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Health System Goes From C's and D's to A's and B's in One Year

In one year, the seven hospitals of CHI Franciscan, based in Tacoma, WA, achieved extraordinary improvements in quality and safety. They did it by adopting more of a team-based approach to patient care, improving communication and reducing silos that prohibit information-sharing.

In 2017, the hospitals scored C's, D's, and one F from The Leapfrog Group, but the fall 2018 Hospital Safety Scores indicated across-the-board improvement in quality and safety ratings — all A's and B's.

CHI Franciscan altered processes to become more reliable around patient safety, explains **John Krueger**, MD, MPH, vice president of quality. He joined CHI Franciscan in 2016 and says he has never seen a health system improve its safety scores so quickly.

Across the seven hospitals, the Leapfrog raw safety score has increased 26% over 18 months, he says. The top hospital's raw score increased by 84%.

Seeking Systemwide Improvement

> "QUALITY IMPROVEMENT DOES NOT COME IN A PRETTY PACKAGE WITH A BOW.... IT'S A LOT OF GRITTY CONVERSATIONS WITH PEOPLE, JUST TRYING TO SOLVE PROBLEMS."

That happened because the health system focused on restructuring itself rather than simply seeking better grades, he says. Part of that restructuring included adopting more of Leapfrog's approach to patient safety.

"When I came here, we saw that there were some opportunities to really improve our scores, and … we thought the Leapfrog methodology had a lot of the structural

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and procedural components that would benefit our organization and our patients," Krueger says. "We saw that we could be most effective by overlaying the Leapfrog structure on our own."

CHI Franciscan uses its own measurement system, called Safety First. Leaders there realized that much of it corresponded well with the Leapfrog indicators. Safety First uses a mix of root cause analysis and failure mode and effects analysis. That allowed them to use the Safety First system to track their internal rating on a daily basis, identifying gaps and socializing best practices across the system, Krueger says.

"Safety First is about becoming a high-reliability organization, using methods that have been proven in the airline and nuclear industries," he says.

"Healthcare is starting down that path toward high reliability, but we're not there yet as an institution or as an industry. This effort takes us a step closer."

Sense of Urgency Required

CHI Franciscan used the eight-step model for change developed by leadership and change management guru John Kotter, a Harvard Business School professor. The first step involves creating a sense of urgency within the organization.

Within the health system, that was achieved using data from Safety First, the Leapfrog scores, and metrics from the CHI parent organization.

"We used that data to say to our hospitals, 'If our patients were going to get perfect care, where would we want all of these things to be?'" he says. "I spent a lot of time being a cheerleader, talking to people and trying to connect with them about why this was important. Everyone knew it, but this was about making it part of their conscious, daily activity."

The second step was to create a guiding team, or a "coalition of the willing," Krueger says. That team included Krueger and his colleagues in quality improvement, but they also had to recruit people from all seven facilities spread over a large geographic area.

"We made the decision right off the bat that we were not going to focus on one facility alone. We were going to try to move our entire organization together," Krueger says. "We knew that we could probably move one hospital to an A faster if we focused on that one facility, but we didn't focus on the grade. We focused on the methodology, on doing the simple things really well."

Easily Understood Goal

The team set a goal of having three hospitals with A grades and three with B grades by the end of 2018, which Krueger says was a simple way to explain the goal across the entire organization, including the board of directors.

The interim steps and improvements required to get there were more complicated, but it was important to have a message that could be communicated simply and effectively to a broad audience, Kruger says.

The board and CEO supported the effort fully, and Krueger says that was key to its success. That brought support from the rest of CHI Franciscan all the way down the line, he says. Such broad support was needed as the health system tackled the problems that led to poor Leapfrog scores.

"Improvement work is not pretty.

It's not a linear line; you sometimes have to go down to go back up," Kruger says. "That's exactly what we experienced, but we were persistent, trying to push forward through the barriers and just solve the problem that was in front of us."

The health system consulted Leapfrog for advice as well as other health systems and hospitals that had scored well. One strategy that emerged early on was for CHI Franciscan to focus on performing well on the scores from one external agency, such as Leapfrog, rather than trying to address performance on a number of outside measures.

Krueger worked closely with the health system's CEO and chief medical officer to confirm that the CHI Franciscan priorities aligned closely with Leapfrog methodology.

Leapfrog Provides Focus

Focusing on the Leapfrog formula helped CHI Franciscan target improvements more effectively rather than scattering resources across multiple quality improvement philosophies, Krueger says.

Krueger notes that CHI Franciscan leaders suspected the earlier poor Leapfrog scores were not entirely accurate in reflecting the quality of care, but the health system took responsibility for not adequately collecting and reporting data that might have improved the scores.

"The Leapfrog methodology does force you to be conscious and thoughtful about how you do things in your organization," Krueger says. "It causes you to focus more intently on assessing and improving what you already thought was high-quality care, and maybe it was, but with room to do better."

Lots of Communication

The CHI Franciscan team also learned the importance of "overcommunicating" about the quality improvement efforts, Krueger says.

"Across an organization as large as ours, with 1,200 clinicians, a large accountable care organization with more than 4,000 physicians, we did a lot of late-night meetings, early-morning meetings, to get in front of as many physicians as we could to communicate what we were doing with Leapfrog and why it was important," he says. "We made some real allies immediately by focusing on our intensive care units because we knew that was where our sickest and most vulnerable patients were."

Krueger's team relied on research from patient safety expert Peter Pronovost, MD, PhD, then John Hopkins Medicine's senior vice president, showing the value of intensivists in ICUs. The research was adopted by The Leapfrog Group to support its assessment of ICU physician staffing. *(The Pronovost research is available at: https://bit.ly/2Bobozy. Information on the related Leapfrog measure is available at: https://bit.ly/2Q7uvGv.)*

CHI Franciscan is now known in the region for its virtual ICU, which provides telemetry monitoring and remote oversight for high-risk patients from board-certified intensivists. Six of the system's hospitals now employ board-certified intensivists available at all times, either in person or virtually, Krueger says.

"Dr. Pronovost found that when you have board-certified intensivists working in your ICUs, the mortality rate drops 30%. That's pretty impressive, and when you're dropping mortality rates, you also lower other complication rates," Krueger says. "Communication was essential because we found out that our intensivists needed some support that would allow them to work more effectively. Getting those stakeholders on board was very important in driving that forward."

Frontline Staff Are Key

CHI Franciscan also emphasized involving every staff member on the front line, particularly by giving them the ability to do what they knew was right for the patient. They heard the organization leaders say that quality, safety, and the patient experience are the most important goals, but they sometimes felt they were constrained in achieving those aims, Krueger says.

"We empowered people to do the right thing. We granted them the power to always do what was in the best interest of the patient, and we have to be explicit about that in healthcare, exactly what that means," Kruger says. "We explained to them that if they ever have any concerns about a patient's safety or quality of care, they should notify someone either by contacting a supervisor, filing a report through our internal system, or simply asking for help. The challenge is convincing them that you really mean that."

Getting the entire organization, including frontline staff, involved in the campaign was one of the hardest parts, but it was key to success, Krueger says. Quality improvement professionals can impede their efforts by thinking they are the ones who will produce change within the organization, he says.

Eliminating Silos

One of the greatest transformations in the culture at CHI Franciscan was

getting staff members to feel like they are part of the quality improvement team rather than being told what they are doing wrong and how to improve, Krueger says.

"Our quality department here can be a consultant, doing data analysis and showing opportunities. We can have some influence over people, explain the methodology, and educate people, but we are not the ones doing the work on the front lines," Krueger says. "It is very important for those people on the front lines to know that we expect them to do the right thing for the patient, and if they don't understand parts of Leapfrog or why it's important, they can reach out to us."

Eliminating the silo in which quality improvement often is relegated made a difference, he says.

Krueger sees the different outlook up and down the line, with frontline staff and administrators embracing the quality improvement effort. The system's chief financial officer and human resources director will stop him in the hallway to ask about ongoing efforts and how they might contribute more, he says.

"Sometimes, because the Leapfrog score is such a large methodology, people don't understand how their role has an impact. Our success was tied to our ability to get all these people who might have been siloed to unite around the common goal of improving safety and quality," Krueger says.

Celebrate Quick Wins

Quick wins were important. Any time a unit had a positive experience like improving a patient safety metric, that was celebrated, Krueger says. The aim was to create momentum and not wait for grand achievements before rewarding those involved, he says.

CHI Franciscan also made a point of quickly and prominently acknowledging staff who brought concerns about safety and quality or who suggested a way to improve.

"Sometimes, it wasn't something we were proud of — an infection or problem that a staff member brought forward. But we championed the fact that they stepped forward and reported it, giving us the opportunity to address it," Krueger says. "We emphasized that this was the behavior we expected from our staff, recognized them for doing so, and thanked them."

The health system also emphasized that the focus was not on the score of any one hospital but rather improving the system structures and culture to improve care overall.

Anticipate Hard Work

Krueger says the CHI Franciscan experience shows that rapid improvement is possible, but he cautions other quality improvement leaders that the task can be formidable.

"It's going to be much harder work than most people anticipate. A lot of the work is very chaotic," Krueger says. "Quality improvement does not come in a pretty package with a bow. A chief nursing officer was telling me that quality improvement is usually about pretty explanations and posters, but the truth of the matter is it's a lot of gritty conversations with people, just trying to solve problems together."

The challenge going forward is to ensure that the changes are permanent and durable, Krueger says.

"You can see that something has transformed when you go out in the hospitals and visit people," Krueger says. "There is a new level of energy, and people are invigorated." ■

SOURCE

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Documentation in Peer Review Meetings: How Much Is Just Right?

The need for documentation of peer review meeting minutes is clear, but there are two schools of thought on how detailed records should be: general and broad to prevent their being used against participants in future challenges to their decisions, or detailed so that they provide a solid explanation and defense.

Many healthcare attorneys come down firmly on the side of keeping detailed records of peer review meeting minutes, says **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix. But detailed does not mean anything akin to a transcript.

Hitting that sweet spot can be tricky for some hospitals.

A very brief account of the meeting serves little purpose, Owens says, while a meatier version can be useful in adversarial proceedings

and serves as a record of what the committee has done in the past. The committee can draw on those records to guide its future actions.

In most states, peer review minutes are confidential and not discoverable in state court proceedings, Owens notes. However, they may be discoverable in federal proceedings. But even if they are not used in court, peer review minutes can be used in other disputes stemming from a physician against whom the peer review committee takes adverse action, Owens explains.

For example, if a physician may lose privileges, the minutes often are made available to the physician in preparation for the hearing. Owens believes it is appropriate for the physicians to have the minutes of the meeting.

"The minutes can be useful in showing that the medical staff committee, in particular the medical executive committee, has considered an issue, thought through it, and there was appropriate consideration of the options. That can be very helpful in establishing the medical executive committee's position," Owens says. "For that reason, I like minutes that contain some real substance."

Show Issues Were Discussed

Meeting minutes should reflect that the pros and cons of any adverse action were adequately discussed, and the substance of those discussions should be described briefly, Owens says.

The goal is to show that the committee discussed evidence, concerns, and options in a thorough manner but without providing excessive detail about the discussion or who said what, Owens says.

"I'm not in favor of meeting minutes that are essentially transcripts because that does not make sense and it is not efficient. I certainly would never recommend that minutes state the name of a particular physician member who made a statement," she explains. "That creates undue attention to a single physician who made a statement rather than the committee's action and how it came to that decision. I'd like the minutes to show that the committee thought about the issues and took action after reasonable discussion."

Hospitals vary widely in how they record peer review committee minutes, Owens says. She has worked with hospitals facing adversarial challenges by physicians and found that the committee minutes were far too detailed, with quotes attributed to named physicians.

"They include lots of information that is not necessary to understand why the committee did what it did," Owens says. "The minutes should provide that clear picture of how the committee reached its decision but without any extraneous information that will only draw focus away and create drama about something besides the real issue at hand."

Too much is not good, but Owens also has found that scanty meeting minutes create unnecessary problems. For instance, physicians justifiably argue that removing or limiting privileges is a major step that should come only after serious consideration, and hospitals should be able to show how the committee reached that decision, she says.

"I've seen minutes that just said, 'Discussion was held' and then the committee's decision, with no information about how that decision was reached," Owens says. "That's not good at all. The minutes are supposed to provide some history of what happened."

Minutes, Not a Transcript

Remember that peer review meeting minutes are not, and should not be, a transcript of the meeting, Owens says. What to include in the minutes is up to the hospital.

How much detail to include in the meeting minutes is the difficult point for hospitals. Some physicians and peer review leaders argue that the committee's decision is what really matters and including details of the discussion leading to that decision can put too much focus on the individual participants rather than what the committee as a whole decided, Owens explains.

"That can lead to all kinds of mischief even if individuals aren't named. You can still have people saying they know who was on the committee and that person's comments are identifiable even without a name attached, and that physician has an interest in seeing adverse action against the physician in question," she says. "That's why minutes need to be very carefully drafted, reviewed, and considered. When there is likely to be an adversarial proceeding, such as a medical staff hearing, it is a good idea to have legal counsel review the minutes before they are finalized."

Also, it is not just about how much detail should be included — it is about which details to include.

To illustrate the danger of poorly conceived minutes, Owens offers the example of minutes from a peer review meeting in which

members discussed allegations of another physician's misbehavior. The minutes indicate that one committee member said, "This physician is so stupid." In the context of the meeting, that comment might have been understood by all present as shorthand to mean the physician had made a series of poor choices.

"But you don't want to put 'This physician is stupid' in the minutes. I have seen things very similar to that in peer review minutes because you had someone who had not been trained in taking minutes, so they were just writing down what he or she heard," Owens explains. "A short phrase like that might be written down as a summary of the point being made or an example of many comments without considering whether it was appropriate and truly told the story of what the committee was doing. It creates a distraction that the physician can focus on and try to dissect as evidence of bias."

There also is a theoretical risk of stifling debate on peer review committees if the members feel such comments, or detailed accounts of the discussion, are going to end up in the minutes, Owens says. Fortunately, most proceedings from the medical executive committee do not involve issues or actions that will prompt a challenge from physicians, so committee members tend not to be shy about speaking their minds, she notes.

However, a habit of producing overly detailed meeting minutes could change that when a sensitive issue arises. The risk is highest when the meeting minutes are written in such a way as to allow the identification of committee members by those with the right knowledge, Owens notes. Peer review processes can be crippled if participants do not trust the hospital to protect their confidentiality, she says.

Train Staff for Discretion

A member of medical staff services will be responsible for producing peer review committee minutes, and that person should be adequately trained on what the hospital wants regarding content and level of detail, Owens says. Professional organizations such as the National Association Medical Staff Services in Washington, DC, offer training on writing minutes, but quality improvement or peer review professionals should assist with training and emphasize the pitfalls of providing too little or too much detail.

A good idea is to provide examples of both good and bad committee meeting minutes, Owens suggests.

"You also can review the draft meeting minutes over a period of time, helping that person get a feel for what is and is not desired in the minutes, until you reach a point at which you're satisfied they have a good understanding. It takes experience to get that kind of understanding," she says. "It takes discretion and thinking about what is appropriate in each instance. That requires paying attention to the substance of what is going on in the meeting and what the consequences might be." ■

SOURCE

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CMS Requiring Price Transparency, Compliance Program

CMS now requires hospitals to post "standard charges" for all hospital inpatient and outpatient services online, but compliance may be a challenge if hospitals are careless about how they post prices. The measure could interfere with efforts to draw in patients who use quality and safety scores to choose their hospitals.

In the Federal Fiscal Year 2019 Medicare Hospital Inpatient Prospective Payment System and Long-Term Acute Care Hospital Prospective Payment System Final Rule, CMS requires that hospitals post their price information on the internet in a machine-readable format. The pricing information must be updated as often as needed and at least annually.

The requirement that hospitals make their pricing information available was part of the Affordable Care Act, and many states have similar requirements. But the CMS requirement that it be posted online in a machine-readable format is new, as is the CMS clarification that the pricing represent hospitals' current standard charges as reflected in their current chargemasters.

(CMS answers to frequently asked questions about the rule are available online at: https://go.cms.gov/2zOr8uQ.)

The new price transparency rules go into effect on Jan. 1, 2019.

They apply to all hospitals in the United States, with no exceptions. The requirement for hospitals to post their chargemasters online in a machine-readable format applies to all items and services that the hospitals provide.

Help Patients Understand

The biggest consideration for hospital quality and compliance officers is not just complying with the measure but also considering how to use price transparency as a means to help patients manage their increasing costs of care, says **Heather Kawamoto**, chief product officer with Recondo Technology, a revenue cycle company based in Denver.

By itself, the CMS measure will not assist patients in better understanding their cost of care. However, it could boost hospitals' website traffic, so hospitals would be wise to have a price estimator embedded online that generates accurate cost estimates based on patients' real-time insurance coverage, Kawamoto says.

"And they need that help. The latest stats tell us that almost half of the insured are now on high-deductible plans. Just publishing the chargemaster list isn't sufficient in giving patients a better handle on their financial responsibility for healthcare, but it can drive them to the hospital's website," Kawamoto says. "Once at the chargemaster list, patients should be directed to an online price calculator that gives a true and accurate estimate based on the patients' current coverage. These calculators can be configured to give patients additional information about financial assistance and payment programs."

This will effectively open the door to meaningful conversations with the patient while increasing the likelihood of payment, she says. It is well established that people who have an accurate understanding of what they will owe prior to services are more likely to pay for those services. Moreover, engaging consumers in financial dialogue can often defer them from bad debt to charity care programs, reducing costly write-offs for providers.

Concerns About Potential Confusion

Hospital leaders are concerned about how best to meet the CMS requirement and specifically about the potential confusion this is going to cause patients, Kawamoto says.

"Many providers are behind in meeting consumer need for accurate estimates of their out-of-pocket responsibility. More and more, we're seeing it not only become an issue of compliance but one of competitive differentiation for those organizations who understand the growing importance of the patient's financial experience," she says.

Problems could arise if any of the chargemaster prices are exorbitant, suggesting charges that are far higher than what patients actually might pay, says **Valerie Barckhoff**, healthcare advisory practice lead at Windham Brannon, an accounting firm in Atlanta.

"The minimum requirement could prove to be problematic for hospitals. Charges do not equal out-of-pocket costs for the patient," Barckhoff says. "Are facilities aware of any 'gotcha' charges that still exist on their chargemaster? Do they know how their story will be told in the local newspaper?"

Hospitals need to think strategically about meeting the requirements of the price transparency rule, Barckhoff says. Step one is to comply without having any public relations issues. Step two is to turn price transparency into a competitive advantage, she says.

"How will the patients know their true out of pocket? Will they be able to quickly access a financial counselor or scheduler?" she says. "What services are more prone to be shopped online?"

Still Questions on Compliance

Even with the clarifications offered by CMS, there still are some questions about compliance with the rule, notes **Jonathan Wiik**, principal for healthcare strategy at Chicago-based TransUnion Healthcare, which assists healthcare organizations with revenue cycle issues.

While the rule applies to all services and items provided by a hospital, some hospitals are trying to provide that information in a format other than their actual chargemasters, he says.

Some also are questioning whether CMS really expects every single procedure and item, thinking they might get away with posting only a list of the top 100 procedures, for instance, or not posting pharmaceuticals. That is risky business, Wiik says.

"The pharmaceuticals are typically transacted directly to a dispensing machine, and people usually aren't shopping drug prices within the hospital," he says. "My advice is that the CMS rule says the chargemaster, and that's what you should go with. You're complying with the regulation at its minimal bare bones, and any

time you're trying to comply with the government, that's the lane you want to be in."

Although healthcare leaders may try to parse the wording of the rule to find ways around posting the chargemaster, Wiik says that is just inviting scrutiny from the government for no real benefit. Any time you deviate from the explicit requirements of a government rule, you have to be able to defend your reasoning, and Wiik says there is no benefit that justifies that effort.

"Your chargemaster should be posted in raw form on the Internet somewhere, without any modification," Wiik says.

There is no requirement for calculating out-of-pocket costs, Wiik says, but doing so still might be a good idea because otherwise the "sticker price" of some procedures could scare patients away and work against the idea of giving consumers more transparency about healthcare costs, he says.

The real effect of the CMS rule may be that hospitals will have to educate patients more about costs the way they have made strides in recent years to educate them about quality and safety, Wiik says.

"You can't just comply with the reg, set it, and forget it. Realize that you're opening a box when you're showing consumers your prices," Wiik says.

"How are you going to help them understand those numbers and how it all relates to their individual experience at your hospital? Once you've opened that up, you have to help them understand what it means or else another hospital might put a better spin on it and draw them away." ■

SOURCES

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- **Jonathan Wiik**, Principal for Healthcare Strategy, TransUnion Healthcare, Chicago. Phone: (800) 916-8800.

Knowledge Gap Threatens Outcomes, Patient Safety

Hospitals should address physician knowledge gaps to improve quality of care, outcomes, and patient safety, says a surgeon who has searched Google mid-surgery to help a fellow physician determine how to proceed.

The knowledge gaps are an offshoot of the rapid advances being made in medicine, says **Justin Barad**, MD, an orthopedic surgeon at Mee Memorial Hospital in King City, CA. He also is co-founder and CEO of Osso VR, a virtual reality surgical training platform. (Other virtual reality platforms for surgeons include Surgical Theater and Medical Realities.)

Medical advances are being made so rapidly that physicians are hard-pressed to stay current, he says.

"The foundation of this problem is very simple math. There is too much to learn and too little time to learn it," he says. "New knowledge, new procedures, and new technology are being developed every day, so learning new things and relearning old things is becoming the norm."

In a recent survey conducted by the online medical video education network VuMedi, 87% of the more than 500 surveyed practicing physicians said they could provide better treatment if they had more immediate access to in-depth information on medical breakthroughs. In addition, 74% percent said patient outcomes are lower in certain parts of the country because surgeons have slower access to medical breakthroughs.

Studies have shown that it can take years for a medical breakthrough to reach clinical practice and affect patient outcomes, Barad says.

Trainees' Experience Limited

The pressure to keep up with clinical advances and the difficulty in obtaining experience in new techniques could play roles in physician burnout, Barad says. Surgical trainees also can be frustrated by their limited ability to learn new procedures due to work hour restrictions and technological advances that mean surgeons need less help from trainees.

Trainee surgeons also can spend a significant amount of time, sometimes as much as half of their work hours, entering data into electronic health records, Barad says. Research has indicated that a substantial portion of residents could not operate independently after graduation, he notes.

Evolving technology also means that surgeons need more practice to become proficient than they did in years past with simpler techniques, he says.

A surgeon used to achieve proficiency in many procedures after about 25 cases, but now that number

might be closer to 75 because of the increased complexity of some procedures, he says.

"Newer technologies are leading to increased complications as surgeons work their way up the learning curve because they're typically practicing on patients," Barad says. "With minimally invasive hip replacement, the complication rate can be 300% higher in your first 15 to 20 cases, and you have to do about 100 cases before you can do the case proficiently at a safe complication rate. People are just working their way up the learning curve."

Consulting YouTube in Surgery

Hospitals also find it difficult to adequately assess surgical skills, Barad notes. Knowledge can be assessed objectively, but assessing technical skills is more challenging, he says.

The knowledge gap can involve even the most experienced surgeons when they are using newly developed techniques or technology, Barad notes. Quality improvement leaders may be unaware of how much the knowledge gap can affect patient outcomes, he says.

"I can attest personally that I was in many surgeries where I was scrubbed in and helping and I was told to scrub out, jump on the computer, and Google either a YouTube video or an instruction manual to figure out what to do next," Barad says. "I can say this is a very serious problem that I saw with alarming frequency."

Quality improvement and patient safety leaders probably would blanch at the thought of a surgeon consulting YouTube during a procedure, but surgeons may see that as the only option when they are unable to keep up with evolving technology and techniques, Barad says.

Hospitals can try to keep surgeons out of that situation by acknowledging the learning gap as an unavoidable offshoot of medical advances rather than any shortcoming of the physician, he says. Simulations and advanced training opportunities can help keep surgeons current, he says.

"Once you've identified the problem, you can intervene," Barad says. "This is very doable today, and forward-thinking hospital leaders will provide surgeons with the time and the resources to improve their skills in ways that don't involve practicing on patients until they reach proficiency."

Consider Effects on Outcomes

Much of the data on the learning curve for new technology is relatively recent and has not been considered in terms of its effects on quality and patient outcomes, Barad says. Hospitals with less-than-optimal quality and safety scores should consider the knowledge and training gap as a potential explanation for some of the problem.

"Often, it's not what we're doing to patients that is the problem but how we're doing it. The implants and medications may be amazing, but the outcome may be determined by how you're doing the surgery and the qualifications of the people involved," Barad says.

"Decision support is also becoming more important as we learn to use artificial intelligence and physician augmentation to help us make better decisions for the patient."

Barad notes that the Association of American Medical Colleges has predicted the United States could see a shortage of up to 120,000 physicians by 2030. *(The report is available online at: https://bit.ly/2FLgzIL.)* That will only increase the chance of poor outcomes, he says.

"Not only will they face these outcome challenges, but every physician will be overloaded," Barad says.

"There is no way we're going to be able to treat them using current methodology. We will have to depend on technology to make these procedures more efficient and something that can be done on such a scale with fewer physicians, and that will only put more pressure on them to stay current." ■

SOURCE

- **Justin Barad**, MD, Mee Memorial Hospital, King City, CA. Phone: (831) 385-6000.

Leadership in the Trenches Helps Hospital Win Awards for Women's Care

Getting leaders out on the floor, mixing it up with patients and staff, is one of the keys to success at South Nassau Communities Hospital in Oceanside, NY, which has established itself as a tertiary referral center and a standout in the region for women's healthcare.

The hospital recently was named by Healthgrades as a 2018 5-Star Recipient for all four women's care cohorts. It also received Healthgrades'

Gynecologic Surgery Excellence Award. Also, South Nassau stands alone in New York State in 2018 for receiving from Healthgrades all five awards in women's health services lines: Gynecologic Surgery Excellence Award (six years in a row), Five-Star for Gynecologic Procedures (six years in a row), Five-Star for Hysterectomy (four years in a row), Five-Star for C-Section Delivery, and Five-Star for Vaginal Delivery.

These awards mean South Nassau is in the top 5% of hospitals evaluated for gynecologic procedures and top 10% of hospitals evaluated for providing quality outcomes in gynecologic surgery, says **Alan Garely**, MD, chair of obstetrics and gynecology at South Nassau and clinical professor of obstetrics, gynecology, and reproductive science at the Icahn School of Medicine at Mount Sinai in New York City.

At South Nassau, breast health, obstetrics and gynecology, maternal fetal medicine, genetic counseling, women's imaging, and gynecologic oncology all are part of its women's services.

"The number-one thing that has pushed us to where we are with women's care is that our leadership is in the trenches every day," Garely says. "We don't manage from an ivory tower; we manage from down there. This comes from our CEO who has mandated the challenge to clinical leadership that we need to be involved with the people who are cleaning the rooms, serving the meals, answering the phones."

Department Chair Visits Patients

Garely makes a habit of visiting each patient on the OB/GYN service at least once a week, talking to them about their experience at the hospital — everything from clinical concerns about their care to logistical issues.

"Immediately, I can find out what's going on with that patient and find out if the issue is at a nursing or physician level, anything they're not comfortable with. Patients can't believe that the chair of the department is putting in their breakfast order because somehow they got skipped over by food service," Garely says. "That sends a message to all the people in the hospital that leadership is willing to get their hands dirty, that they're not just telling people what to do. It speaks to the philosophy of the hospital."

Garely recently visited a morbidly obese patient who was experiencing shortness of breath after a cesarean section. The nurse had given her more oxygen, but when Garely visited, the patient said it was not helping.

Garely called for a rapid response team and had the woman transferred to intensive care immediately. The patient ultimately ended up with a pulmonary embolism. A half-hour delay could have been fatal, Garely says.

"That probably would have happened without me, but the fact that I'm on the ground means things happen faster," he says. "It also elevates the expectations for people who work here because they know that ultimately everything is going to be checked and double-checked. They know that that patient is going to be visited by the department chair, and so they want to make sure everything is right."

The motivation is not fear of being caught but rather taking pride in their work, Garely explains. Morale is extremely high among employees at South Nassau overall and particularly in its women's care areas, he says. The hospital also enjoys a strong reputation in the community.

PI Committees Empowered

South Nassau also places a lot of power in the performance improvement committees at the hospital. Each specialty has its own performance improvement committee. Obstetrics and gynecology each have their own committee.

"I let them set the protocols and look at all the safety and quality measures. I oversee the committees, but we leave it to the professionals in each of those areas to make the decisions," Garely says. "We're very protocol-based. When doctors apply for privileges here, they have to understand it's not the Wild West and we have very strict protocols. That's why we have amazing outcomes in terms of safety and quality."

Such an emphasis on protocols only works if you have buy-in from physicians, Garely says. They must understand the reasoning behind the protocol, or they will not adhere to it, he says.

"We don't just launch it on the department. We have a protocol committee that meets once a month to come up with standardization protocols, and then those are sent by email to all the attendings in the department and nursing leadership," he explains. "We'll say, 'This is the protocol we'd like to implement for a specific scenario, and here are the recommendations from the professional organizations, but we think we can do better. Is this practical?'"

The protocol committee considers the feedback and may alter the protocol as necessary. No suggested protocol ever gets 100% support from physicians and nursing leaders, but those supported by a majority are implemented.

Once implemented, the protocol is monitored for compliance and effectiveness, and it may be altered as a result.

"We're a very fluid organization, and the leadership of the department are good listeners. We don't rule by fiat," Garely says. "We hear doctors talking about other hospitals where it's 'my way or the highway,' one size fits all, with not a lot of listening."

South Nassau's chief medical officer also has chairman rounds once a month where all department chairs discuss patient care across specialties.

Metrics, Not Opinions

Healthgrades analyzed patient outcomes from 15 states and the District of Columbia, showing differences between hospitals that received its Gynecologic Surgery Excellence Award and hospitals that did not (it looked at years 2014 through 2016).

Patients in hospitals that won the award had a 46% lower risk of experiencing a complication while hospitalized compared with patients in other hospitals.

As a pelvic reconstructive surgeon, Garely puts great emphasis on operating room metrics.

"We try to run the department not based on opinion, feelings, and gestalt but on deep analytics. We look at individual physician metrics like transfusion rates, operative times, and admitted days in the hospital before discharge," he says. "Those are things we can immediately intervene with because we follow them on a monthly basis and I always know from a scorecard where people are."

South Nassau adheres to a just culture and works with physicians in a positive way without making it punitive. Physicians used to be afraid of receiving a level letter from the performance improvement committee, Garely says, but now they see it as the hospital reaching out in a proactive way to offer help.

"It's a collegial atmosphere. I know it sounds quaint, but a lot of the complaints you hear at the major academic centers are that the big specialists are telling the generalists what to do," Garely says. "We don't manage like that. We manage more from the bottom up than from the top down."

The hospital also makes liberal use of root cause analysis.

"We're very interested in process but also in having everyone involved in analyzing and improving processes. Regular floor nurses are not afraid to bring up in a meeting what they think is a problem and offer a solution," he says. "We try to maintain consistency in how we address problems, with committees that are structured to follow the same methodology each time."

South Nassau uses the TeamSTEPPS approach, a set of evidence-based strategies and tools from the Agency for Healthcare Research and Quality (AHRQ) that includes checklists and mnemonic devices. It is intended to improve teamwork and communication in healthcare settings. *(More information on TeamSTEPPS is available at: http://bit.ly/2p0Ysd2.)*

Nursing usually takes the lead in coordinating any investigation into a poor clinical outcome, Garely notes.

Garely attributes South Nassau's excellent scores in women's health to other factors as well. The hospital has a robust imaging program for breast cancer screening and diagnosis, and the radiology staff are active clinicians rather than primarily reading images, he says.

The hospital also has one of the largest pelvic floor centers in the country, with four board-certified urogynecologists performing the most advanced pelvic floor reconstructive surgery in the country, Garely says. They work closely with the hospital's colorectal surgeons and urologists.

South Nassau also is a leader in what it calls "gentle C-sections," in which the drapes are clear and the parents can see the baby being delivered and even participate. The hospital also is expanding its relationship with midwives in response to community interests. ■

SOURCE

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CE QUESTIONS

1. **Why did CHI Franciscan focus exclusively on Leapfrog when trying to improve its quality and safety scores?**
   a. Focusing on Leapfrog's formula helped CHI Franciscan target improvements more effectively rather than scattering resources across multiple quality improvement philosophies.
   b. Leapfrog required the exclusivity in order to offer assistance to the health system.
   c. The health system had focused exclusively on other scoring systems in the past, with good results, but had not yet focused its attention on Leapfrog.
   d. Leapfrog was the only group that had issued recent quality and safety scores for the health system.

2. **What was one strategy that helped improve CHI Franciscan's Leapfrog scores?**
   a. Mandating attendance for all staff at meetings to review Leapfrog scores
   b. Eliminating silos and getting everyone involved with quality improvement
   c. Deliberately avoiding any mention of Leapfrog with frontline staff
   d. Revising clinical protocols that were inconsistent with those from other high-scoring hospitals

3. **What does Karen Owens, JD, advise regarding the minutes of peer review committee meetings?**
   a. They should be sufficiently detailed to document what was discussed, but they should not be a transcript of the meeting.
   b. They should be a transcript of the meeting with verbatim accounts of what each member said.
   c. The minutes should only list topics discussed, with no further description.
   d. The minutes should include quotes attributed to specific named committee members whenever possible.

4. **What does Jonathan Wiik advise regarding compliance with the CMS rule on posting hospital prices?**
   a. A short summary of the most common charges is sufficient.
   b. Hospitals should only post out-of-pocket estimates.
   c. Hospitals should avoid providing a cost calculator or similar aid to determining out-of-pocket costs.
   d. The hospital's entire chargemaster should be posted, with no alterations.

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.