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CMS demonstration project offers potential new collaboration model

Hospitals, physicians will work together to improve efficiency, quality

The Centers for Medicare & Medicaid Services (CMS) may be giving hospital quality managers and other leaders a glimpse of the future with its new Acute Care Episode (ACE) demonstration, which it "expects to demonstrate how to better coordinate inpatient care and achieve savings in the delivery of that care that can ultimately be shared between hospitals, physicians, beneficiaries, and Medicare," according to CMS acting administrator Kerry Weems. CMS has just revealed the site selections for the initiative, which was slated to launch in March 2009.

The sites are: Baptist Health System, San Antonio; Oklahoma Heart Hospital LLC, Oklahoma City; Exempla Saint Joseph Hospital, Denver; Hillcrest Medical Center, Tulsa, OK; and Lovelace Health System, Albuquerque, NM.

The hospital-based demonstration, another of CMS' value-based purchasing approaches, will test the use of a bundled payment for both hospital and physician services for a designated group of inpatient episodes of care. "Too often, there are missed opportunities to coordinate care, which can adversely impact Medicare beneficiaries' health. This important demonstration brings hospitals, physicians, and patients together in an innovative cooperative effort to improve the quality of care," said Weems upon

Key Points

- Demonstration will operate on a bundled payment model.
- "Gainsharing" or other structures may be used to reward physicians, patients for savings.
- CMS will monitor performance of programs, and may cancel any that have not demonstrated quality outcomes.

announcing the initiative.

ACE will seek to better align the incentives for both hospitals and physicians, leading to better quality and greater efficiency in the care that is delivered. It also will test the effect that transparent price and quality information has on beneficiary choice for select inpatient care.

For purposes of this demonstration, a bundled payment is a single payment for both Part A and Part B Medicare services furnished during an inpatient stay. Currently, CMS generally pays the hospital a single prospectively determined amount under the Inpatient Prospective Payment System (IPPS) for all the care it furnishes to the patient during an inpatient stay.

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The physicians who care for the patient during the stay are paid separately under the Medicare Physician Fee Schedule for each service they perform.

CMS has included 28 cardiac and nine orthopedic inpatient surgical services and procedures in the bundled payment demonstration, stating that that were selected because volume has historically been high; there is sufficient marketplace competition to ensure interested demonstration applicants; the services are easy to specify; and quality metrics are available for them.

"I think it's terrific," says **Janelle Raborn**, chief operating officer for Lovelace Women's Hospital. "It brings alignment between all the parties; it's a new approach from CMS that practitioners find intriguing."

How demonstration will work

Shannon Fiser, MACC, vice president of financial operations for Ardent Health Services, the parent company of Hillcrest, explains how ACE will work. "We will submit our normal claim for Part A services to CMS, and any physician who participates in the project agrees to accept payment from our organization," he explains. "But once we submit the Part A claim, it triggers CMS to pay our bundled rate, and it will be the hospital's responsibility to reimburse the physicians for their professional service."

Typically, he continues, the hospital can only bill and collect for the services rendered in the hospital, and the doctor has the responsibility to bill and collect for his or her professional services. "The intent of the project is to foster collaboration between the doctors and the hospitals to create more efficient delivery of care while at the same time monitoring the effect on quality," says Fiser.

"The opportunity in this collaborative model, for example, is that you can sit down with the doctors, scan the site with them, and talk about the products they use in their care," adds **Steve Dobbs**, CEO of Hillcrest Medical Center. In addition, he says, this model allows for gainsharing incentives for the physicians based on improved efficiencies.

"The doctor can earn up to 125% of the Medicare fee schedule based on savings," says Dobbs, adding that CMS must be informed of the specific gainsharing structures.

Savings, he continues, can be realized in "anything we can come to agreement on, like are we

going to buy one implant from one particular vendor so we use all the same implants, and agree to push volume to a specific vendor and get favorable rates?"

How did the physicians react to this model? "We got total support from doctors here in Oklahoma," he says.

Coordination and consistency

When implementing the demonstration across an entire system, coordination is critical, says Raborn. "We worked on that from the 'get-go' — from the application phase," she says. "Each one of the hospitals has unique nuances, but there are some things we do as a division that are similar. This took at lot of coordination and communicating with one another."

"We wanted to create an environment where the physicians were able to choose which hospitals they wanted to use for these procedures but still be part of the program, so we set it up so they could practice where they had been practicing or where they would feel comfortable moving between facilities," adds Fiser.

Despite the uniqueness of the different hospitals, for the sake of quality "one of the things we wanted to do was have consistency, because we certainly wanted to have similar quality outcomes," notes Raborn.

"Our goal is to prevent readmissions and returns to our ORs," she continues. "But within those goals, practitioners may have different perspectives on how they can best achieve that — and it may be specific at each site. That gives us the opportunity to apply best practices across the board but allow nuances to be recognized."

How does that play out? "For example, at our women's hospital we initiated a 'pre-hab' program for joint replacement patients," Raborn explains. "Before the procedure, the patient comes to the hospital and sees the physical therapist and case manager. They review the course of care and receive education designed to produce good outcomes."

This is offered to all the "orthopods" who practice there, says Raborn, and they all like the concept and see the benefits. "But they have specific things the want to do, so the teaching sheets may vary." The plan is to roll this program out at each of the system's acute care hospitals. "Women's had done it as a trial program and it proved to be beneficial," she reports.

Raborn says she agrees with the concept of aligning incentives for quality and efficient care. "The communication we have with our practitioners is very much focused on that," she says. "Sometimes CMS may have an initiative that is focused on hospitals and others on practitioners, but this is one CMS program that says to both parties that patients reap big benefits from having the hospital and practitioners aligned under a single approach. That tweaks the interest of the practitioner and gives us the opportunity to have conversations with them about quality and have it aligned in philosophy with CMS."

CMS will be watching

The hospitals and CMS will maintain regular communication during the three-year demonstration, Dobbs explains. "As part of this project, we will focus on the collaborative model with physician order sets and measure outcomes, and CMS has the right to come in at any time and stop the program if it is not collaborative and/or has not demonstrated quality outcomes," he says, adding that "we continue to learn about the program." (This article was written prior to the formal launch, and participating facilities were given only two months between being notified they were selected and the formal launch of ACE.)

For example, he says, there is a third component that allows hospitals to incentivize patients to receive services at a specific facility. "Here we have had co-insurance and co-pays up to the Part B premium," Raborn explains, "But the patients can get a refund back from CMS; CMS will share half the savings with the beneficiary up to the Part B payment — around $1,100 a year."

"This way, all three parties come together to demonstrate the focus on the patient so that hopefully it will cause CMS to choose us as a value-based provider," says Dobbs. "Then, subject to CMS approval, we can promote that through advertising."

Before the formal launch, says Fiser, the system will be creating infrastructures to pay physician claims, record quality outcomes, and show what it is accomplishing in real-time — and reporting data back to CMS in a quarterly summary report. "There will also be a comprehensive wrap-up report at the end of three years," he adds.

"We're very excited about the potential from

the project," he continues. "Any time you are aligning the goals of the physician and the hospital, hopefully this will lead to more efficiency — and quality metrics should improve."

So could this be the wave of the future? "CMS chose a demonstration project in just four states to pilot ACE," Dobbs notes. "I think in the future they may take this to other cities later on and based on how that goes make their decision."

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Kentucky hospital saves close to 400 lives

Getting 'Board on Board' initiatives one key to success

Sometimes large numbers don't hit home as much as smaller ones. When the Institute for Healthcare Improvement launched its "5 Million Lives" campaign, the concept of saving five million lives was almost too large to get one's mind around. But when the Owensboro (KY) Medical Health System announces that by participating in the campaign it has saved nearly 400 lives, that can really grab your attention.

Part of the reason for this success, says **Lisa Thompson**, the system's director, quality improvement, is that it was part of the campaign right from the beginning. "We joined the day the IHI announced it," she says, adding that the system already had been participating in the predecessor "100,000 Lives" campaign. "Our CEO was sitting in the audience at IHI's national forum, and when they announced it, he knew our hospital was going to be one of the participants. He got out of his chair and said we wanted to be part of it." Thompson notes that Owensboro also had done several IHI collaboratives and had participated in all six projects in the "5 Million Lives" campaign.

Key Points

- System is pioneer participant in IHI's 'Five Million Lives' campaign.
- Free 'how-to' guide from IHI shows hospitals how to implement 'Boards on Board' initiative.
- Committees are restructured to reflect renewed emphasis on quality and safety.

Another key was the successful implementation of the "Getting Boards on Board" initiative. "When they announced the 'Five Million Lives,' we were doing all those initiatives except for getting the board on board," says Thompson. "We talked about quality in [board] meetings, but I don't know that anyone ever really understood it."

Getting board 'on board'

So, how did Owensboro implement the initiative? "We got the IHI how-to guide [available free of charge on the IHI web site], pored over it, and started implementing it," says Thompson. "Then, the IHI held sessions on the topic and we took several board members, who were educated by IHI faculty." Whenever someone new joins the board, she says, "that's now one of the first things we do."

The hospital already had in place a subcommittee of the board that dealt with quality, "but they had looked at it more from the aspect of finance; their main function was assessing equipment," Thompson explains.

The committee was totally restructured and renamed the "board quality and safety committee."

"They do not talk money at all now," says Thompson. The committee is made up of some board lay people, physician board members, and physicians from the medical staff.

"We also have a medical quality committee, which reports to them," Thompson adds. "It's all physician-driven. The patient safety committee is also led by a doctor, and he makes monthly reports to that committee."

In addition, says Thompson, quality is now the first topic on every board agenda. "That's what it recommended in the 'how-to' guide," she explains.

Quality at the hospital "has risen several notches" as a result of the initiative, Thompson asserts. "The board always said its focus was on

quality, but now they actually *do* focus and look at quality in a more in-depth manner; they ask questions, they are involved," she says. "The doctors appreciate getting a chance to talk about their work and what we as an organization have accomplished." It's made a difference with the medical staff and clinical staff "because the board has a better understanding of what we do and how it impacts our outcomes," she adds.

Measuring results

How does Thompson know that 400 lives were saved? "We took our patient population and said, What would happen if we continued to practice at the same rate we were, and we multiply it out,'" she says. "Say five years ago our mortality rate was 10% and now it's 2%. You take your number of patients and multiply by 10%, and that's where we would be if we had not done the interventions."

Thompson concedes that this method may not be high statistics, "but it helps people understand, and it makes it real — one of them could have been my Mom or Dad."

It's an effective way of grabbing the public's attention, she continues. "When I tell you I decreased our mortality rate by 20%, people will see that and say, 'So what?'" she notes. "But if I say we made a difference for 480 people, they say 'AHA!' It gives you a much better picture of what we're doing."

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Telemedicine improves care in child sexual assaults

Majority of rural practitioners improve their processes

Telemedicine has long been known to assist rural facilities in delivering more expert care in a number of specialties, but sexual assault examinations have not typically been among them. However, a new study in the journal *Pediatrics* shows that it can have dramatic results.[1]

Key Points

- Collection of forensic evidence significantly improved using telemedicine.
- Nearly half of participating practitioners change their interviewing methods.
- Improvement also was seen in ability to discover injuries.

The study looked at the effectiveness of consults performed at two rural northern California clinics linked by videoconference to experts with the UC Davis Children's Hospital Child and Adolescent Abuse Resource and Evaluation (CAARE) Center through the UC Davis Center for Health and Technology and its telemedicine program. One site was in Eureka in Humboldt County; the other was in Clearlake in Lake County.

UC Davis provided each study site with videoconferencing equipment, including a camera, a flat-screen television monitor, and a video camera connected to the site's colposcope (a lighted magnifying instrument that is used to examine the vagina and cervix). The CAARE Center expert in Sacramento video-conferenced with the community physician and the patient in the exam room at the study site. The expert provided guidance on all aspects of the examination by alternating between viewing the community physician and the patient in the exam room and the images captured by the colposcope.

In all, 42 child sexual assault cases were included in the study, which involved one male and 41 female patients ranging in age from seven months to 17 years. In 47% of the consults, the presence of the CAARE Center expert resulted in changes to the interview methods used. There were nine acute sexual assault telemedicine consults that resulted in improved collection of forensic evidence.

The presence of the expert also resulted in changes in the manner in which 35 — or 89% — of the consults used what is called the "multimethod technique," which involves using multiple, complimentary avenues for obtaining information about instances of sexual assault.

Educating practitioners

"The quality-of-care piece is this: Delivery of care becomes an educational program where our practitioners sit on one side of the monitor

and assist the practitioner with the exam and with obtaining forensic medicine," explains **Kristen Rogers**, PhD, an assistant professor in the department of pediatrics working in CAARE, and one of the study's authors. "It's live assistance, so it increases the quality of care — which we've shown in our research. It's a higher level of care because you're getting the experts."

For instance, she says, a lot of rural practitioners are not expert in looking for injuries resulting from sexual assault. "Our experts coach them through the exam and say 'Look here,' or 'Manipulate this,'" Rogers explains. "We can look through the colposcope and see a magnified picture, and say, 'Now look at the bottom left corner; do you see that?' It's a great teaching mechanism."

This led to the aforementioned changes in the multi-method technique."These are techniques used by the experts that help visualize the injuries; these are what we assist them with," Rogers explains.

Evidence collection improved

Rogers argues that even improved collection of forensic evidence has quality implications. "It definitely impacts quality of care in terms of a holistic approach — looking at the whole child," she asserts. "It is a mechanism from which evidence is collected to help the whole milieu of obtaining sufficient evidence to prosecute the offender and keep them away from the community."

Not too long ago, Rogers recalls, a local practitioner was examining a child who had been raped and couldn't find any evidence. "Our practitioner said, 'Ask the child what happened,' and she said the man kept whispering in her ear throughout the assault," Rogers shares. "So, our practitioner suggested they swab her ear, and sure enough they got DNA and the guy pled out."

The CAARE experts also are invaluable in assisting with the medical history, Rogers continues. "Local practitioners are pretty good, but not as good as we are at asking questions about the assault — what happened, where, what the child was doing, and so forth," she explains. "It's harder for them because they do not do it all the time, but these questions are also important for gathering evidence. Oftentimes this helps get information about the actual assault — details leading up to it, during and after."

The way the questions are asked also is important in terms of a future trial, Rogers notes. "You can't lead the patient, because it won't hold up in court," she explains. "For example, 'He did this to you, didn't he?' rather than 'Who did this?'"

Care and sensitivity also are crucial, she adds — not just for the victim, but for the provider as well. "This is a very emotionally upsetting prospect that even the local practitioners go through, and to have the consultant 'with' them is very reassuring," Rogers notes. "It's very difficult for everybody."

Reference

1. MacLeod et al. Using Telemedicine to Improve the Care Delivered to Sexually Abused Children in Rural, Underserved Hospitals. *Pediatrics* 2009; 123: 223-228.

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Does your documentation program stop short?

Make sure the record is complete

If your documentation assurance program focuses on reimbursement alone, you're not going far enough. With pay-for-performance initiatives on the rise and increasing mandates for public reporting of hospital data, it's critical that the medical record accurately reflect the severity of illness and the services provided to your patients.

Many times, documentation specialists do a great job of picking up the complications/comorbidities (CCs) and major complications/comorbidities (MCCs) but stop right there and miss the opportunity to add additional documentation, which will affect the drivers of acuity level and risk of mortality. **Bert Amison**, managing director of health care advisory services for KPMG LLP, who works with hospitals on documentation improvement projects, says he has found this to be true.

"So often, hospitals concentrate so much on

reimbursement that they put other issues on the back burner. Many times, when we conduct an analysis of hospital documentation, we find little or no opportunity on the hospital reimbursement side, but there is a lot of opportunity on the risk-adjusted mortality side," Amison says.

The MS-DRG system is somewhat severity-adjusted, but it still doesn't give a comprehensive picture of how severely ill the patient is, adds **Tamara Hicks**, RN, BSN, CCS, manager of care coordination at North Carolina Baptist Hospital in Winston-Salem, NC.

This means it's no longer enough just to get the MS-DRG correct and ensure that your hospital is appropriately paid for the services it provides, she adds.

Often just one comorbid condition will put a patient into a higher-paying MS-DRG, but if the patient has multiple comorbidities, it can affect the hospital's severity of illness data, Hicks says.

"When we first started our documentation integrity program, we looked only at Medicare patients and their DRGs. When we got a complication/comorbidity documented, we stopped because we had gotten the patient in the highest-paying DRG. But if there is a patient who is in the ICU for 50 days and we document only enough for the highest reimbursement, it skews our severity of illness and expected mortality data," she says.

When the administration asked for data that showed how sick the patients really are, the care coordination department evolved its documentation integrity process to ensure that the documentation gives a complete picture of the patients' condition and services received, Hicks says.

Draw complete picture

"It's important for the documentation to be complete. If a patient dies while in the hospital, we want our data to show that we expected it. We don't want the record to show that the patient had only a 10% chance of dying because the documentation was not complete," she says.

Web sites such as The Leapfrog Group and HealthGrades include expected mortality and the mortality index in their hospital report cards, says **Liz Youngblood**, RN, MBA, vice president, patient care support services at Baylor Health Care System in Dallas.

Documentation that accurately shows severity of illness and mortality data is more critical than ever because so many decisions are being made based on administrative data, she adds.

Patients are starting to shop for health care and may use public report cards in their decision-making process, Youngblood says.

"Consumers are becoming more savvy and more active in making decisions about their health care. They no longer rely solely on their physicians when it comes to choosing a hospital. They are looking on the internet and asking a lot of questions," she says.

The data also affect the hospital-specific assigned base rate with which Medicare reimbursement is calculated. Quality information that is based on administrative data also may be considered during the negotiation of managed care contracts, adds Youngblood.

Commercial insurers are focusing more and more on quality of care and are taking comparative data into account as they contract with providers, she says.

Managed care payers have claims data as well and can use the information to analyze hospital outcomes of care, Youngblood adds.

"Providers with more favorable outcomes may be considered the best choice for payer populations," she adds.

For instance, The Leapfrog Group's Hospital Rewards Program ranks hospitals in four tiers, based on quality measures and resources use, allowing commercial insurance and employer groups to use the information for pay-for-performance initiatives.

Reporting accurate mortality data is important as Centers for Medicare & Medicaid Services moves toward value-based purchasing and begins to tie reimbursement to quality indicators, Amison points out.

"The trend is going in the direction of possibly tying more payments to hospitals who report more appropriately and more accurately," he adds.

Mortality reporting, severity of illness, and risk

Key Points

- Documentation specialists often do a good job of marking CCs and MCCs but stop right there.
- It's not enough just to get the MS-DRG correct.
- Start by pulling multisciplinary team together to see how the process would look.

of mortality all are driven off of coding. This means the documentation in the medical record should be complete and accurate to fully reflect the patient's condition, Hicks says.

Documentation assurance makes sure you are paid appropriately for the care provided by ensuring that you have the documentation in place to support medical necessity. Additionally, other rules, such as whether a condition was present on admission, must be clearly documented to allow coders to appropriately code, Youngblood says.

"It's really about compliance — making sure that you have accurate coding, and that entails making sure you have the proper documentation in the medical record," Youngblood says.

Whether your department is starting a brand-new program or beefing up an existing program, you need to be able to demonstrate a business case for documentation assurance in order to sell it to management, Amison says.

Return on investment

"Return on investment for a documentation assurance program is very real, especially when Medicare and Medicaid are proactively looking to recoup funds through the Recovery Audit Contractor and Zoned Program Integrity initiative," Amison says.

"A proactive and robust documentation improvement program produces a financial return on investment, a compliance return on investment, and appropriate documentation of the severity level of patients," he says.

Start by pulling together a multidisciplinary team to evaluate what the program might look like, Amison suggests.

In addition to case management, the health information management director, the quality and/or compliance officer, the chief financial officer or a representative from finance, and the chief medical officer or the chief nursing officer or both should be on the team.

"The team should include representation from every department that has a stake in documentation assurance. If people are involved from the beginning in the evaluation process and the creation of the program, they're more likely to be involved and promote the program with their staffs when it is rolled out," Amison says.

The team should review the medical record and the coding to determine where the documentation deficits are and where there is room for improvement, Youngblood suggests.

Don't concentrate on every MS-DRG at once. Pick a few areas where you can make the biggest difference, she advises.

Don't assume that the areas other hospitals struggle with are the same areas where you should focus. All hospitals are different, Amison adds.

Amison strongly advises his clients to dedicate full-time staff to a documentation improvement program.

"The solution isn't just to put the documentation improvement process on the case managers' plate when they typically have more pressing things to do. If you take into account all of the benefits of a documentation assurance program and compare that to the salary for dedicated staff, it's a no-brainer," he says.

Before beginning the program, educate everyone who is going to be involved in the process.

Take a three-pronged approach to education, Amison suggests.

"You can't educate the documentation specialists and the coders and not the physicians," he adds.

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Community network eases transition of care

Hospital, nursing homes work together

After Summa Health System began a series of initiatives to provide a seamless transition as patients move between levels of care, the rate of hospital readmissions within 31 days dropped from 26% to 24%.

"Avoiding readmission is a challenge for every care manager and discharge planner. We identified where the potential risk factors are and came up with strategies to manage them," says **Carolyn**

Key Points

- Summa Health System was able to drop its rate of hospital readmissions within 31 days from 26% to 24%.
- You can't just look at medical conditions, but all the risk factors that could put the patient back in the hospital.
- Hospital staff were educated on what nursing homes need.

Holder, MSN, GCNS-BC, manager of transitional care for senior services/post-acute for the integrated health care delivery system in Summit County, OH.

The challenge is compounded by the fact that today's hospitalized patients are older and far sicker than in the past and many have multiple chronic illnesses.

"We have an increasing number of patients who are aging with pre-existing functional impairments, as well as lack of caregiver and social support. In the past, patients were admitted with simple pneumonia or heart failure. Today, nothing is simple," Holder adds.

Today, a likely scenario would be a patient with pneumonia who is admitted for a two-day stay. The patient is elderly, living alone, and has functional problems and other comorbidities such as heart failure, lung disease, diabetes, or a complex medication regimen.

"We can't just look at medical conditions. We have to take into account all the risk factors that could prevent these patients from successfully managing their own care, preferably at home or in another level of care" Holder says.

Summa's post-discharge initiatives include collaborating with local skilled nursing facilities on communication issues as well as taking a proactive approach to discharge planning and patient and family education.

"We knew we couldn't do this by ourselves. We have to reach out to the nursing homes and other community providers in order to provide a seamless transition between levels of care," Holder says.

One key factor in improving the transfer process was the development of the Care Coordination Network, a coalition of representatives from the hospital system and 28 nursing facilities in the community.

The goals of the Care Coordination Network are to reduce fragmentation of care, decrease hospital length of stay and unnecessary readmissions, and enhance quality and patient outcomes, Holder says.

Representatives from each of the nursing facilities work collaboratively with hospital staff to improve the way information is shared and ensure continuity of care as patients transition from one level of care to another.

"The network has been a real plus. We are looking at it from both sides when it comes to improving transfer of care between facilities. There would have been no way for us to change the process without knowing what the nursing facilities needed," she says.

The network team identified factors that impede smooth transition, including the time it takes to identify available beds at post-acute facilities and gaps in information the hospital provides to post-acute providers.

One of the first steps was to create a standardized nursing facility transfer form for orders and information needed as patients are transferred from the acute care hospital to the nursing facility. Based on the success of this effort, Summa contributed to the development of a regional post-acute transfer form that is now used for transfers between hospitals and nursing facilities in a four-county area of northeast Ohio. The Akron Regional Hospital Association took a leadership role in the development of the regional transfer form.

"We also asked the nursing facilities to tell us what they need to make a decision on whether they could take the patient. This includes bed availability, patient needs, and other transitional issues," Holder says.

Using the information, Summa implemented an electronic referral process, using an electronic discharge planning product that has increased the timeliness and efficiency.

"As a result of this interaction, hospital staff were educated on what the nursing facilities need and why. Another positive effect of the interaction is the decrease in requests for chart forms to be faxed to the facilities. The network developed a core list of information needed, which decreased work time for the acute care staff," Holder says.

In the past, each nursing facility wanted different information, which meant the hospital staff had to copy as many as 30 or 40 different forms. The facilities got together and narrowed it down to about 14 areas of key information, she adds.

After creating the nursing facility transfer

form for regional use, Akron Regional Hospital Association, in collaboration with Summa and the Care Coordination Network, developed a referral form for nursing facilities to use when they transfer patients to an emergency department.

"The communications process goes back and forth. They are telling us what they need from us, and we are telling them what we need from them," Holder says.

All of the nursing homes in the area use the transfer form to give the emergency department staff details on why the patients are coming in. The nursing homes also put a patient identification band on every patient transferred to the hospital or emergency department.

The post-acute care to emergency department/hospital transfer form provides information about the reason for the transfer and the baseline history and functional level of the patient.

The Care Coordination Network is working to review the quality of patient transfers and to identify factors that contribute to patients being admitted to the hospital within seven days.

"We're looking to see what we could have done differently and to develop initiatives to address them. We are seeing a trend for patients being admitted within seven days with symptoms of delirium," she says.

"Before we started this process, we had no way of knowing why they were coming back. We asked them to critique us and let us know how we could do a better job in providing information about the patient. It really helped us close the loop on what we needed to include when we transfer a patient," Holder says.

At the same time, the hospital system is able to communicate quality issues with nursing facilities, such as how a quick response for bed availability helps with hospital capacity. In turn, the hospital staff learned that when the patient is going to need a particular type of bed, such as for a bariatric care patient, the nursing home needs to know up front.

"They understand that we have to be able to move our patients when we're full. We have educated each other about what each of us needs to ensure a quality transfer," she says.

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Use guidelines to improve pharmacy's performance

Expert points to 8 domains

Hospital pharmacies continually search for ways to improve quality, safety, and develop best practices. But they might not be going about this as efficiently and effectively as they can.

A first step is to establish your institution's priorities, an expert advises.

"We look at the industry as a whole and decide from our perspective what is the best practice," says **Robert Sobolik**, RPh, quality advisor for McKesson Health Systems of Great Falls, MT.

The first step in developing your own best practices is to decide how big your focus will be, Sobolik says.

"If you're talking about best practices with medication safety, then you have to decide whether you'll focus on medication administration only," Sobolik says.

"But we think medication safety best practices are a whole lot more than that," he notes.

A more effective focus might be to work toward becoming a high performance pharmacy, Sobolik says.

High performance pharmacies focus on how to maximize what's spent on drugs and quality outcomes, he says.

As part of the quality outcomes focus, McKesson Health Systems does an assessment of hospitals' medication safety, how the system works, and how it can be improved, Sobolik says.

"Everything the pharmacy does can reflect on the leadership," Sobolik says. "That's one of the hardest ones to quantify and get your arms around."

So it's a good idea to create a reference document, which can run more than 30 pages, to show to what Sobolik calls the C-fleet: the CEO, CFO, etc.

"You can set it up in sections so they don't have to read it all at once," he explains. "It breaks up the information so someone doesn't have to spend an hour or so to read everything at one time."

Next, develop an assessment tool, using Excel spreadsheet software, to create a spreadsheet for each area or domain. The last area is an action plan. Each spreadsheet has columns for when a pharmacy is in full compliance or whether this

Key Points

- Develop a reference document with readable sections to show hospital leaders.
- Create a spreadsheet, including an action plan, for each section or domain.
- Focus on "low-hanging fruit" first and then tackle more costly projects.

compliance is occasional, never, or not addressed, Sobolik says.

Sometimes a particular area of compliance is not addressed because no one has thought about that issue, he adds.

"Then, if the compliance is sometimes or never, you move it to an action plan page along with a comment," Sobolik explains. "And you create a macro to collapse the blank lines so that all you have is the action plan there."

The action plan includes priorities.

"I recommend that you look at that action plan for potential sentinel events and other major areas that would strongly impact patient safety, and those become your high-priority items," Sobolik says. "Then you share the action plan with the C-fleet because a lot of those things are high-ticket budget items, and you can gauge where their priorities are, too."

Once the hospital's top leaders buy in to the plan, then implementation can begin.

Keep in mind that it's wise to shoot for the low-hanging fruit first because these early successes will foster an attitude among staff that the organization is moving in the right direction, and it can create momentum for future successes, Sobolik advises.

"Then work through the plan," he says. "Nothing in the world is stagnant, so you'll have to look at this regularly — we look at our documents every year — to see what new technologies are out there and what other hospitals have reported that they're doing."

Pharmacy directors should look at peers' best practices as reported in management studies and at sessions held during mid-year meetings.

And they need to keep in mind that their job is only half done if they research all of the regulatory and accreditation standards, implement those, and stop there.

"Our belief is that because these are either regulations or used as regulations, those are not best practices," Sobolik says. "Those become the minimum standard if they're regulations because you have to do that at the very least."

Best practices are when organizations go beyond what's required.

For example, hospitals are recommended to vent their chemotherapy hoods outside, but it's not a requirement, Sobolik says.

"So that's a best practice because you have to vent that hood somewhere, and the best practice is to vent it outside," he adds. "This is above and beyond."

Although it's common these days to hear that hospitals do not have the financial resources to spend on practices and items that are not absolutely necessary, it's still important to focus on providing patients with the best care possible, Sobolik adds.

"I still think the best care we can provide our patients is the only way to go," he says. ■

Discharge unit helps speed patient flow

ED goes more than 4 years without diversion

ED managers agree that overcrowding and gridlock, while often manifested most graphically in their department, are decidedly hospital-wide issues, and the experience of Sarasota (FL) Memorial Hospital seems to prove their point. For several years now, the hospital has run a "discharge unit," which houses patients who are ready to leave the facility while they wait for their transportation home to arrive. The unit is

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■ Montana hospitals start integrating patient data

■ Re-engineered discharge program aims to decrease readmissions

open from 8 a.m. until 7:30 p.m. Monday through Friday.

How has this unit affected the ED? "We have not been on divert since Dec. 1, 2004," says **Lynne Grief**, RN, PHD, director of emergency services. "We see about 80,000 patients a year, and for a department of our size, this is especially unusual."

The ED's overall flow situation is very smooth, Grief continues. "For example," she says, "last week we saw 83% of our patients in 30 minutes or less." During that same period, she adds, only nine patients left before treatment, which represented 0.6% of the department's volume. On an ongoing basis, she says, 75%-80% of the ED's patients are seen in 30 minutes or less, and 1%-2% leave before receiving treatment. "We know from research that the reason people walk back out is typically related to how long they have to wait," Grief notes.

Grief especially appreciates the unit because she has never worked in an ED before that had access to one. "Generally, if a hospital has a discharge unit, it means their philosophy is focused on patient throughput," she says. "It's one of the cogs in the wheel we have in place to make sure we get them upstairs in a timely manner."

The discharge unit "originated on the back of an ED doc's cocktail napkin," according to Janet Steves, RN, BSN, MBA, interim patient care director. The unit is located on first floor of the hospital, "directly near and visually connected to where patients drive up and also near the ED." It includes four private room areas, each with "a nice, full stretcher," where patients can continue their convalescence if need be. The other half of the unit is an open area with lounge chairs, a TV, and an entertainment center. The unit accepts discharged patients from inpatient units, the clinical decision unit, and the ED.

"We help the ED more by getting inpatients out of the hospital than by taking discharged patients from the ED," says Steves. "If the ED discharges patients and they are waiting for a ride, they can come to us, but a lot of them want to smoke and we are a nonsmoking campus, so their toleration for the unit is low."

There is one notable exception, however. "The ED has a clinical decision unit for observing patients," notes Steves. "Many times those folks, [once they are discharged] will use the discharge unit, too, if they need a ride and that ride will not be coming in a timely manner."

In other units in the hospital, Steves continues, patients are pulled from the floors as soon as they are ready to leave. ■