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INSIDE

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Watch for PTSD in Healthcare Workers Following Their COVID-19 Experience

Physicians, nurses, and other healthcare workers who treated patients during the worst of the COVID-19 pandemic may experience post-traumatic stress disorder (PTSD) or similar aftereffects that could threaten patient safety and quality of care if not adequately addressed, according to experts who study the lasting effects of trauma.

Quality improvement and peer review professionals may be among the best suited to detect the signs of PTSD among healthcare workers and to initiate the help they need. Some quality metrics commonly monitored in hospitals can provide an early warning that healthcare workers are in distress.

For some healthcare workers, the COVID-19 experience will produce significant and lasting effects that will cause serious emotional problems and potentially affect the quality of their work, says **Shauna Springer**, PhD, chief psychologist at Stella Center, a treatment center in Oak Brook, IL, for the relief of mental trauma-related conditions.

"Many of the war fighters I have worked with are physicians. They are now on the front lines of the COVID outbreak. They are telling me this trauma is worse than even many of the combat zones they have been in," Springer says. "That carries a lot of weight with me. The healthcare workers on the front lines are the new warriors. The kind of trauma they are facing is very similar to what active duty service members and veterans have experienced for years."

That comparison is apt, Springer says, because healthcare workers addressing the pandemic face some particularly unnerving elements. The virus cannot be seen, and much is unknown about its transmission and how to prevent it. Even the slightest error could be a matter of life and death. Healthcare workers are constantly trying to protect themselves and their colleagues while providing the best care to patients.

"They're often doing this fight without the necessary protective

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equipment," Springer notes. "Because of all of these factors, many of them are going to require long-term treatment once the pandemic ends. I don't think we're ready to meet this threat unless we have a new model of trauma care that combines innovative biological intervention with high-quality psychological care."

Recently, researchers surveyed 1,379 healthcare workers during the peak of the COVID-19 outbreak in Italy. Almost half of frontline healthcare workers who responded to the survey reported PTSD symptoms. One-quarter of respondents reported depression symptoms, and 20% reported symptoms of anxiety.

More than 8% of respondents reported insomnia and 22% said they suffered from "high perceived stress." The researchers said the results are "in line with previous reports from China, confirming a substantial proportion of mental health issues" among frontline healthcare workers. They recommend further monitoring and interventions "to prevent long-term mental health-related disabilities." *(The research is available online at: https://bit.ly/2U3NBy7.)*

Similar to 9/11 PTSD

Physicians and other frontline healthcare workers will soon show PTSD symptoms similar to what first responders developed after responding to the terrorist attacks of Sept. 11, 2001, says **Wilfred G. van Gorp**, PhD, ABPP, an expert in neuropsychology based in New York City and Chicago.

He treated first responders for their trauma and stress after 9/11 and has led the neuropsychology testing programs in three of the nation's leading departments of psychiatry: University of California, Los Angeles, Cornell, and Columbia University. "The effects will be different because with 9/11 there was one single event and ripple effects. With the pandemic, we have this amorphous, ongoing crisis," he explains. "But just like with 9/11, I would expect to see some trauma-like reactions, either full-blown PTSD or some of the symptoms, along with anxiety and mood disorders. For some people, these symptoms will happen right away. For other people, the response might be delayed by three or six months."

One of the first symptoms will be difficulty sleeping, van Gorp says. This often is a key indicator of stress and anxiety, he says. They also may be more temperamental and short with colleagues or family members. An increase in alcohol intake or other substance use can indicate that stress is becoming problematic, he adds.

"Intrusive thoughts will be a problem, such as reliving the moment a patient died without family members present or a patient going into cardiac arrest," van Gorp says. "They may not want to talk about any of this to family or friends, but the thoughts will be intrusive."

Effects Will Show in Quality Metrics

The stress and aftereffects of the pandemic response will show up in quality metrics, says **Eugene Lipov**, MD, a board-certified physician in anesthesiology and pain management. He is chief medical officer at the Stella Center and has treated hundreds of military and civilian patients with PTSD, pioneering the adaption of a procedure called stellate ganglion block (SGB) for treating trauma-related symptoms.

Lipov advises paying particular attention to error rates of all types, including diagnosis and medication errors.

"I think those rates are going to go sky high now. I've been a physician for 32 years. At the end of the day, I'm tired, so think about how tired your physicians must be when they are working long hours with a high patient volume. At the same time, they are terrified of getting the virus themselves and taking it home to their families," Lipov says. "No physician can perform at his or her best under those conditions during the pandemic. We will see lasting effects that hinder their performance long after."

One metric to watch is the conversion rate from a patient's first visit to continuing care, Springer says. Patients vote with their feet, even if they cannot pinpoint what they did not like about the first visit with a healthcare worker, Springer says. A low conversion rate after an initial visit could signal trouble.

"That is an underexamined metric that I think we should look at. In the context of the COVID-19 experience, patient transfer rates would be a good gauge of whether a physician is consciously engaging trust and getting patients to dig into their care," she says. "There will always be some doctors who have lots of patient transfer requests, and some who have almost none. If you look at those metrics now, some of those high performers who have done a good job engaging their patients will suddenly have a shift in those metrics."

Van Gorp also suggests watching for any changes in patient or peer review ratings.

"It's analogous to how if parents are getting divorced, the child often has a decline in grades. The same thing happens with physicians under extreme stress," van Gorp says. "Performance appraisals and scores on patient satisfaction surveys often go down because the physician is unable to perform at the usual level of competence, even if he or she does not recognize that drop in performance."

Intervene When Symptoms Show

A change in performance should prompt an intervention that helps healthcare workers understand how the pandemic experience may have lasting effects, and how to cope, Springer says. Many healthcare workers suffering from pandemic aftereffects will not recognize that as the cause of their ongoing stress or performance issues, she says. Without proper intervention, performance may continue to degrade.

The hospital should seek to help healthcare workers rather than punish them. Administrators should help healthcare workers avoid placing all the blame on themselves as too weak or unable to cope.

"A shift in that kind of metric most likely will be the result of their traumatic experience, rather than core to who they are as a physician," Springer suggests. "It would be a shame to lose good physicians because we are not supporting them well in this massive trauma they are facing."

Lipov emphasizes the need to rotate physicians and nurses in and out of the most stressful and demanding patient care positions, a lesson learned in the military. Providing the proper rest periods and opportunities to decompress can make a huge difference in the lasting effects of a traumatic experience, he underscores. Keeping the same physicians and nurses working until they collapse is a recipe for long-lasting traumatic effects and, ultimately, will hurt the hospital when those workers leave or can no longer perform well, Lipov says.

Springer notes most healthcare workers suffering in this way from their pandemic experiences will never receive an actual diagnosis of PTSD, yet the effects on them and their job performance will be the same. They may suffer from "chronic threat response," which Springer says is the constant feeling of living in survival mode, requiring them to be hypervigilant.

"They are going to have certain clusters of symptoms, one of which is fragmented concentration, which leads to more errors and errors from people who do not typically make them," Springer says. "Their concentration is affected, their sleep is impacted, and they simply cannot perform at the level they normally do."

More healthcare worker suicides also are likely, Lipov adds.

Provide Support for Stressed Workers

Hospitals must act proactively to identify stressed workers and provide them relief, Lipov says. During the heavy work periods, that might mean asking a senior physician, senior nurse, or other respected leader walking around to spot those who are overworked and likely to perform poorly, insisting the person take a break and sleep, he says.

That kind of intervention must be supported by scheduling and staffing allowances that make it possible for a physician or nurse to rotate off the floor when necessary, Springer says. Hospitals also should provide space for healthcare workers to connect

with each other and talk through their experiences. "They form tribes in these circumstances, just like elite military units do. There is protection in the connection among members of that tribe," Springer says. "When we connect, we survive. When you look at someone who's on the frontline with you, you can communicate everything in your heart with one look. They can nod back and know what you mean, and you're confident they understand."

When dealing with an outside person trying to help, like a counselor brought in by the hospital, he or she has to first explain their experience. Then, he or she probably still will not be confident the other person understands.

"Right now, we need to do the most potent thing we can to support them. That means making time for them to be with each other," Springer says. "Not when they are on duty, but just in a safe space where they can decompress and recharge."

However, employee assistance programs still can be helpful, van Gorp notes. When providing counseling to healthcare workers stressed by their COVID-19 experience, they often respond best to someone completely outside the hospital or health system, he notes.

"Providing them with a list of therapists who are in-network for the insurance but not employed by the facility is the best scenario," van Gorp says. "Physicians have a hard time opening up about their work experience to a counselor who is employed by the same organization. That will be especially true if part of their stress is rooted in how the employer responded to the crisis or failed to support employees in some way."

The Stella Center produced a brief video for frontline healthcare workers to discuss ways to cope with the stresses of pandemic. The video can be provided to healthcare workers, but also provides guidance on how administrators can support them. The video can be viewed online at this link: https://bit.ly/3gq71GR.

Skepticism About Hospital Support

Springer and Lipov are doubtful about the ability of hospitals and health systems to respond adequately to the potential for PTSD in healthcare workers. Nevertheless, they say it is worthwhile to try, even from a purely economic standpoint. Without addressing the issue, hospitals will lose workers to burnout and early retirement. Replacing physicians and nurses can be costly, Lipov notes.

Van Gorp agrees with that point, saying that paying attention to mental health needs of healthcare workers can head off a crisis in staffing. "If they don't, we're going to have more people calling in sick, more people taking leaves of absence, and we'll see resignations," van Gorp predicts. "Don't be shortsighted and only worry about the number of beds. It's important to pay attention to the mental health needs of staff. Otherwise, it will affect your organization when physicians find ways to leave the place that is causing them stress."

Springer also cautions hospital quality leaders need to be supportive when they discover use fluctuations in performance metrics.

"I hope hospital administrators take a critical look at performance measures, but use them to support their people rather than using them to make them feel more inadequate," she says. "There are a lot of feelings of helplessness on the frontlines right now. Hospitals are in danger of losing some of their best people if they don't support them with the data."

Pandemic Will Exacerbate Burnout

The pandemic experience will be particularly hard for healthcare workers who already may have been nearing burnout, says **Sharona Hoffman**, JD, LLM, SJD, professor of law, bioethics, and jurisprudence, and co-director of the Law-Medicine Center at Case Western Reserve University School of Law in Cleveland. They will be more susceptible to all the symptoms of burnout, including less engagement with patients, less satisfaction with their work, insomnia, marital problems, anxiety, and depression.

"If the clinicians were in a hospital that was overwhelmed, with patients in the hospital and very sick but you couldn't find beds for them, they are more likely to have actual PTSD," she says. "This is also a whole new ballgame where physicians have to worry so much for their own health in addition to all the stress of typical work in a hospital."

Healthcare workers experiencing burnout self-report they make more mistakes because they cannot concentrate, Hoffman says. She recommends using tools like the Maslach Burnout Index to assess those with a higher rate of errors.

Staff on the verge of burnout often benefit when employers offer assistance with practical issues such as child care. However, Hoffman cautions against pushing physicians to participate in wellness activities such as meditation or yoga. Although well-intended, pressing staff to participate in those activities can

backfire if they feel it is just another demand on their time and energy. Any strong encouragement to attend such offerings can make healthcare workers feel they have to go, or else they will appear not to support the culture of wellness, she explains.

"We're not adequately addressing this, and it has only gotten worse during this crisis. I don't think burnout has been on the radar screen on a lot of healthcare employers as a real problem," Hoffman explains. "There are unprecedented pressures and worries that we've never had before."

Monitor After Pandemic Subsides

Hospital leaders should be careful to continue monitoring healthcare workers even after the initial wave of the pandemic subsides, says **Tasha Holland-Kornegay**, PhD, LPCS, a licensed counselor and founder of the platform Wellness In Real Life, which assists healthcare providers who are looking to destress to prevent burn out.

Healthcare workers were celebrated as heroes during the worst of the pandemic response, but their stress will not go away instantly once the patient load decreases and the public attention wanes, Holland-Kornegay cautions. "When health professionals are bravely taking on the crisis with a problem-solving mentality, working around the clock under terrible conditions, with increasing patient mortalities, it is expected that stress levels are high. What occurs afterward is more difficult to deal with," she says. "As the pandemic drags on, people get sicker, and more colleagues, patients, and families are affected, healthcare workers will need help dealing with anxiety, depression, and symptoms of [PTSD]."

Whether the COVID-19 crisis continues to grow or diminishes in coming months, the workforce will soon show signs of their experiences, Holland-Kornegay says. Hospital quality leaders should be prepared with a plan for keeping healthcare professionals healthy, effective, and on the job:

• **Consider using more locum tenens.** Locum tenens healthcare providers help provide continuity of care to patients who need it most while alleviating burnout for their permanent colleagues. This gives healthcare workers time to step back and process the experience, rest, and recharge.

• **Maintain a culture of wellness.** This can be accomplished by including leaders in the well-being needs of healthcare workers. They can help reduce stress in the clinicians. The system also must watch out for the physicians' needs to refresh and sustain. Institutional policies must be stable. Ensure paid time off and sick days remain unaffected for all employees for COVID-19-related illnesses. Ensure no out-of-pocket expenses for employees with COVID-19-related illnesses.

• **Maintain balance.** During these times, it is imperative to monitor the time and effort that healthcare delivery teams are spending in direct patient care.

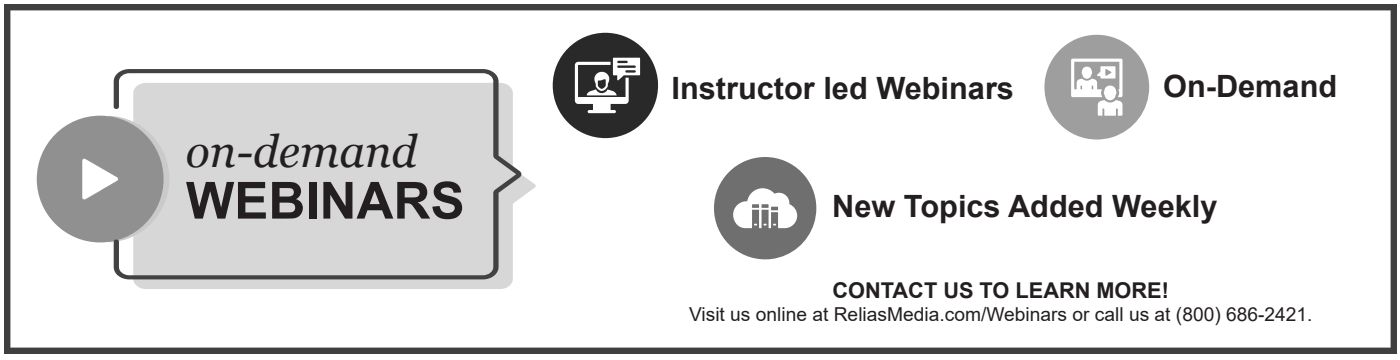
Respect the time when providers are away. Recognize the 24/7 virtual environment in which everyone lives. Do not disturb staff or expect them to participate in virtual meetings. Encourage them to disconnect and recharge.

Watch for Substance Abuse

The unusual stress of the pandemic also can make healthcare workers more susceptible to substance abuse, says **Charles Smith**, MD, an addictionologist at Recovery First Treatment Center in Hollywood, FL.

"When you add in the pressure of living up to the hero image and concerns about their own health status, it's a perfect storm that puts doctors at increased risk for issues like PTSD and substance use," Smith says. "For some, alcohol and/or drugs become a coping mechanism."

Investigators found 69% of doctors abused prescription drugs



to manage stress and emotional or psychiatric distress, Smith says. *(The study is available online at this link: https://bit.ly/3daz6Qf.)*

"Sadly, doctors may be less likely to reach out for help right away because of social stigma and a fear of losing their license to practice medicine," Smith observes. "It's likely we may not see the true impact of the crisis on these frontline workers for months or even years down the line when their addiction spirals out of control or leads to an overdose or death."

Smith says he is most concerned about emergency physicians or any other provider on the frontlines consistently exposed to extreme levels of stress.

Quality leaders need to be mindful that some staff may be struggling to cope and turning to substances, Smith says. "Part of that awareness should include taking a proactive approach to providing ongoing support for those on the frontlines, such as virtual peer support groups and online counseling services," he says. "Staff should also be trained on the warning signs of addiction and on what to do if they suspect a physician is struggling. It is critical that colleagues and employers not turn a blind eye." ■

SOURCES

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When PTSD Happens: Recognize the Signs, Prescribe the Right Treatment

Post-traumatic stress disorder (PTSD) is most commonly associated with members of the military, but it can affect anyone who has survived a traumatic experience. This includes healthcare workers who were overwhelmed by the surge of COVID-19 patients and struggled to allocate scarce resources, all while worrying about their own health and transmitting the virus to loved ones.

PTSD occurs most commonly through direct exposure to traumatic events and secondarily through witnessing a traumatic event experienced by another, often referred to as vicarious traumatization, notes **George Vergolias**, PsyD, CTM, a forensic psychologist and medical director for R3 Continuum, a company based in Minneapolis that provides behavioral health and security solutions for workplace well-being.

PTSD is not uncommon among healthcare workers in general, Vergolias says. They must face a host of stressful and often competing issues as they navigate treating the ill during the pandemic. Often, these workers do so in far less than ideal circumstances.

Vergolias notes that a recent study showed emergency physicians are five times more likely to experience PTSD than the general population, with 15% of emergency physicians meeting the criteria vs. 3% of the general population. *(More about the study is available online at this link: https://bit.ly/3cfe5D3.)*

"It is important to note that [study] was [conducted] prior to the [COVID-19] pandemic. We are still studying and understanding the impact of the pandemic on healthcare workers in general," Vergolias says. "Without doubt, it has taken an emotional toll. The question remains to what extent healthcare workers will rebound from the past eight weeks within a reasonable window, or will they show an increased prevalence of sustained PTSD symptoms?"

Emotional Reactions, Avoidance

Vergolias identifies several common symptoms of PTSD:

• **Intrusive symptoms.** Traumatic memories, recurrent dreams, thoughts or flashbacks of the event(s), and heightened emotional and physical reaction to cues reminding one of the trauma.

• **Avoidance symptoms.** Excessive efforts to avoid places, people, or other cues that remind one of the trauma; attempts to emotionally numb oneself from intrusion.

• **Alterations in cognitions and emotions.** Distraction; reduced memory function; and increased difficulty with decision-making, anxiety, and depression.

• **Increased physiological arousal and emotional reactivity.**

These can affect sleep, appetite, and/or physical energy levels. Those symptoms can overlap in manifestation, such as when someone has intrusive thoughts or flashbacks while attempting to avoid thinking about traumatic images, Vergolias says. For healthcare workers who might be affected by their COVID-19 experience, Vergolias advises watching for these signs:

• **Pattern of mistakes made on minor procedural steps the physician should know and has demonstrated consistent habitual performance on in the past.**

These mistakes often are a function of distractibility, intrusive symptoms, and/or changes in mood or cognition. These are the kinds of mistakes the person has not made before. Such errors may occur on tasks or procedures he or she has completed successfully numerous times.

• **Attempts to avoid exposure to locations or situations that were perceived as traumatic.**

For example, an emergency physician who must return to the emergency department or a nurse who must return to an intensive care unit where he or she treated virus patients. They may show increased emotional reactions such as hypervigilance, irritability, or anger reactions that are out of character.

"With physicians, this can manifest as avoidance of going into certain hospital units or even certain patient rooms that have been associated with a traumatic moment," Vergolias says. "The avoidance may not be so pronounced as avoiding physical space. Instead, the physician may simply emotionally 'tune out' and does not seem fully engaged while at work. They are physically there, but not emotionally or cognitively present in the moment."

• **Significant changes in mood.**

This can manifest as increased emotionality (frustration, anger reactions, temper, anxiety, panic attacks), yet also can manifest as restricted emotions, too (social and emotional withdrawal, depression, self-isolation).

Vergolias offers one point of caution: While increased fatigue and worse personal hygiene can be indicators of difficulty in these situations, remember that most healthcare staff are working extensive hours. This may be the simplest explanation for troubling signs. As such, these two symptoms are not the best indicators to separate stress reactions from the healthcare worker simply feeling tired from an excessive workload, he says.

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"The best way to monitor this issue is to monitor overall behavioral performance in general. There can be many reasons a given physician's performance falters. The first step is to identify that a performance issue exists and be clear on the nature and scope of the negative performance impact," he says. "Next is the task of determining what is contributing to that performance issue. I recommend starting with an open and supportive discussion with the physician. If approached from a caring and supportive perspective, most physicians who are indeed struggling will be more open to admitting such and seeking needed support."

Once a problem is detected, Vergolias says there are treatment options for consideration:

- Refer to supportive peer groups or resources.
- Provide psychoeducational materials so the worker can better understand his or her reactions and place them into a proper context.
- Consider referring to mental health counseling if more serious symptoms present or seem entrenched over several weeks.

"In some cases with a repeated performance issue, in which the physician is unable or unwilling to recognize the identified problems, it might be appropriate to consider referral for a psychological fitness for duty evaluation to help assess functional capability and determine next steps to assist in return to pre-morbid functioning," Vergolias explains.

The best way hospitals can assist healthcare workers through these difficult times is to provide clear and accessible support, and convey that message loud and often, Vergolias says. Support should be in the form of both physical and logistical needs, including adequate personal protective equipment and clear procedural protocols.

Make sure to include emotional support, such as providing support groups, psychoeducational materials, and counseling as needed.

"Lastly, recognizing and acknowledging the herculean effort that physicians and other healthcare workers have made during this time is another very simple yet powerful way that hospitals can show support," Vergolias adds. ■

SOURCE

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Health System Tweaks Survey Process, Dramatically Improves Care for Stroke Patients

Hospitals in the Piedmont Healthcare system in Georgia have made great strides in safety and quality by improving their care for stroke patients. Consolidating some accreditation survey activities was part of the successful strategy.

The initiative led to six of the system's hospitals receiving certification in stroke care from DNV GL Healthcare, in Milford, OH, which offers hospital accreditation integrating ISO 9001 with the Medicare Conditions of Participation. Piedmont Healthcare uses DNV GL Healthcare for accreditation throughout its system.

Debbie Camp, RN, MHA, CCM, SCRN, stroke program manager at Piedmont Newnan Hospital in Georgia, was hired to help that hospital achieve designation as a certified stroke center. She worked with other hospitals in the system to standardize processes so they all could make improvements to their stroke programs at the same time. They also worked with the accreditor to streamline the survey process.

"We set up our annual stroke surveys so that they would all coincide ... which meant we had two weeks of surveys with DNV. The stroke managers from four hospitals would all do the surveys together. We learned a lot from doing that," Camp reports. "We recognized that we had an opportunity to do what they call a system or consolidated survey. The surveyors would come, and we had to do our presentations. Because we had standardized everything, the surveyors were hearing the same thing each time."

Previously, each hospital survey started with a half day of presentations and then a full day of assessments. With the consolidated process, the stroke managers at the hospitals can spend a day going over their programs together. Then, when the surveyor visits each hospital, managers can review the tracer that DNV uses to track a patient's experience through the hospital, beginning at the moment he or she enters the facility.

"The surveyor is able to spend a lot more time on the floor with the bedside nurses, rehab services, radiology. They're able to go to all these departments and make sure the staff really knows what is going on,"

Camp says. "If the surveyor is there when we have a code stroke come in, they actually go down to the ED [emergency department] and see the code stroke in action."

Strong Collaboration Necessary

The tracer looks at each step of the care process, involving many different elements of the hospital. Camp says it helps the stroke program optimize its multidisciplinary approach.

"The stroke program cannot be successful unless you have really strong collaboration among radiology, lab, rehab, transportation — all these services, in addition to the unit where the patient actually lands, like the ICU [intensive care unit] or stroke unit," Camp says. "You have to have support from case management, dietary, [and] chaplain service. There's nothing we do that is not impacted by each division of the hospital."

Piedmont Healthcare also consolidated how its stroke programs addressed any deficiencies found in the accreditation survey. In previous years, it was common for one hospital to be dinged on a certain element of stroke care and respond with the appropriate improvement, only to have another Piedmont stroke center cited for the same deficiency the next year.

To change that pattern, the hospitals began considering any survey deficiency (NC1 or NC2) and opportunities for improvement (OFIs) at any hospital to be a systemwide problem.

"If one hospital is having trouble with it, then that is something for the entire system to pay attention to. We all look at our processes to see what is going on," Camp says. "We are able, as a system, to request changes in our electronic medical record to improve processes. Everyone [has] input before we do it, but everyone benefit[s] from the changes immediately. It has really improved our quality program and outcomes for our patients."

A primary focus in the improvement effort was making sure stroke patients received the clot-busting drug alteplase quickly, and then were admitted to receive intensive care. One of the Piedmont Healthcare hospitals, Piedmont Henry Hospital in Stockbridge, GA, had problematic "door out" times of more than eight hours in early 2017. Within months, the system's stroke improvement efforts had reduced that time to less than three hours by the summer of 2017.

The stroke programs also sought to decrease the number of stroke patients arriving at Piedmont Henry by private vehicle, a factor that is known to delay the introduction of alteplase. The percentage of patients arriving by private vehicle was cut by more than half (from 56% in 2012 to 25% in 2017). The use of ambulances rose from 41% to 73%, the result of community education about the need for emergency transport for anyone suspected of experiencing a stroke.

Include Frontline Workers

Camp and colleagues worked closely with frontline clinicians to improve the documentation process, acknowledging that in many cases of apparently insufficient care, the proper care was provided but not documented correctly.

"People make mistakes. Most of the time, it's just that the care was not documented. If it's not documented, it officially didn't happen," Camp notes. "As a system, we tried to provide our clinicians with ways to improve documentation, like changes to the EMR [electronic medical record]. We shared everything we did with the other hospitals rather than operating only within our own silos."

Camp credits input from frontline clinicians with much of the improvement that led to four Piedmont Healthcare hospitals achieving stroke certification. Seemingly small changes to a process can produce important results, she says. The clinicians at the bedside often can tell leaders why a big idea is misguided.

"You need to standardize and bring the people at the bedside into the discussion to figure out how to do things better," Camp explains. "One of the worst things we do sometimes is to have people come in and dictate how things should be done. They have the best intentions and think they really do have a better way. Sometimes, we have to say no, that's not how it's done at the bedside."

Transparency also is important, Camp says. Not only do Piedmont Healthcare hospitals collaborate and share data, but Camp and colleagues regularly share their experiences and best practices with other hospitals in the region.

That cooperation is facilitated by the Georgia Coverdell Acute Stroke Registry (GCASR) program, named in honor of the late U.S. Sen. Paul Coverdell, R-GA, who died of a massive stroke in 2000. Funded by the Centers for Disease Control and Prevention, the GCASR recognizes states in the southeastern United States have the highest incidence and mortality of stroke, and encourages an active exchange of data and ideas.

"A lesson I've learned is that if you have a program within your program, whatever it may be, don't

just sit at your desk and try to fix it. Call up your counterparts at other hospitals and health systems, and see what they're doing," Camp offers. "Sometimes, I know how Piedmont does it, but I want to know how Emory does it, how WellStar does it, so we can look for common problems and how somebody else has successfully addressed it. We share a lot in Georgia, and it benefits patients in a big way." ■

SOURCE

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Stroke Program Survey Includes Data Review, Close Observation

A DNV GL Healthcare survey for a stroke program begins with a data review that includes a look at trend lines, action plans for improving on some trends, goals and stretch goals, and how data are validated.

Next, a visit to the emergency department (ED) to understand the patient's experience in entering the hospital for treatment, the agency describes in material provided to *Hospital Peer Review*. The surveyor will study the patient's first moments in the ED, the personnel involved, the responsibilities of various team members, the documentation process, order sets, and how orders are processed when electronic tools are down. Surveyors always are interested in speaking with any team members interacting from other departments, such as pharmacists.

After the ED, the surveyor will move on to assessing CT scans, MRIs, and interventional radiology. The surveyor will pay close attention to how those departments and technicians are alerted, the care process, staffing, and educational requirements. Following a lunch break, the surveyor will continue with a document review of "the binders" that include order sets, community education, transfer agreements, policies and procedures, medication management, informed consent, scope of service, call schedules, and emergency medical services contracts and education.

The surveyor often will end his or her day by touring the neurology intensive care unit as well as the subacute unit. Agents will engage with staff and ask them questions about stroke care, educational requirements, and their feedback on the stroke program. ■

How Hospital Won Top Designation from Leapfrog Group

When St. Joseph Medical Center in Tacoma, WA, was recognized as the only hospital in Washington state to earn the 2019 Top Teaching Hospital award from Leapfrog Group, it was the result of a team effort among advanced practice providers, hospitalists, and specialists.

The award also was the result of the hospital making itself a data-driven organization that is supported by a robust quality and clinical effectiveness department, says **Tim O'Haver**, vice president of operations and chief operating officer at St. Joseph Medical Center. "The focus on data ensures the process improvement work we're engaged in is focused and specific to achieving improvements across a broad array of clinical measures and care processes," O'Haver says. "This has also been facilitated by clinical integration across the care continuum. Ambulatory care programs work to identify, intervene, and mitigate certain risk factors that we know influence wellness and health outcomes in the acute care setting and beyond."

The hospital's success was made possible by collaboration among the acute care, ambulatory, and outpatient components of the facility, O'Haver reports. Leapfrog recently announced changes to the 2020 survey process, including an option for hospitals to maintain their 2019 survey results in lieu of reporting for the 2020 Leapfrog Hospital Survey. *(See the story on the next page for details about the changes.)*

Leapfrog categorizes hospitals as a general, children's, rural, or teaching hospital, assessing them with a value-based purchasing program methodology that includes measures for maternity care, medication safety, and inpatient surgery. St. Joseph Medical Center, part of the CHI Franciscan health

system, has a comprehensive SafetyFirst program that strives for safety and reliability performance improvement, O'Haver says. All new employees must complete training in SafetyFirst methods, which are based on reliability science and human performance in complex systems, he adds. "The program was launched here in 2014. We've seen year-over-year improvements in care since the program's inception across CHI Franciscan. Of course, none of this would be possible without the full support and engagement of the combined healthcare team," O'Haver acknowledges. "We have worked diligently to foster and enrich a culture of safety here at St. Joseph Medical Center that values a multidisciplinary approach and one that encourages the reporting of near misses." O'Haver cites these specific initiatives that contributed to the hospital's overall quality improvement:

• Developed a Quality and Safety Leadership Council structure with performance improvement teams addressing key initiatives;

• More attention on documentation and coding to accurately reflect the acuity of the patient's condition during stay in hospital;

• Ensuring structures and processes are in place to meet the Leapfrog performance standards, such as computerized physician order entry, intensive care unit staffing, and National Quality Forum Safe Practices;

• Implemented multidisciplinary care rounds, which involves bedside nursing, care management, social work services, clinical documentation improvement staff, and hospitalists who can sync the care plan with good communication. ■

COVID-19 Prompts Leapfrog to Change Surveys for 2020

The Leapfrog Group is making changes to its survey program for 2020 in response to the COVID-19 pandemic, including an option that allows hospitals to maintain their 2019 results instead of receiving new results for 2020. *(Read the complete announcement online at this link: https://bit.ly/3gEL1Im.)*

The changes are intended to shorten the time required to participate in surveys but "will uphold our shared vision for quality, safety, and transparency, while allowing our hospital and ambulatory surgery center colleagues to devote their time to the urgent needs of the moment," Leapfrog announced. Other changes:

• Hospitals may maintain their 2019 survey results in lieu of reporting to the 2020 Leapfrog Hospital Survey.

• Significant reductions to the submission requirements for the 2020 Leapfrog Hospital Survey. "Hospitals choosing to submit the 2020 Leapfrog Hospital Survey must complete the five sections of the survey that constitute Leapfrog's minimum requirements for submission," Leapfrog said. "Hospitals submitting the minimum required sections will not be scored or publicly reported as 'Declined to Respond' for any additional survey sections that are not submitted. Leapfrog will score and publicly report the remaining sections of the survey as 'Not Available,' which will be described on our public reporting website as unavailable data due to the COVID-19 crisis. Hospitals are still encouraged to submit all applicable sections of the survey."

• Late submission deadline is extended to Dec. 31 instead of Nov. 30. "This also applies to hospitals that initially decide to continue reporting their 2019 results and wish to update by submitting the 2020 Leapfrog Hospital Survey later in the year."

• More time for the National Quality Forum Safe Practice 2 Culture of Safety Measurement, Feedback, and Intervention (Section 6B). "The reporting period for administering a culture of safety survey will be updated to the last 36 months, rather than the last 24 months, and for additional practice elements to the last 24 months, rather than the last 12 months."

• Limited reporting for Hand Hygiene (Section 6D). "All hospitals submitting a 2020 Leapfrog Hospital Survey will be required to respond to the new Hand Hygiene subsection," but Leapfrog will publicly report results only for "hospitals that are scored as 'Achieved the Standard' (four out of four bars) or 'Considerable Achievement' (three out of four bars)." Others will be publicly reported as "Not Available" due to the COVID-19 crisis.

• Suspension of On-Site Data Verification. "As part of Leapfrog's standard protocols to ensure data accuracy, we will suspend On-Site Data Verification of 2020 Leapfrog Hospital Survey Results.

"All other verification protocols will continue including warnings in the Online Survey Tool, extensive monthly data verification, and monthly documentation requirements." ■

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CE QUESTIONS

1. **George Vergolias, PsyD, CTM, a forensic psychologist, says research indicates emergency physicians suffer post-traumatic stress disorder (PTSD):**
   a. about the same as the general population.
   b. twice the rate of the general population.
   c. five times the rate of the general population.
   d. 15 times the rate of the general population.

2. **What was one change made within the Piedmont Healthcare system to improve stroke care?**
   a. All stroke patients were treated at just two hospitals specializing in stroke care.
   b. The use of private car transportation to the hospital was encouraged.
   c. Hospital stroke centers were surveyed at different times of the year to diminish the workload on staff.
   d. Hospitals began considering any survey deficiency (NC1 or 2) and opportunities for improvement at any hospital to be a systemwide problem.

3. **What does Shauna Springer, a psychologist and a leading expert on PTSD, call an "unexamined metric" that may indicate a healthcare worker is suffering from PTSD?**
   a. Medical errors
   b. Conversion rate from first patient visit to continuing care
   c. Complaints from colleagues
   d. Days away from typical work shifts

4. **Springer says most healthcare workers will never receive an actual PTSD diagnosis, but may suffer from "chronic threat response," which is the constant feeling:**
   a. of living in survival mode, requiring them to be hypervigilant.
   b. that no one else is suffering, that you are the only one.
   c. that you did not do enough during the COVID-19 pandemic.
   d. of wanting to leave the medical profession.