HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

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

INSIDE

HCAHPS may be offered electronically 87

Hospital improves Leapfrog scores with telemedicine. 88

Health system wins with sepsis, falls prevention initiative 91

Hip fractures addressed with co-management approach. 93

TJC requires antimicrobial programs in ambulatory care 95

Connection between nurse staffing and hospital-acquired infections 95

AUGUST 2019 Vol. 44, No. 8; p. 85-96

Can Regulators Be Friends? CMS Seen as Aiding Innovation, Quality

Recent survey of healthcare leaders yields surprising findings

Can quality leaders see regulators like CMS as an ally in their mission, rather than an adversary? A recent report suggests one can and might see improved results.

A survey from Proskauer Rose asked healthcare leaders to rank CMS on a scale of 1-10 for effectiveness in fostering and driving innovation. The results were encouraging for a sense of cooperation, with more than half scoring CMS 8 or higher. *(Key findings from the report are listed on the next page. The full report is available online at: http://bit.ly/2S8REaa.)*

CMS' average score of 6.49 outperformed state health departments, which scored an average 5.94. The surveyed healthcare leaders also said compliance is getting easier, with only 15% of those surveyed citing compliance as a top three business challenge.

The survey reflects the healthcare community's commitment to the Triple Aim promoted by CMS and the Institute for Healthcare Improvement (IHI), says **Richard J. Zall**, JD, partner and chair of the healthcare department at Proskauer Rose. The Triple Aim refers to simultaneously pursuing improvements in the patient experience of care, the health of populations, and the per capita cost of healthcare.

"We thought it interesting that the survey indicated these leaders as focused on quality, access, patient satisfaction, and cost effectiveness are really important objectives, as opposed to just getting bigger," Zall says. "In the past, there was a focus among executives on just improving scale as opposed to becoming a high-quality organization with existing services. Now, we see people adding services to their core organizations rather just getting bigger" through mergers and acquisitions.

Healthcare leaders cite the Triple Aim objectives even when they talk about acquiring cutting-edge technology like artificial intelligence

Financial Disclosure: Author **Greg Freeman**, Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Nurse Planner **Jill A. Winkler**, BSN, RN, MA-ODL, Consulting Editor **Patrice Spath**, MA, RHIT, Editorial Group Manager **Leslie Coplin,** and Accreditations Manager **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

***Hospital Peer Review*® (ISSN 0149-2632) is published monthly by Relias LLC, 1010 Sync Street, Suite 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Peer Review*, Relias LLC, 1010 Sync Street, Suite 100, Morrisville, NC 27560-5468.**

GST registration number: R128870672.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.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@reliasmedia.com or (866) 213-0844.

ACCREDITATION:
Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is valid 36 months from the date of publication.

The target audience for *Hospital Peer Review*® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Greg Freeman
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

and machine learning capabilities, Zall says. They see challenges in training their workforces in this new technology, and also ensuring their business partners have interoperability in the same technology.

"We still have some distance to go in terms of having common data systems through which you can transfer information readily when referring a patient to someone," Zall says. "Unlike the financial services industry, where that has become very standardized, there is still a long way to go in healthcare."

CMS Seen as Partner

Zall says the most surprising finding from the research was that the healthcare leaders showed more consistency in looking at CMS and other regulators more as a partner in achieving the Triple Aim.

"The ranking of CMS contrasted with how they saw state health departments. CMS in particular controls payment and it has really supported innovation of the last half a dozen years in a way that is a departure from how they behaved in the past," Zall says. "In the past, Medicare and CMS were very focused on fee-for-service payments, making sure there wasn't overutilization or abuse of billing practices. As part of the Affordable Care Act, CMS promoted innovation and meaningful use payments. The more innovative healthcare companies have seen CMS as interested and supportive because of its grant money, bundled payment initiatives, and promoting population health."

State health departments, on the other hand, are seen as pure regulators, Zall says. They oversee licensing and certificates of need, and they conduct surveys in which hospitals are told exactly what they are doing wrong, he says.

Look to CMS for Resources

The research findings could influence the daily efforts of quality

TOP SURVEY FINDINGS

"Checking Up on the Quest for Triple Aim" revealed these important results:

- To better promote a coordinated, innovative, and value-based care approach, healthcare executives cited the need to improve employee training of technology (43%), incentivize participation in existing information-sharing groups (38%), and incentivize vendors to offer electronic health record products that are interoperable (35%).
- When it comes to what keeps hospital executives up at night, 32% of executives noted streamlining operating costs and improving data privacy. These concerns are guiding a majority of their business decisions, including mergers and acquistion (M&A) strategy. Specifically, 31% of healthcare executives are focusing on tech-related M&A to improve the patient experience and boost efficiency.
- Cybersecurity remains a critical concern for healthcare executives. No more than one-third of organizations leverage any single cybersecurity best practice to protect their data.

improvement professionals, Zall suggests.

"When you are thinking about initiatives that would improve quality, reduce variation that isn't necessary, you can look to CMS to provide funding, support, and ideas. The Center for Medicare & Medicaid Innovation has a lot of money allocated to it every year [and] is interested in funding and supporting clinical innovation on the ground," Zall says. "Staying in close touch with what they're doing, what funding they're offering, is a way for someone in clinical improvement to have a catalyst for your desired activities beyond just going to the CFO and asking for more staff or more money."

Zall expects the trend toward cooperation to continue with CMS. The move toward value-based care will spur more efforts by CMS to fund innovative projects and provide other types of support for quality improvement, he says.

"Improving outcomes in support of the Triple Aim are going to receive support from CMS not only because it is important to improve the health of the public. I do think CMS is interested in that, but also because that will then bend the cost curve," Zall says. "We continue to have increases in spending for healthcare in the United States that is dramatically above the rate of inflation and the rates of spending in other countries. We will continue to see incentives and financial support to try to push the industry to be more cost effective and quality- [and] outcome-oriented." ■

CMS May Revise HCAHPS to Improve Response Rates

Traditional snail mail and phone methods may be outdated

CMS has stated that it wants to make changes to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS), perhaps offering an electronic survey option to address declining response rates.

CMS requested approval from the Office of Management and Budget to collect public feedback on possible changes to the mandatory survey for hospitals. *(The notice is available online at: https://bit.ly/2WF8JsS.)*

The request asked that CMS be allowed to gather public comments on changes that could include an electronic version of the HCAHPS survey, which currently is conducted only by mail and/or phone.

Although hospitals must participate, the patient response rate for the 29-question survey is only 27%, according to the most current data. *(The most recent HCAHPS data are available to review online at: https://bit.ly/2NjLHbD.)*

Response Rate Declining

The primary motivation behind evaluating this new approach is to increase capture of responses, according to **Elizabeth Godsey**, vice president for advance analytics and insights with Vizient. Response rate percentages are dipping lower than the average (mid to upper 30s). There are benefits to the current HCAHPS format, but allowing electronic surveys could bring additional advantages, Godsey explains.

"In the current survey method, there's a level of rigor that ensures you're only sampling the patient one time. These methods help maintain singular survey responses as well as a level of security for protected health information," she says. "Currently, discharged patients have within 30 days to respond to mailed or phone surveys. A lot can change between the end of the discharge and the actual follow-up. Leveraging electronic surveys could allow for

more timely and actionable feedback for providers than current methods."

Electronic surveys also could allow the opportunity for a broader population of patients to be represented in the responses, Godsey adds.

Some Weaknesses to Address

The current system is not without its weaknesses. Providers are challenged to make improvements in the care they provide based on feedback that arrives at least one month after treating a patient. Further, that feedback represents the opinions of only a small subset of the patients who a provider saw, Godsey notes. "It's really important to make the surveying process not only easy for patients, but also more valuable for providers," Godsey says. "CMS is striving for a patients-over-paper approach to minimize patient and provider burden. Exploring electronic HCAHPS survey options would be a step in the right direction."

Hospitals are yearning for more current, actionable, and comprehensive data. Quality improvement leaders might welcome the addition of electronic surveying, Godsey suggests.

"Having HCAHPS include an electronic patient experience assessment option would hopefully close the information gap between patients and providers, and could pave the way for more meaningful patient-provider experience," she says. "Additionally, improving the quality and timeliness of HCAHPS data, which is used in CMS' pay-for-performance measures, and coupling it with additional risk adjustment components, is essential in the how-do-we-improve-faster conversation."

Potential Issues With New Approach

There are a few potentially problematic aspects to watch, Godsey cautions. How do providers ensure the protection of patients' personal health information in an electronic format? How does one ensure the patient can access the electronic survey and that the process is easy to complete? How do survey facilitators ensure a patient does not respond multiple times? Does an electronic survey come through the vendor or the hospital? Is there a portal?

"I also wonder if there are any concerns around patients, such as older patients. Maybe they're not as electronically savvy," Godsey says. "Some patients, elderly patients, or patients with disabilities, may not necessarily have the same dexterity with electronic surveys or familiarity with electronic ways of providing feedback as they would paper or phone, as an example. These are all important questions for CMS to consider and address."

Even if the request is approved, Godsey says there probably would be little immediate effect on hospitals and no need to change anything they are doing regarding quality scores. Hospitals do not administer the survey today and probably would not in the future, she says.

"There are vendors that they contract with to do this. For now, there isn't anything that they need to change. When considering a new format, I think CMS should understand any financial impact to hospitals," Godsey says. "If they're shifting from paper or phone surveys to electronic surveys, is there any overhead or any extra costs that hospitals would incur for that? It should be a budget-neutral effort from the provider's perspective." ■

Improving Telemedicine Can Raise Leapfrog Scores

To earn full credit, ICUs must be managed or co-managed by intensivists who are present during daytime hours and provide clinical care exclusively in the ICU

Hospitals seeking to elevate their Leapfrog scores might want to look to telemedicine, especially if one weakness is intensivists or critical care-trained physicians managing patient care around the clock. A hospital in Georgia has lifted its scores this way.

Leapfrog administrators note that because death rates for patients admitted to the ICU average 10-20% in most hospitals, quality of care for these patients plays a big role in Leapfrog scores. Research indicates that staffing ICUs with

doctors specializing in critical care medicine can reduce ICU mortality by as much as 40%.

"Hospitals can earn partial credit for having teleintensivist coverage 24 hours per day, seven days per week with onsite care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine," Leapfrog guidelines state. "Recent evidence suggests that teleintensivist coverage can reduce ICU mortality by 15-30%; however, the impact on patient care is not as significant as the reduction in mortality associated with on-site intensivist coverage. Thus, Leapfrog awards partial credit to hospitals with teleintensivist coverage."

To earn full credit from Leapfrog, ICUs must be managed or co-managed by intensivists who are present during daytime hours and provide clinical care exclusively in the ICU. In addition, when they are not present on site or via telemedicine, they must return notification alerts at least 95% of the time within five minutes and arrange for a physician, physician assistant, nurse practitioner, or critical care nurse to reach ICU patients within five minutes. *(A fact sheet on Leapfrog's standards for physician coverage is available online at: https://bit.ly/2Q7uvGv.)*

That is a challenging level of coverage for many hospitals. Those without that intensivist coverage are consistently downgraded on their Leapfrog scores, notes **Talbot McCormick**, MD, president and CEO of Eagle Telemedicine in Atlanta.

"They find it hard to accomplish Leapfrog scores of A and B. They're hamstrung from the lack of that kind of clinical leadership and also lacking those professionals who can work in conjunction with other individuals like nurses, respiratory therapists, and hospital leadership," McCormick says. "Their ability to accomplish some goals in patient quality and safety are hampered if they don't have this captain of the patient's care."

> "RECENT EVIDENCE SUGGESTS THAT TELEINTENSIVIST COVERAGE CAN REDUCE ICU MORTALITY BY 15-30%."

One challenge is the lack of critical care specialists, McCormick says. There simply are not enough to be employed at every ICU in the country around the clock, every day of the year. Even if there were enough to go around, many hospitals cannot afford to employ them for uninterrupted coverage. That is especially true of hospitals with smaller ICUs that typically do not have enough volume to justify the expense. This is where telemedicine can help hospitals make the most of limited resources.

"Leapfrog recognizes the option of having an intensivist available through telemedicine and working with qualified physicians there at the hospital, giving partial credit toward that ideal physician staffing," McCormick says. "A telemedicine ICU physician, working in collaboration with an on-the-ground attending, can accomplish reductions in mortality and improvement in scores. With telemedicine, we can have one critical care physician who can cover a number of small hospital ICUs, providing them that critical care physician engagement that makes a difference in outcomes, even if none of those individual hospitals could afford their own in-house intensivist."

McCormick cautions that such an arrangement still requires significant coordination among the critical care physician contacted via telemedicine and the rest of the staff at the hospital. Using telemedicine is not as simple as contacting the distant physician, he says. The same level of communication and coordination is

required as if the physician were in house, McCormick says.

Telemedicine was used to improve Leapfrog scores at Meadows Regional Medical Center, a 60-bed, not-for-profit hospital in Vidalia, GA, says **Karen McColl**, MD, chief medical officer and vice president of medical affairs. For many years, the hospital had not paid much attention to its Leapfrog scores. About five years ago, leaders realized that the scores were receiving more public attention, McColl says. Meadow Regional's scores were not good.

"We had a revamp of our quality department and made some changes regarding hospital-acquired infections that got those rates down over the past three or four years. That helped our scores," she reports. "But one item where we were having trouble was ICU coverage, where we were making some progress but weren't able to get above a C grade. We have employed physicians and two intensivists for an eight-bed ICU."

Need to Cover Off-Hours

The patient volume was not enough to warrant a third intensivist, McColl explains, and the intensivists also were pulmonologists who saw outpatients.

"We were scratching our heads over how to provide that 24-hour coverage without working our two intensivists to death or going into that locums arena to get more coverage," McColl says. "We looked at the telemedicine option. One concern was that we didn't want to work with someone who had a great number of providers for us to interact with because that meant credentialing each one. We wanted to work with four to six providers maximum."

Meadows Regional landed with Eagle Telemedicine, arranging for the remote intensivist to cover the ICU when the hospital's own physicians were not available.

"Our model is that we flip to our telemedicine providers when our own providers are either off or on vacation. We typically average about four to six days per month when we are on telemedicine," McColl says. "It has worked well, and we have not received any patient complaints regarding the use of telemedicine. Our hospital staff have found it to be a help and a comfort to know that when our own intensivists are not here there is that higher level of care available for consultation and monitoring the patients who are ventilated."

Implementing the telemedicine intensivist program required coordinating with emergency physicians, surgeons, and anesthesiologists, asking them to participate when the intensivist needed hands-on care that required their skill levels, McColl explains.

"If the intensivist needs intubation or line placement of the patient, they're hamstrung by being remote. We had conversations with each of those services, and they were willing to assist when needed," she says. "Thus far, it's been a good working relationship. We also brought our hospitalists into the conversation since they most likely would be the ones with the most direct interaction with the telemedicine intensivists."

The hospital held implementation meetings monthly at first. Then, as providers were credentialed, the meetings became more frequent, McColl says. Sixty days out from the go-live date, hospital leaders were meeting at least weekly to discuss details. There was a mock go-live date in which the procedures were tested, including the use of the telemedicine device, which primarily is a cart with a computer that provides interaction with the intensivist.

"It has Bluetooth interactivity with a stethoscope and monitor with a camera that the remote physician can control. If he's talking with the family, he can move the monitor to look at the person speaking," McColl says. "Patients' families have found it helpful, and the intensivists do family rounds in addition to patient rounds."

Billing Hurdle

The in-house intensivists usually sign out at noon on Friday; the telemedicine service takes over until they return on Monday at 8 a.m., McColl says. The telemedicine service might be used for several days during the week and if one of the intensivists is on vacation. After more than a year and a half with the telemedicine intensivists, the only real stumbling block has been financial, McColl says.

"Right now, we are unable to bill for the providers in our telemedicine ICU because they are not credentialed with any of the health plans," she notes. "We try to improve the return on our investment by being more efficient with our use of the ICU and ventilator days. At some point, we're going to have to look at how to recoup some of the costs. Telemedicine is moving in that direction with the health plans, but it might take some legislative action ... to get some of these programs billable for services other than just the teleconnection, which is a very minor charge you can bill." ■

Quick Wins With Focus on Sepsis, Fall Prevention

Dedicated coordinators, focused teamwork key to turning around poor outcomes

Quality improvement leaders at Spectrum Health, based in Grand Rapids, MI, are seeing success with several initiatives addressing sepsis, preventive screenings, and fall prevention. Their experiences may offer lessons for other hospitals.

To help prevent mortality from sepsis, clinicians at Spectrum Health use a checklist to ensure all components of the sepsis treatment bundles have been completed within the three-hour and six-hour windows for care, says **Julie B. Bonewell**, MBA, BSN, RN, CPHQ, senior director for quality improvement at Spectrum Health.

"We noticed a couple years ago that our sepsis rates were going in a direction we didn't want, so we launched a concentrated effort to reduce our sepsis mortality rates," Bonewell says. "This started right after we had an [electronic health record] go live, which was an opportunity to refocus on quality improvement. One of the key things we learned was the importance of hiring a sepsis coordinator."

Spectrum had taken a similar path before with hiring a full-time stroke coordinator, with responsibilities for both improving and coordinating care with stroke patients. The same approach was used for sepsis. A prime role for the sepsis coordinator is to follow compliance with sepsis prevention bundles and protocols, says **Leslie M. Jurecko**, MD, MBA, senior vice president for system quality, safety, and experience at Spectrum Health.

"A lot of hospitals use these bundles and track them, but she follows them in real time. She works with a couple of physician leaders and they do almost instant feedback with providers when they have fallout following the sepsis bundle of care," Jurecko says. "That's been really well received. It's either the coordinator or a physician letting a physician know that they may have missed one or more opportunities to lessen mortality and morbidity from sepsis. The feedback loop has been fabulous and really moved the needle on this project."

> SPECTRUM HEALTH'S SEPSIS RATE HAD BEEN AS HIGH AS 30%. AFTER MAKING CHANGES, THAT RATE HAS DECREASED TO 15% ACROSS THE SYSTEM.

The team also uses a swarm approach for patients at risk for sepsis, which Bonewell describes as similar to calling a code. A page is sent to targeted team members so that everyone needed to assess the risk and institute preventive measures is in one room to discuss the patient's condition and implement the protocol.

"The team can discuss and determine that the lab needs to do this, nursing needs to do this, and all the questions can be answered right then. It facilitates getting the care initiated more quickly, rather than someone having another question and paging the provider, then someone else having a question and waiting to hear the answer before they do anything," Bonewell says. "We've spread that model now to our ICU and inpatient spaces as well."

Jurecko notes that clinicians usually refer to the gathering as a "Code Sepsis" and respond with urgency similar to other code calls.

Spectrum Health's sepsis mortality rate had been as high as 30%. After making changes, that rate has decreased to 15% across the system, Bonewell reports. Part of the reduction can be attributed to ensuring the appropriate care starts at regional facilities and continues as sepsis patients are transferred for treatment to the health system's main tertiary care campus.

"The clock starts in the regional spaces on these patients. That has been a great culture shift for us," Jurecko says. "The coordinator and some of the other changes all came together about a year ago. If you look at where we were with that baseline and where we are now, we've saved about 118 lives in the last year from sepsis mortality."

Surgical site infections also were addressed in a similar way at Spectrum Health, with a checklist to ensure all the appropriate preoperative interventions are completed. Now, Spectrum is trying to reduce surgical site infections by addressing the optimization period before surgery, not just the perioperative period. "Recently, we decided to move toward setting hard cutoffs for elective surgery regarding [body mass index], hemoglobin A1c, and smoking status. We've ramped up our surgical

optimization center to make sure patients are on plan to meet those goals so they can move forward with the surgery they're requesting," Jurecko explains. "We had seen some significant improvements in infection rates with the perioperative work. Then, we plateaued and realized we needed to look at the entire continuum of care. The team put out a model of what needed to be done and when."

Spectrum Health also studied nutritional status, implementing changes such as providing colorectal patients a liquid nutrition supplement to improve their immunological status before surgery, Jurecko explains.

Bonewell notes the surgical site infection efforts were led by physicians; there was no reluctance from surgeons to follow the checklist and other protocols, including an intraoperative timeout. The interventions were introduced first with colorectal patients; now, these techniques are adopted for all surgery.

Compliance is monitored, and the results have been encouraging, Jurecko says. For instance, orthopedics recently reported 100% compliance with the universal protocol.

"We have nurses document it, and then we're able to show those compliance rates transparently. We have a physician leader follow up with physicians who are falling out of the compliance range we want," Jurecko says.

The efforts have reduced colorectal surgical site infections enough to get Spectrum out of a Hospital-Acquired Condition Reduction Program penalty imposed by CMS a couple years ago, Bonewell notes.

Additionally, Spectrum Health improved preventive screenings. At one point, the health system had become overwhelmed with all the different expectations of health plans, which called for their patients to undergo certain preventive screenings at specific times. Spectrum created a more efficient way to handle the demand.

"Every insurance company has different targets. We got to the point where we just couldn't manage individual payer programs. There was way too much complexity," Bonewell says. "We created our Integrated Payer Program and a tool called Gaps in Care, which takes the most stringent expectation from payers. If one payer wants the A1c below 11 and one wants it below 9, we take the one that's below 9."

NURSING LEADERS PILOTED THE FALL PREVENTION INITIATIVE, WHICH HAS LED TO A REDUCTION IN FALLS TO A RATE BELOW THE NATIONAL BENCHMARK.

Medical assistants at Spectrum Health use a report generated by that tool that quickly shows which tests are due for a patient. "We can call patients in when they are due for a screening, and we can look at the patients who are already coming in today and make sure we take care of any gaps in care during this visit," Bonewell says.

This approach has resulted in higher compliance with preventive screening as well as better control of chronic diseases such as high blood pressure and diabetes. In addition to improving the screening of individual patients, the program helps clinical teams hit their targets for preventive screenings, Jurecko says.

"It's one of our best stories of team-based care," she notes. "The teams use an operational deployment system with a board called our Managing for Daily Improvement board. The team in that office huddles around the board to discuss where they are with getting their blood pressure screenings, cancer screenings, and other targets."

Spectrum Health also has been addressing fall prevention with its "Go Green" initiative, playing off the idea that visual cues are a great way to help staff with ensuring interventions are in place for patient safety. Nursing leadership piloted the initiative on a unit in which all beds with a patient in them had to have a green light.

This green light indicated that the team had programmed the bed in the safest position for the patient, which would be unique to the patient, and included bed alarm, number of side rails, and bed height. Team members can hold each other accountable if they notice an orange flashing light on the bed, as well as remedy the safety concern in real time, Jurecko explains.

Nurses program the bed for the settings appropriate to that patient and then push a button that activates the green light. The light stays green as long as those settings are not changed, indicating at a glance that the safety measures are in place. If anyone changes those settings, the light turns orange to signify that attention is needed.

"The beauty of this initiative was that it crossed over all disciplines, engaging environmental service,

pharmacists — anyone who spent any time on the unit, as well as the patients and families," Jurecko says. "If all the components of the bed are not properly engaged, the light at the end of the bed will flash orange instead of being green. Anybody who sees it ... is supposed to stop everything, get help from staff, and be near the patient so the patient doesn't fall out of bed."

For the six months prior to the Go Green initiative, the Spectrum Health unit experienced four to five falls each month, a rate higher than the national benchmark. After implementing the program, falls decreased significantly. For December 2018 and January, February, and March 2019, the unit performed better than the national benchmark for falls. Leaders are expanding the techniques to other units. ■

Hip Fracture Outcomes, Time to Surgery Addressed With Co-Management

Approach can lead to shorter lengths of stay, reduced costs for patients

Co-management of hip fractures among different disciplines can be effective in improving care and outcomes, according to the experience of one healthcare network.

With the support of a grant from The John A. Hartford Foundation, a nonprofit, nonpartisan organization in New York City that works to improve conditions for the care of older adults in the healthcare system, Northwell Health, a healthcare network also based in New York City, has implemented such a program at two hospitals and plans to expand it to two more by 2020.

A 2013 study of hip fracture co-management found that it "resulted in a reduced requirement for patient admission to the ICU, decreased lengths of stay for patients in the hospital and in the ICU, and decreased hospital charges per patient." *(The study is available online at: https://bit.ly/2LxzMnS.)*

The first step in implementing the program involved forming a steering committee that met monthly for six months to determine what was needed to execute the co-management best practices, explains **Maria Torroella Carney**, MD, chief of geriatrics and palliative medicine at Northwell Health. The healthcare network already had put some best practices in place, but the committee developed ways to implement them in a comprehensive way in one hospital.

The first hospital was chosen because it had extensive buy-in from key stakeholders like leadership, nursing, anesthesia, and orthopedics. Also, there was a geriatric specialist present at the hospital.

"We looked at our electronic record order sets and we realized that the order sets for hip fractures were good for orthopedics but they were not good for older patients. We had to adjust them for medications and dosages that were safer because they were not always appropriate for an older adult with a hip fracture who may be more frail than the average adult," Carney says. "We had a data analyst in place to measure outcomes also. We got all of that in place in the first six months to a year. Then, we had to meet with the hospital leadership to explain what we were doing."

Committee members also met with frontline clinical leadership, who responded well and were eager

to learn about co-management of hip fractures, Carney recalls. The program kicked off with a breakfast for participants, followed by educational modules, monthly meetings to monitor progress, and additional meetings to discuss difficult patients.

Once the first hospital was running the program efficiently, staff helped introduce the process to a second hospital with mostly the same features but allowing some flexibility that works with the unique aspects of each facility.

Co-Management Begins in ED

The co-management of hip fractures begins as soon as the patient arrives in the ED, Carney notes. The ED calls orthopedics, which then notifies hospital medicine. Someone from both departments will see the patient soon.

"The orthopedic department begins the admission and gets them to a floor bed, but what is different is that the patient goes to an orthopedic floor and is co-managed with medicine, with the input of geriatrics as well," Carney says. "Co-management is not just coming by and giving consultation. It's actually dividing up who is going to do what, the orthopedist dealing with orthopedic, surgical, and pain management issues, while medicine is involved with everything outside of the orthopedic injury."

That means medicine deals with issues such as avoiding misuse of medications, minimizing pain medications, bowel motility, getting out of bed as soon as possible, diabetes issues, heart failure, and similar concerns.

"A lot of times people with complex medical issues would not go to the orthopedic floor. They would go on medicine, and the nursing staff on the medicine floor might not have been comfortable dealing with the hip fracture," Carney explains. "It's important that they go on the orthopedic floor where the staff is best capable of dealing with that primary issue, but they're still receiving coordinated care for their other medical concerns by a medical, geriatric provider."

> IT IS IMPORTANT TO SHOW WHAT IS DIFFERENT ABOUT THE HIP FRACTURE PROTOCOLS AND WHY CO-MANAGEMENT IS NECESSARY.

Provide Education on Differences

Successfully implementing such a program requires educating clinicians and hospital leadership on the unique risks faced by patients with hip fractures, Carney says. They are a vulnerable population with a high rate of complications and mortality as well as a high risk of readmission without a good plan of care.

"Once you educate them that this is a high-risk, vulnerable population, then everyone will fall into place and try to help these patients and their families," Carney says. "We can intervene, and the protocols that exist to support this population show benefit. Co-management can really improve the quality of care."

It is important to show clinicians and hospital leaders what is different about the hip fracture protocols and why co-management is necessary, Carney says. No one thinks clinicians are providing inadequate care to these patients, so they must understand what is different about what leaders are asking them to do.

"Whenever we bring this up, people tell us they are already doing this well," Carney says. "But once they follow the protocol, they realize they thought they were doing it fine, but they're doing it better now."

Shorter Times to Surgery

The program has been in place at the first hospital for a year and has lowered the length of stay for hip fracture patients by one day, Carney reports. Metrics also indicate the hospital is managing pain better and shortening time to the operating room. The goal is send hip fracture patients to surgery within 24 hours. The hospital is at almost 100% reaching the operating room within 48 hours. That was achieved partly by prioritizing these cases for surgery, whereas in the past they may have been delayed when operating rooms were busy.

"The program has helped us identify the barriers to getting surgery within the time frame we wanted. A big one was feeling that patients needed cardiac clearance before surgery; that would delay getting to surgery by a day," Carney explains. "We found that we don't need an echocardiogram of the heart, for instance, for

every patient before surgery. These are mostly older adult patients. Many of them have cardiac histories, but we determined that we can stabilize, do the surgery, and get any further workup we need afterward." ■

TJC Requires Antimicrobial Stewardship Programs for Ambulatory Care

Updates are part of agency's long-term project on patient safety improvements

A new accreditation requirement from The Joint Commission (TJC) calls for ambulatory care centers to institute antimicrobial stewardship programs.

Beginning Jan. 1, 2020, outpatient facilities that "routinely prescribe antimicrobial medications" must have programs in place to combat antibiotic misuse, which promotes antibiotic resistance, according to a report from TJC released on June 20.

The accrediting body already requires similar programs for hospitals and long-term care facilities. The report from TJC outlines five new requirements for ambulatory care facilities:

- Designate an individual responsible for developing and monitoring appropriate prescribing practices (this can be the person's sole job or an additional assignment);
- Establish at least one goal each year related to antimicrobial stewardship;
- Use evidence-based guidelines to complete the goal;
- Educate staff and physicians on the stewardship goal and prescribing practices that discourage antibiotic misuse;
- Collect and analyze related data.

"The inappropriate use of antimicrobial medications contributes to antibiotic resistance and adverse drug events," TJC said upon releasing the report. "Improving antimicrobial prescribing practices is a patient safety priority."

Many more details about the report are available to view online at: https://bit.ly/2IXEmdz. ■

Inadequate Nurse Staffing Tied to Increase in Hospital-Acquired Infections

Insufficient staffing levels for nurses can lead to an increase in hospital-acquired infections (HAIs), according to research from the Columbia University School of Nursing.

Researchers studied data collected at a large urban hospital system between 2007 and 2012. Using a Cox proportional-hazards regression model, investigators looked at the association between nurse staff levels (two days before the onset of HAI) and potential outbreaks.

"Fifteen percent of patient-days had one shift understaffed, defined as staffing below 80% of the unit median for a shift, and 6.2% had both day and night shifts understaffed," the researchers found. "Patients on units with both shifts understaffed were significantly more likely to develop HAIs two days later."

To view an abstract of the report and to learn more information about what researchers discovered during their investigation, please visit: https://bit.ly/2XeffXW. ■

CE OBJECTIVES

After completing this activity, participants will 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.

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **According to the results of a recent survey, how did CMS and state health agencies compare for effectiveness in fostering and driving innovation?**

   a. CMS scored higher than state health agencies.
   b. CMS scored lower than state health agencies.
   c. CMS and state health agencies scored the same.
   d. CMS scored 0; state health agencies scored 8.

2. **What is one way that CMS has stated it wants to make changes to the Hospital Consumer Assessment of Healthcare Providers and Systems survey?**

   a. Conducting the survey only every other year
   b. Releasing the survey results only every three years
   c. Conducting the survey electronically
   d. Penalizing hospitals with less than 50% participation

3. **What is one challenge Meadows Regional Medical Center faces when using telemedicine intensivists?**

   a. Many patients object to the use of telemedicine.
   b. The telemedicine intensivists are not available when needed.
   c. The hospital cannot bill for the telemedicine intensivists because they are not credentialed by health plans.
   d. Leapfrog does not recognize telemedicine intensivists.

4. **What is one way Northwell Health shortened the time it takes for a hip fracture patient to arrive at surgery?**

   a. Eliminated some presurgical cardiac testing
   b. Streamlined paperwork requirements in the ED
   c. Provided financial incentives to ED physicians
   d. Created a special transport team for hip fracture patients