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# National Patient Safety Goal on HAIs to be phased in by January: Are you ready?

*Consultants highlight where hospitals are falling short*

"What [Goal 7] is doing is... reminding us that more Americans are dying of these infections than breast cancer, motor vehicle incidents, and HIV infection combined in this country," says **Stephen Weber**, MD, associate professor in the section of infectious diseases and chief health care epidemiologist at the University of Chicago Medical Center and consultant with Joint Commission Resources.

An expensive, and often fatal, scourge to hospitals, health care workers, and patients, "these infections" include multidrug-resistant organisms (MDROs) such as *Staphylococcus aureus* (MRSA), *Clostridium difficile* (CDI), vancomycin-resistant Enterococci (VRE), as well as central-line associated bloodstream and surgical-site infections. And hospitals are dealing with them on two fronts: as "never events" for which the Centers for Medicare & Medicaid Services will not reimburse when they are acquired after admission to the hospital and as a Joint Commission National Patient Safety Goal.

Goal 7 on reducing health care-associated infections is pegged to be phased in, with all elements implemented, by Jan. 1. It touches on goals in areas from infection control, environment of care, and human resources, as well as issues including hand hygiene and contact precautions. "The things that are demanded or insisted upon are, what I think, pretty core elements of any sensible infection control program. [They're] saying: Are we educating our staff about these matters? Are we keeping tabs on what these numbers actually look like? Are we communicating these risks and, in essence, their part in prevention to patients and family members?" Weber says.

"When you look at it with a very narrow view, one could say, 'Boy, what a pain to have this added on to our other work.' I prefer to think of it a little more broadly and just say, this really gives an organization an opportunity to take one particular problem, here as it relates to infection control, and really map it through the entire organization — everything from communication to education to information systems support — to really see that it's hard-wired instead of just another reactive leap for an accreditation standard."

How does your infrastructure stand? Weber and fellow Joint Commission Resources consultant **Barbara Soule**, RN, MPA, CIC, practice leader, infection prevention and control, spoke with *Hospital Peer Review*

about where hospitals should focus in order to be ready come 2010 and to build a lasting foundation for preventing health care-associated infections.

## Checklist for readiness

"I think there's wide variation in what hospitals are struggling with and where they are in their process," says Soule, but she has noticed some common themes.

• **Conduct thorough risk assessments.**

"I don't think everyone is currently performing thorough risk assessments for multidrug-resistant organisms and how they're acquired or transmitted in that organization," Soule says. For each infection type, the goal requires "periodic risk assessments."

For MDROs, for example, she suggests annual assessments, which obviously doesn't prohibit a hospital from conducting them more often, especially if things change. "What I see mostly, for instance, with MDROs, is the risk assessment looks at the pathogen, looks at the organisms to see if there's a high or low prevalence. But what I don't often see is a look at the other aspects that could prevent MDROs from occurring or might actually contribute to them occurring."

She says organizations should ask themselves if they are educating all the necessary staff — medical, nursing, support, and environmental services. And they should ask themselves how well staff are following appropriate isolation precautions. Are those precautions part of a policy, and is the policy always being monitored?

Your risk assessment should clarify what issues you need to measure, Weber says. "[Y]our leadership, whether their primary role is in clinical quality or that administrative infrastructure that supports quality, needs to really know when it comes to infection control that the way their dollars are being spent, and the way their resources are being expended, that it makes sense given the particular challenges of the organization," he says.

• **Monitor environmental hygiene.**

"I suggest that [hospitals] do monitor and see if people are truly following the policies, and that's for all the different professional groups that might go into a patient's room. Another issue we feel can contribute to MDRO transmission is the environmental contamination with these organisms," she says.

Monitor cleaning procedures, particularly in areas where patients and staff come in contact, around patient beds, and where patients go for examinations. She says some of the organisms the goal covers can live for months if areas aren't appropriately cleaned.

• **Provide staff education according to the requirements of the goal.**

Hospitals should make sure they are providing education in accordance with the goal. This involves *any* staff who would be involved with

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the issue. Education must take place at the time of hire and annually thereafter. Education also must be offered when a staff member changes position — for instance, becoming involved with central line insertion where before he or she was not.

"Not only does an organization need to provide the education," Soule says, "they need to evaluate it to see if learning has taken place."

Surveyors will want to see records of education that has been performed. "They might pull a person's HR personnel record, say a new nurse in the ICU or a new staff physician who's been working in the ED, and see if there's documentation of education," Soule says.

While education for staff must be presented, evaluated, and documented, education for the patient and his or her family can just be documented in the chart, she says. For central lines, family and patients must be educated when a central line is placed.

**• Use evidence-based guidelines or best practices.**

Another requirement, she says, is using evidence-based guidelines or best practices for all three types of infection. "An organization would want to monitor whether they're actually complying, for example, with the Centers for Disease Control and Prevention [CDC] guidelines or, if they're not, why they aren't, and do they have a justifiable reason that they can assure that they're providing the same level of patient safety by doing something different."

She points facilities to guidelines from both the CDC and the "Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals" published by The Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the American Hospital Association, The Joint Commission, and the Association for Professionals in Infection Control and Epidemiology. **(You can download the the compendium at www.shea-online.org/about/compendium.cfm.)**

**• Communicate data across the hospital.**

Another challenge for hospitals is getting information about incidences of all health care-acquired infections "to all the different stakeholders. We would like to see them get that information all the way up to the board of directors or the governing body of the organization; that group is responsible for the care provided in the organization," Soule says.

Those data, she says, should be provided in an easy-to-digest way and in appropriate formats to accommodate different learning styles.

**• Monitor outcomes using evidence-based metrics and conduct surveillance.**

For MDROs, the goal requires hospitals to implement a surveillance program based on the findings of their risk assessment.

"I'm always worried when someone says, 'Well, we don't have a really strong surveillance system for a resistant organism or *C. difficil*e because we don't have a big problem with that,'" Weber says. "And I guess what that immediately brings to mind is, 'Well, how can you say you don't have a big problem with it if you're not even following it or mapping it?' I don't think anyone on the administration side, when it comes to budget time would say, 'Well, we don't really need to look at our expenditures or revenues because we're basically doing OK.' That wouldn't pass muster in the board room. So I'm not sure why the standard on the issue related to patient safety or quality of care would be approached any less rigorously."

He adds that "active surveillance, as it's now known, is not some magic wand that you just start doing and MRSA goes away. You need to make a commitment to all the business interactive surveillance, which is people following precautions in order for it to have a benefit."

Soule points hospitals to CDC guidelines on metrics for monitoring outcomes. "There's an excellent paper on this by Cohen et al.[1] It's all on metrics for measuring MDROs. It really goes into ways you can measure for MDROs. For central line, the CDC guideline is pretty old; there's a new one that's under review now. But in the compendium of strategies, they give recommendations for metrics for measurement for those areas," she says.

You should be able to show you're using a specific metric, one that makes sense, and then that you collect data, and that you act on those data in constant surveillance.

**• Consider carefully what data to collect.**

Soule says there is still a wide variation in what data hospitals are collecting. In the compendium, she says there are suggestions for process and outcome measures. "I think the first thing to do is a risk assessment, and that helps the organization focus on what data it needs to collect. Because you don't want to be just collecting all kinds of data that you don't need or that can't use," Weber says. Then design your

surveillance plan based on the organizational challenges found in the risk assessment.

• **Improve hand hygiene compliance.**

As Weber says, the goal touches on so many fundamental elements of safety, one of which is hand hygiene. Speaking of the low compliance numbers surrounding hand hygiene, Weber says, "I think it's the most awful shortcoming in patient safety and hospital quality, at least for the last half century and I guess going back before that. To go to national meetings that I have of infection control folks and have a leading authority in the field get up and say, 'Wake up folks, we'll never get to 100% [compliance on hand hygiene].' It seems preposterous to me that we're giving up on this.

"It's remarkable how we've shied away from the idea of giving individual and direct feedback," he says. At the University of Chicago, they are looking at strategies to automatically detect hand hygiene adherence, one of which is radiofrequency identifier tags.

"And I'll tell you, our viewpoint is to provide individual feedback. It's remarkable that some of the groups that are doing similar work are saying, 'Well, we would never detect down to the individual health care worker level. We'd never want to get involved in that privacy issue.' I think that's just silly. When I orient the medical students, I say, 'If you came into a patient room and you saw the dean of students punching the patient in the face, would you say anything about it?' And I think everybody would," he says.

• **Assign responsibility.**

Soule says you should assign responsibility for oversight and coordination of the goals and document that in minutes from the infection control committee or group such as quality and patient safety or senior leadership. For instance, she says at the unit level, there should be an assigned physician, nurse, and then another person who is the driver for quality.

It's certainly a hospitalwide effort she says and neither an infection control's nor a quality department's sole responsibility. "The effort has to be broader [than the infection control and quality departments], because none of those groups put their hands on patients or perform the procedures that put patients at risk," Soule says. "They are the ones who can help guide and coordinate, but if there's no cooperation or buy-in from the nursing staff, the surgery staff, so forth, then it won't work." In the end, she says, it's the people giving care who have to say, "We're going to make this happen."

### Reference

1. Cohen AL, et al. *Infect Control Hosp Epidemiol.* "Recommendations for metrics for multidrug-resistant organisms in healthcare settings: SHEA/HICPAC Position paper" Oct 2008;29:901-913. ■

# Hospital looks at itself, culture to fight MDROs

*Florida Hospital starts changes at unit level*

As part of its journey to prevent health care-associated infections, Florida Hospital's clinical excellence team asked staff what risks they saw. The answers they got were sometimes unexpected, but they helped the team understand the organization's culture and determine which fundamentals should be saved and which should be altered.

This year, **Lee Adler**, DO, vice president, quality, safety innovation, and research at Florida Hospital in Orlando, was assigned with strategic oversight for the eight-hospital system's rollout to fight multidrug-resistant infections (MDROs). He began the journey by asking a lot of questions on the front lines, getting input from multiple disciplines and piloting projects on a unit level.

### Assessing where it was

With more than 120,000 patient admissions, 1 million patient contacts, and more than 360,000 ED visits in a year, Florida Hospital, "is a big outfit," Adler says.

"Organizations have various attitudes to [addressing MDROs]. Since Florida Hospital is so complex, we needed to ask ourselves, 'What do we have to do to change the fundamentals within the organization, and what are the nice-to-haves once the fundamentals are in place?'"

To answer this, they first performed a risk assessment. In the formal risk assessment, Adler collaborated with **Christine Kaptur**, RN, BS, MA, CIC, LHRM, administrative director, office of clinical excellence, which includes an infection preventionist and project manager. They chose to separate out the emergency department and the acute care inpatient departments. "The ED is a complex, pressure-filled environment," Adler says. Many patients coming in are an unknown

risk, already immune-compromised or harboring bacteria with common complaints including abdominal pain, diarrhea, fever, cough or many are coming from nursing homes or long-term care facilities.

"We knew we needed a different mindset than that from the inpatient side, where the patient has somewhat been screened either by a physician upon entry into the hospital or by the ED," he says.

Adler also assembled interdisciplinary health care workers from the front lines of patient care at the system level and each of the eight hospital campuses to identify differences in terms of risk. The evaluation team was trained to look at risk first in terms of highest-perceived risk from staff and consumers. That highlighted critical quality issues, including hand hygiene, environmental cleanliness, contact precautions, and education. With education, he found, it wasn't necessarily related to the education of doctors and nurses, but of other staff — transport, environmental services, nutrition, respiratory therapy, pharmacy, and others who "go in and out of rooms."

Adler's team asked staff: What are the pebbles in your shoes? What are the things that you believe are not safe? What would you change? What do you see as the issues? One conclusion he found was "the way nurses felt about the physicians in the hierarchal sense was the same way the environmental service worker felt about nursing." Building a team-based environment is a critical success factor, Adler says. Staff "help each other all the time, but they don't necessarily communicate effectively."

## Using spread to get change

Adler chose to use the spread improvement plan from the Institute for Healthcare Improvement (IHI) to tackle MDROs. Using the model, you begin a pilot and then spread it using early-adopter units and personnel. These early adopters are the ones who "really want to make a difference," Adler says. From there, you move to include two or three other units and "eventually when you get your 10 to 20 units, depending on how big your organization is, you can probably get a standard work process and then spread it from there much more quickly."

Most of the units have what Adler calls nurse practice counsels. He told them and the unit's nurse managers he wanted them to do these three things:

- convene a triad including the unit medical director, the unit nurse manager, and the infection preventionist (who acts as an expert resource);
- "really believe," as a unit, that "this is important and have enough volume of infections or transmission of infection on that unit to establish a baseline data and track and trend change following implementation of any changes";
- be willing to communicate and share with other units the challenges it faces and how it created solutions.

## Cleanliness, cleanliness, cleanliness

In talking with staff, the team discovered that the roles in cleaning a room for discharge varied from nurse to nurse and unit to unit. In addition to patients being discharged, there was a different environmental service cleaning standard for isolation and non-isolation patients.

Systemwide implementation of hand hygiene protocols also was being led by Kaptur on a unit basis. Adler, who has published studies on the topic, says it's critical to understand that education, policy, and testing knowledge are each insufficient on their own. To become effective, one must focus on both behavioral and ergonomic issues. "It's more than just having enough sinks, enough soap, and everything else; it also comes down to ownership and holding each other mutually responsible, offering mutual support, establishing mutual respect, and it's all unit based among core team members," he says.

Compliance, he says, often varies from one unit to another. "I believe our bone marrow units are 95% or better. You don't walk onto their floor unless you're going to wash your hands and practice appropriate isolation procedures because that's the culture of expectation to which you're held. You may go to a routine medical-surgical unit and find a totally different microculture and patient medical conditions. And you may find a much lower percentage of hand hygiene," he says.

To gauge actual compliance, units collected baseline measurements. Did the units have adequate dispensers? Were they positioned correctly? Was the foam in the dispensers and were adequate levels available? After determining their compliance, the units came to a consensus on their own about how to keep the dispensers filled and how to coordinate with environmental services.

Adler says compliance audits were done. Sometimes nurse managers would turn in a compliance order reporting 92% compliance, but a "secret shopper"-type audit would reveal that compliance actually was 30-40%. "Many of our campuses' unit nurse managers agreed to assign different frontline nurses to rotate the responsibility for doing the observations. The nurses who were assigned were unknown by their colleagues," Adler says.

"We did that for a couple of reasons. One is to get everyone to own and believe the validity of their data. There is a place for external audits; however, it is counterproductive when outside people collect data, telling you the data are right when you believe they're wrong. If your group is responsible for the data, you're more likely to take responsibility for monitoring and holding each other accountable."

## Environmental services must be on team

Adler also asked the nurse managers to convene on a daily basis at a huddle with frontline nurses, environmental service workers, respiratory therapists, and others, if available, such as the unit medical director. This core team could exchange ideas, review performance, and inform the nurse managers regarding issues of isolation, discharge cleans, hand hygiene, and barriers.

The risk analysis showed high risk on the unit level regarding environmental cleaning. So Adler's team took a picture of a dirty discharge room and turned it into a big poster. They had environmental service staff come in and place green tabs on areas they thought should be cleaned; nurses placed red tabs. Their managers could then identify gaps and engage staff in discussions of any issues regarding specific roles on each unit and create a standard work process for system leadership's ultimate approval.

## Alert systems, education to be improved

National Patient Safety Goal 7 on health care-associated infections requires that after a risk assessment, facilities must implement an alert system that identifies new patients with MDROs as well as readmitted or transferred MDRO-positive patients.

Adler says the system's MDRO alert system required improvement and increased stakeholder support, and assessing those was definitely a part of the risk assessment they did at the outset. "We had some electronic alerts, but they were not effective or fully deployed or aligned throughout the organization," he says. So a collaborative clinical team including physicians, nurses, and infection preventionists started working with the information systems department to improve them.

Annual education of licensed independent practitioners, also a component of the goal, is new and challenging, he says. Building annual education for physicians, allied health care workers — such as physician assistants and nurse practitioners — the rest of the staff, and new employees is critical and mandatory.

"We're turning toward several methodologies for education, which include computer-based learning programs, [to be done] at their convenience or show at their departmental or campus medical staff meetings. We'll conduct grand rounds that we will video and distribute to the campuses for physicians who are unable to attend. We will offer continuing medical education credits and expect physician participation," he says.

He suggests reviewing and adapting your hospital's medical staff bylaws to obligate physicians and those in allied health to complete these annual programs and require documentation to incorporate into physicians' credentialing files.

## Define priorities with risk assessment, metrics

Adler suggests formulating data collection and information flow plans and asking: What processes will you monitor — hand hygiene, contact precautions, etc.? How often will you report them and to whom? Get hospital executives involved. At Florida Hospital, they are piloting executive visits to the units at least once a month in which the executives question staff if they perceive any barriers; the senior leaders also have been charged to do three or four observations of hand hygiene or contact precaution compliance and leave a note for the nurse manager describing their observations — for example, two out of four hand hygiene opportunities were compliant. "Even though we're not expecting executives to keep count, it sends a message of organizational commitment to the frontline nurse manager and their staff, that this is not another flavor of the month," Adler says.

Adler says all the processes that are to be answered on the system level — such as the alert system, prevalence studies, and active surveil-

lance — are or will be piloted on the unit level.

His suggestion for other hospital quality, safety, and risk departments looking at preventing MDROs: "It's very important not to forget to do the baseline and post-intervention measurements. Once you achieve your goals, select key processes to monitor in order to sustain the gains. Post the results in a visible unit location. Scope your projects carefully and get the frontline and nurse management engaged early on to, create a team-based mindset. Engage the assigned unit physician directors to pull in their colleagues. Florida Hospital is still on the journey — MDRO programs require continuous improvement and social networking to achieve patient safety, reduce transmission, and decrease infections." ■

# Doc speak: How to get them on board with quality

*Six step plan to getting buy in*

It might feel like you're speaking a different language when you try to get physicians on board for your quality initiatives. And you actually are, according to one lawyer and health care consultant well versed on the topic. But it doesn't have to be this way. You communicate differently depending on who you're talking to — that's common in business and life. You just have to understand your audience.

The truth is the idea of helping the hospital work on core measure sets isn't what gets physicians out of bed in the morning. Not generally, at least, says **Alice G. Gosfield**, JD, a Philadelphia-based attorney and consultant specializing in quality improvement. And year and year, in response to the annual *Hospital Peer Review* reader survey, you tell us that one of your toughest challenges is getting physicians on board. Gosfield has some answers on speaking effectively with your physician colleagues to engage them where you need them.

"The basic message," she says, "is that the reason physicians are standoffish when it comes to quality is that when hospital people try to engage them, they don't speak to physicians in terms that are meaningful to physicians." So it's like speaking in foreign terms. But, she grants, "on the other hand, they have common cause — physicians and hospitals — around patient safety and quality. And if the hospital were to speak to the physicians and engage with them around the business case for quality, they would make enormous headway. Because physicians are really enormously compelled by this stuff."

## Recognize physicians' need, fears

What's the most precious resource to physicians? Time, says Gosfield. So keep this in mind when eliciting their help.

"It is a quality problem that they need more time in their day. Anything a hospital can do with regard to standardizing order sets, facilitating documentation around guidelines that saves physicians time, the more likely they are to do it," she says.

They are also more likely to adopt a new practice if they are involved in its inception. Gosfield says a small group of physicians, the right ones, must be at the table when something like an order set is being established. Some hospitals have gotten beyond this cultural tension between physicians and administration, but in most hospitals, she says, physicians "live in a mild state of perpetual paranoia" with a lack of trust between what the administration and medical staff say.

Getting at the central tension is integral to successful collaboration. Gosfield says "every hospital has some freight train of baggage driving around that no one talks about. They all know about it, but no one talks about it." In her work with the Institute for Healthcare Improvement, with which she coauthored a white paper entitled "Engaging Physicians in a Shared Quality Agenda," she has created a tool to gauge how physicians feel about the culture of the hospital and the support they receive.

The tool involves asking physicians about the medical staff culture within the hospitals, with questions such as:

- How long has the medical staff culture been stable?
- What does the medical executive committee represents? Is it fair and balanced? Does it represent the medical staff? Does it represent individual physician rights?
- How well and thoroughly does the board engage with the medical staff?

If staff don't feel they're listened to and heard — for instance, if they've brought up suggestions or comments that are never acted on — they often feel a disconnect and might not be motivated to engage further in a team.

Also, acknowledging the unique fears of physicians is essential to truly working hand in hand with them, Gosfield says. "Nobody really acknowledges the fears that physicians have, the anxieties they bring to the table, and the terrible pressure they're under to do right for their patients, make the right decisions using imperfect information in an imperfect system on the fly," she says, adding that physicians feel this "accountability profoundly."

She says when she's talked to physicians about this, she's literally seen their walls melt away at being understood, at somebody voicing the unique pressures they feel. She acknowledges that many feel physicians must be specifically catered to to get their engagement. But she thinks that makes sense. Physicians "have what's called plenary legal authority. The doctors have the broadest scope of authority of anybody in the health care system. They admit people, they order services, they discharge people. Nobody else really does all that... everything that happens in a hospital is ultimately derivative of the physician order. And you don't need physicians involved in every quality and patient safety initiative, but if they aren't supportive, it can bring your program to a grinding halt. Just by their recalcitrance," she says.

Her framework for engaging physicians, which she created for the IHI white paper, includes six points:

**1. Discover common purposes.**

Finding common cause comes first, Gosfield says, and recognizing the most important thing to physicians: time, time, time.

Flip the story around. Instead of telling them you need their help, she suggests asking them what the quality department can to do help them. As for the pervasive thought that what gets physicians on board is constantly putting peer-reviewed literature in front of them, Gosfield says that's not it at all. "There's studies that show that physicians are ultimate empiricists. What they really believe is what has happened to them personally," and they actually discount peer-reviewed literature.

"Secretly," she says, "they discount it because they believe all those guys who are writing peer-reviewed literature are writing their way up the academic food chain and that the purity of literature never publishes negative studies."

Frame the quality discussion in terms of what affects physicians: reducing needless deaths and readmissions. Not "make our scores look better" or "reduce length of stay."

And use data. Don't try to make something mandatory or penalize people who don't do something until "you've got 95% of people who are the 'target market' doing it."

**2. Reframe values and beliefs.**

Physicians are passionate about their own patients, Gosfield says. As health care has changed, they have had to feel that sense of responsibility for *all* the patients in a hospital. That's a "very significant cultural change," Gosfield says. "If you can get them to look at the context in which their patients are being served, it becomes easier to get to the place where they believe that the entire institution ought to be functioning in the same way. But what we talk about is that you want to help them standardize the science, so they can custom craft the art of medicine, which means making the right thing to do the easy thing to do."

She uses an example from Park Nicollet, a health care system in Minneapolis. Physicians and nurses sat down with nurses in the coronary care unit to create a standing order set for AMI. Then it became mandatory to use it; for every patient admitted with AMI, the order sheet was attached to the outside of the record. "So when the physician came in for the initial visit to do the orders for the patient's stay, he could either check off the things he wanted on the standing order set or open the medical record and confront the blank and empty page for which he now has to write a Russian novel," Gosfield says. What do you think happened, she asks then. "They all used the standing order set and their compliance with evidence based [care] shot up to like 97% in 14 minutes."

To reframe administrators' values and beliefs change this sentence "Physicians make care decisions; we run the finances and facilities" to "Physicians are our partners in running the system."

To reframe physician's values and beliefs change "I must have complete autonomy for everything" to "I need autonomy for the art of medicine, but I share it with other physicians for the science of medicine."

**3. Segment the engagement plan.**

"You may think that you have a medical staff. That does not mean that they're all interested in the same stuff or working together the same way or as enthusiastic each to the next," Gosfield says.

For each quality project, there's going to be a few people who get it and are interested in

participating. "They're not necessarily the leaders," she says. "They're not what I call the guys with the crown and scepter all the time." They might be younger people who are more innovative, enthusiastic, eager to get involved with new things. They'll say, "Oh yeah, I want to try that!" Those are the champions, she says.

Then you need the people who will try it after the first innovators do it, saying "That looks interesting. We'll try it, too." Those aren't the people who'll be first in line to try something new, but they're willing to give it a go next.

Then, figure out who wears the "crown and scepter." Those are the people, Gosfield says, "who are willing to stand up and be proponents for this."

To what she terms "cautious critics" — maybe an older doctor more set in his or her ways and less likely to quickly adopt a new way — "go talk to them first," she suggests. "When you get your idea, go say, 'You're so good at figuring out what's wrong.' Frequently, they actually have an important piece of information to share about what's wrong with the way you're going about it."

Segmenting the engagement plan is discerning and identifying who plays these different roles in your organization and the likely players for any specific initiative.

**4. Use "engaging" improvement methods.**

Ask yourself: Are you trying to standardize too much? Do you have endless meetings to discover the right answer, as if this opportunity is the only one you'll have to find it?

Don't ask the same eight guys to do everything a billion times, Gosfield advises. "They get burn out." And don't have endless meetings where nothing ever gets done. That's a way to snuff out motivation quickly. She suggests using "small pockets of people who try things in rapid cycles of improvement."

She suggests the following four things:

- "give physicians raw data; they don't trust interpreted data";
- be aware of which doctors are really respected in your organization;
- make involvement of physicians visible; people should know they're involved;
- build and rebuild trust.

The last is a tough one, she says. And she has a very simple phrase to illustrate what must happen to garner this trust: "Do what you say, say what you do, consistently over time. That means you have to be able to articulate what you're doing and then you have to do what you said you were going to do. And do it again and again and again," she says.

**5. Show courage.**

From the board and the administration to nursing, don't have a culture in which if someone stands up and says, "I don't think this is right," the thought and the person get squashed. Back your staff up. "That meaningful, constructive inquiry is really important, and showing courage is when you adopt a policy, it is real. And when doctors say they're not going to abide by the policy, and everybody has voted on it [and you already had the 95% compliance rate], you don't let them get away with it," she says.

**6. Adopt an engaging style.**

Adopt all of the practices and you will have an engaging style. For instance, involving doctors from the outset, building trust, and communicating frequently will help you get physicians not only on board but involved and committed to the outcomes both of you will want. ■

# How do they do it? Baylor has lowest HF readmissions

*Bad media drove medical center to the top*

When the Centers for Medicare & Medicaid Services announced it would publicly report hospitals' readmission and mortality rates for heart failure, heart attack, and pneumonia, Baylor University Medical Center (BUMC) was front and center. According to a front-page article in *USA Today*, it had the lowest readmission rate for heart failure patients in U.S. hospitals at 15.9%. The next hospital was two percentage points away.

**Pam Stafford**, RN, BSN, CPHQ, health care improvement process consultant for the Baylor Healthcare System with headquarters in Dallas, says the work the system has done continues today. And its rates are the result of a multifaceted improvement process.

### *Where did Baylor begin?*

The improvement process, Stafford says, began about two years ago when a very different article with a very different story ran. It was in a local paper, and it reported that one Baylor facility had

one of the highest mortality rates in heart failure. The system decided to create a heart failure task force. Since its inception, Stafford says it has honed its action plan to four components:

- implementation and use of a standardized order set across the system;
- improving medication reconciliation;
- focusing on the transition, or continuity, of care;
- rethinking palliative care of end-of-life issues.

### *Using an order set*

In adopting a bundle for heart failure care, Stafford says, the team made sure all components were best of, or evidence-based, care on issues including angiotensin-converting enzyme inhibitors (ACE) and angiotensin II receptor blockers (ARB) and discharge instructions. It took some elements from the Institute for Healthcare Improvement's 5 Million Lives Campaign to ensure that all HF patients had the appropriate vaccines, anticoagulants, and beta-blockers as appropriate. ***(Editor's note: The Centers for Medicare & Medicaid Services and The Joint Commission removed the AMI-6 measure, which required heart patients to receive beta blockers on arrival, effective for discharges after April 1, 2009.)***

The set includes checkboxes that are already checked for mandatory elements, and then spaces to write in, for optional things such as which drug to order. To track compliance, for any patient who falls into Baylor's core measure population for heart failure, data are entered into an electronic medical record system, and one piece is whether the order set is used. "It's been difficult to get doctors to buy in. So we spend a lot of time on promoting the use of that order set," she says. Systemwide, compliance is at 70%. In some facilities, it's 100%.

"I think one of our strengths is physician champions," Stafford says. Each facility within the system has a heart failure physician champion. "And if you're running into barriers or having particular problems with one group of physicians or one physician, they talk peer to peer. The physician goes and talks to the other physician about order set use," she says. The champion prompts the physician by asking: What keeps you from using it? That face-to-face interaction has made a difference, she says; it's not health care improvement staff holding physicians

## CNE *questions*

13. National Patient Safety Goal 7 involves which of the following:
A. multidrug-resistant infections
B. central-line infections
C. surgical-site infections
D. all of the above

14. Florida Hospital's MDRO initiative starts with testing changes on the system level, not the unit level.
A. true
B. false

15. Baylor Healthcare System tracks compliance with use of the heart failure order set.
A. true
B. false

16. How many elements are in the framework for the engagement of physicians published in an Institute for Healthcare Improvement white paper?
A. two
B. three
C. four
D. six

**Answer Key: 13. D; 14. B; 15. A; 16. D.**

## CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

accountable, but the physicians champions and senior leadership.

Monthly data are disseminated showing a run chart of each facility's order set use. Health care improvement directors and physician champions receive the unblinded data down to the individual physician level — who's complying and who's not. The system has just begun to post that information in the hospital in areas such as hospitalists' offices, physician dining rooms, or physician lounges.

BUMC and the Baylor Heart and Vascular Hospital have the lowest HF readmission rates, respectively, among the hospitals in the system. Both hospitals can refer patients to their outpatient heart failure clinic, which has a 3-4% readmission rate. Stafford attributes the low rate to the individualized care patients can get there. "The things we teach [the patients] when they're inpatients are actually getting followed as an outpatient," she says. Medications, diet, weight can all be monitored and, if any problems arise, can be dealt with immediately before that patient would elect to go back to the hospital.

### Transition of care pilot

Another thing one of the facilities is doing is piloting the transitional care model developed by Mary Naylor **(see *Hospital Peer Review*, September 2009, page 108)** in which an advanced practice nurse sees patients first on the inpatient side, then follows them at home, seeing them within 24 hours of discharge and then for three more months.

In the hospital, the APN sees patients Monday, Tuesday, Thursday, and Friday and then chooses one weekend day to check on patients still in the hospital. Stafford points out that this isn't a cost-prohibitive model. Since the particular APN at this community hospital has been in that line of work for about a dozen years, not much money had to be expended on training. She handles all the patients for the hospital.

### Addressing end-of-life issues

One day Stafford looked through patient charts to find out who exactly is being readmitted. One of the first charts she looked at was that of a 95-year-old man who lived in a nursing home. He had been readmitted seven times in one year and



## CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review,* CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

## COMING IN FUTURE MONTHS

- ■ Are you in compliance with CMS requirements for patient grievances?
- ■ Lessons learned from one hospital's safety journey
- ■ What is TJC's Medicare Condition-Level Deficiency Follow-Up Survey?
- ■ More tips on being survey ready now

eventually died in the hospital. "Someone needed to talk to that family and that patient long before than seventh readmission," she says.

One particular hospital in the system has an older patient population and was noticing, in essence, that the local "nursing homes send patients to [this] hospital to die," Stafford says. The facility worked with the nursing homes that admitted the most patients, educating them on palliative care and hospice. "They were able to affect the inpatient mortality and readmission rate because they were working on those end-of-life issues," she says.

Part of the system's action plan deals with palliative and end-of-life care, with the instruction "to not admit inappropriate patients," Stafford says. "Don't admit patients who really should be on some sort of end-of-life care plan."

It's a subject people don't want to talk about, especially physicians, who are not taught how to discuss end-of-life issues with patients. Stafford says many cardiologists and internists have come to her addressing their concern with broaching the topic with patients and their families.

The system has palliative care teams to help the physicians educate patients about their options when they are nearing end of life. Nurses use a screening tool for advanced heart failure patients to address risk. Depending on the score, the checklist instructs the nurse to:

- talk to the physician about patient needs such as controlling symptoms, referral to disease management, or advance care planning; continue to monitor and reassess weekly;
- suggest palliative care consult;
- ask the physician to strongly consider palliative care consult.

Physicians "know there's a team and a palliative care doctor that could come and either talk to them or the patient — someone that's comfortable and knowledgeable in end-of-life issues and talking to patients. And if [patients] need palliative care or hospice, that's what we need to do rather than continue readmitting them until they die in the hospital," Stafford says.

She says there is not one single thing she can point to for the success the hospital has had with readmission rates. But, she says, "what is starting to be obvious is that heart failure care is a bundle much like ventilator-associated pneumonia or central-line infections. That care is a bundle. You can't just do one thing and expect it to improve. You can't just use discharge instructions or just do one component of the medications or one piece of transitional care. It has to be all of it, and you have to be working on all of that at the same time." ■