole and good for the patients."

Technology infrastructure also is important in making a focused metric approach work, Green says. For instance, the patient portal and electronic health record should be linked so that the system can alert a physician to care gaps, such as the patient coming in for an appointment while not on the proper medication.

Clinicians are bogged down with "measurement mania," says **Amy A. Adome**, MD, senior vice president for clinical effectiveness with Sharp Healthcare in San Diego. Green's medical group is affiliated with Sharp Healthcare.

"Many of the metrics are not voluntary, so you're just required to report them whether you think they yield anything useful or not.

Move to Fewer and Better Measures, Physicians Say

Existing quality measures should be winnowed down from several hundred to two dozen, according to "Moving the Needle to Meaningful Health Care Quality Measurement," the first in a three-part series of white papers by the Council of Accountable Physician Practices (CAPP), a coalition of multispecialty medical groups and health systems based in Alexandria, VA.

"An emphasis should be placed on measures for preventive care through immunizations and screenings, management of chronic diseases such as congestive heart failure and diabetes, and other areas where better performance translates into meaningful health improvements. Outcomes should also be measured more definitively," the report says. "For example, asthmatics should not just be measured on whether they received their medication, but whether they take it, whether they suffered any asthma attacks, and whether they were able to undertake their normal exercise regimen."

The CAPP report says a more meaningful quality measurement system would include both fewer and better measures, focusing on clinical areas with evidence that improvements in performance result in actual improvements to patient health.

CAPP advocates a set of about 24 measures in a limited number of domains. These would include prevention and chronic disease management and result in meaningful quality information.

"It is critical that physicians and other stakeholders continue to advance the science of outcomes (as opposed to process) measurement, focusing on those that are meaningful to patients — for example, return to normal functioning after illness. The initial focus for external reporting must be on areas where there is strong evidence that process improvements lead to clear improvements in population health and well-being. Examples include: immunization rates, colon cancer screening rates, use of beta-blockers in patients with heart failure, and control of lipids and blood pressure in diabetics," according to the report.

"Another important piece of ensuring the right measures is being nimble enough to change directions if the technology or science changes rapidly. For example, the Centers for Disease Control and Prevention recently recommended that 11- to 12-year-olds receive two doses of Human Papillomavirus vaccine at least six months apart, rather than the previously recommended three doses. However, many quality-reporting systems have not changed their standard, so that a medical practice complying with the clinical recommendation of two doses may be penalized financially for failing to meet the measurement standard of three doses." *(Continued on page 33)*

That is not a choice, and it can take considerable time and resources," Adome says. "Nevertheless, you have to find time to partner with physicians to come up with meaningful metrics."

Moving Toward Outcomes

The healthcare community generally agrees that there should be more focus on outcomes measurement than process measurement, but making that transition is not easy, Adome says.

"The struggle is that to get true outcome measurement, you have to be able to track patients across the continuum for an extended period of time. A physician who touches a patient in an outpatient clinic may not always know what the outcome of that patient is down the road," Adome says. "You can find that so many physicians have touched that patient through the continuum of care that it is hard to attribute the outcome to one individual provider. So as we think about these measures, we have to be careful around attribution."

Sharp Healthcare focuses on metrics that its physicians find useful in improving patient care, such as sepsis mortality, whether they are required or not. Physicians will engage best when they are involved in the decision-making, she says. Also, be sure to explain why a certain metric is being measured, particularly if it is one that is required and was not suggested by the physicians.

"Physicians are so busy during the day and may have no idea why a certain metric is required by the health system. Help them understand not just what is being measured, but why it is being measured," Adome says.

"The measurement system in place today is not perfect but the intentions are pure. Helping them understand the 'why' is an important way to engage the physicians," she adds.

The transition to outcomes measurement may have to come in small increments, she says.

"To manage the number of metrics means prioritization, taking on the challenge in slices. We agree on a couple of metrics per year that seem to make sense," Adome says. "Hunkering down and working hard on those metrics helps you chip away at the elephant." ■

(Continued from page 32) The healthcare community also should advance the science of outcomes measurement, CAPP says, focusing on outcomes that patients care about. The group cites the example of measuring whether an asthmatic adult received proper medication, when the measure that really matters is whether he or she suffered an acute asthma-related traumatic event or died. Another useful measure would be whether the prescribed treatment allowed the patient to continue his or her daily three-mile walks to and from work.

"One challenge in shifting from process to outcomes measures is the long time horizon required for many outcomes to become apparent. Healthcare buyers make purchasing decisions in one-year increments, an artifact of the one-year insurance cycle," according to the report. "Patients may switch plans and doctors each year, making it difficult to attribute high-quality, longer-term outcomes to the practice that originally provided the care." ■

SOURCES

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JAHF Age-friendly Initiative Showing Results

Hospitals are reporting positive results from a program sponsored by The John A. Hartford Foundation (JAHF), a nonprofit, nonpartisan organization in New York City that works to improve conditions for the care of older adults in the healthcare system.

The Age-Friendly Health System initiative seeks to improve care transitions and the way episodes of care are addressed for an aging population, says JAHF President **Terry Fulmer**, PhD, RN, FAAN.

Five health systems providing care in 40 states have adopted the program, which focuses on four key elements that can be applied to any

hospital or health system. JAHF calls them the four M's:

- what matters to the patient;
- medications;
- mobility;
- mentation, or mental activity.

This includes confusion, delirium, and mood.

JAHF also urges an age-friendly healthcare system to employ leadership committed to addressing ageism, a geriatric care prototype specific to older adults, clinical staff who are specifically trained and expert in the care of older adults, care teams that are high-performing and can show measurable results for care of older adults, a systematic approach for coordinating care with organizations beyond their walls, and a strategy to identify, coordinate with, and support family caregivers.

The organization also should elicit patient goals and preferences so as to define a plan of concordant care, reduce polypharmacy, address common geriatric syndromes, manage pain and symptoms, and support the needs of family and caregivers.

Fits Well in Population Health

The age-friendly initiative is an opportunity to explore population health and person-centric care models, says **Ann Hendrich**, PhD, RN, FAAN, senior vice president and chief quality/safety and nursing officer with Ascension Health in St. Louis. Ascension is adopting and testing many of the age-friendly prototype models not only in its population health management systems, but also on the acute care side, working directly with providers.

"In the area of pharmacy, there are a lot of medications that should be minimized or not used at all in the older adult. Often, they're unnecessary," Hendrich says. "We've worked with our pharmacists at a national health level to identify medications that can be minimized and avoided. We want to understand why the medication is needed before we provide it, especially if it might have an effect on mobility."

THE AGE-FRIENDLY INITIATIVE IS AN OPPORTUNITY TO EXPLORE POPULATION HEALTH AND PERSON-CENTRIC CARE MODELS.

Ascension also is addressing ways to explore what is most important to older adults, including end-of-life care decisions.

"In our clinic and ambulatory areas, our providers are changing the way they do assessments and taking histories, trying to understand what matters most to these patients. We are trying to have meaningful discussions about what they want and having that guide decisions in their care process," Hendrich says.

Four M's Provide Structure

The four M's of the JAHF Age-Friendly Health System initiative provide a structure for any organization to address the concerns of older Americans, Hendrich says.

"Those four M's apply to any healthcare system regardless of size, and in the ambulatory system as well," Hendrich says. "Ascension has set a goal of reaching 20,000 adults this year with age-friendly care, and I think every system could set a goal like that to see how many older adults they reach."

The age-friendly initiative should fit into any integrated model of care, she says.

"Don't consider it an add-on. Look at it as an integral part of your healthcare system's efforts to improve quality of care," Hendrich says. "Once you get your providers involved, these changes are not hard to implement with small numbers and then you grow from there. The impact on older adults can be tremendous. Our challenge is to scale these programs up quickly."

There are existing geriatric models of care, but they reach only about 10% of the older adults who need that kind of care, says **Amy Berman**, RN, LHD, FAAN, senior program officer with JAHF.

"We brought together the people who developed these models and looked at 17 that had the greatest spread and the highest degree of evidence, asking these innovators to deconstruct their models to find the key elements. We found there were 90 key elements and a lot of overlap, with about 24 common themes," Berman says. "Then, we asked the people who developed this evidence, leaders from health systems, and older adults to pick the things that would have the greatest impact on cost and quality. We wanted to find the things that would be the most influential in helping this group of patients have

a better life, and that became the four M's."

Interventions May Be Small

The four M's are implemented in various ways, including some small interventions. For instance, an older adult with cognitive impairment typically has a hospital length of stay 3.5 times longer than average, Berman notes. If that impairment is not recognized and addressed, nurses may take little notice of the fact that the patient did not eat a meal.

Under an age-friendly model, the clinician would be more attuned to that and perhaps suggest that family members stay with the patient during meal times, Berman says.

"One participating hospital is focusing on hydration. The typical bedside pitchers were not being used much, so they changed to the big cups with straws like people carry around in the park every day," Berman says. "They're finding that older adults are more comfortable with them and using them more, so hydration is improved. Something as simple as a cup and straw can have a huge impact because people who are dehydrated are at more risk of falls and delirium."

Mobility is another major concern. Clinicians can be so concerned about the risk of falls that they keep older patients immobile, which leads to an overall deterioration of health, Berman notes.

"Some facilities are implementing mobility programs that actively seek to keep older patients mobile and not let them decline to a state of immobility just because they are hospitalized," she says. "Some are making it a goal to improve the patient's mobility while an inpatient, even if that is unrelated to the primary reason for the hospitalization. This is a new way of looking at the care of older adults, but we're seeing organizations take these steps in the right direction." ■

SOURCES

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CMS Issues Text Message Guidance

CMS has issued clarification of its position regarding the use of text messaging with patient information between providers, saying it is "permissible if accomplished through a secure platform."

The clarification came after hospitals reported receiving emails from CMS that essentially said it had a zero-tolerance policy on text messaging and that it violated the HIPAA Security Rule and the Conditions of Participation (CoPs) or Conditions for Coverage (CfCs).

CMS now is backtracking on that stance, saying text messages are allowed if they are secure.

(The CMS memo is available online at: http://go.cms.gov/2As9SJ2.)

"CMS recognizes that the use of texting as a means of communication with other members of the healthcare team has become an essential and valuable means of communication among the team members. In order to be compliant with the CoPs or CfCs, all providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality as per HIPAA regulations and the CoPs or CfCs," according to the memo.

"It is expected that providers/organizations will implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized in order to avoid negative outcomes that could compromise the care of patients."

However, CMS underscored text messaging is not allowed for patient orders under any circumstances, even with a secure platform.

The CMS clarification is consistent with The Joint Commission (TJC)'s statement on text messaging from December 2016, which specifies that text messaging cannot be used to order patient care, treatment, or healthcare services. *(The TJC statement is available online at: http://bit.ly/2DTISsD.)*

TJC and CMS say they prefer computerized provider order entry because orders can be entered directly into the electronic health record. ■

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CE QUESTIONS

1. **In its 2013 Healthcare Facilities Accreditation Program (HFAP), what was the most common type of deficiency for Wilson Memorial Hospital in Sydney, OH?**

   a. Survey quality assessment and performance indicators (QAPIs)
   b. Life safety from fire
   c. Content of records
   d. Exercise of patient rights

2. **What was one strategy employed to improve quality after Wilson Memorial's poor survey results?**

   a. Decentralized quality improvement department
   b. Lean process improvement methods
   c. Tying quality metrics to individual employee pay rates
   d. More oversight of data security for quality metrics

3. **In the patient feedback system used at Methodist Hospital of Southern California, in Arcadia, how are reward points distributed?**

   a. Only to employees for their individual performance
   b. Only to units and floors for their collective performance
   c. To employees for their individual performance and also for the unit or floor's collective performance
   d. Only to department heads and supervisors for the performance of their staff

4. **How many reward points are now required at Methodist Hospital to earn the first gift card reward?**

   a. 2,500
   b. 2,000
   c. 1,500
   d. 1,000

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.