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April 2010: Vol. 35, No. 4
Pages 37-48

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Financial Disclosure:
Managing Editor and Writer Jill Robbins, Associate Publisher Russ Underwood, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

Build a process to manage all of your contracted services

Managing contracted services is required by both The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) and if not managed well can be a huge risk to your organization. And as **Frank Ruelas**, MBA, principal of www.hipaabootcamp.com and director of compliance and risk management at Maryvale Hospital in Phoenix, says, "if it happens under your roof, you better know what's going on."

The Joint Commission requires an annual evaluation of whether to continue or terminate a contract. And CMS requires that a senior staff person be responsible for contracts, which led to a new element of performance this year for The Joint Commission, says **Michael Troncone**, FACHE, principal of Michael T. Troncone and Associates and administrator for patient intake services at Calvary Hospital in the Bronx.

Because it's a high-risk area, The Joint Commission may be looking closely at this, Troncone says. Can you imagine, he asks, going in front of a judge and saying "No your honor, I didn't know the person installing the new televisions on the pediatric unit was a sexual predator. No your honor, I didn't know what cleaners the window washer was using, and I didn't know he was going to use bleach and ammonia to wash our windows." He evens recounts a story of a surgeon bringing in his unemployed brother-in-law to assist in surgery.

Troncone says that, when thinking about contracted services, a hospital should ask: "Who is representing the hospital? Do those contracts you have in place meet all the appropriate regulatory and legal requirements? Are we getting our money's worth? Are we getting what we paid for?"

Getting started

Troncone suggests these steps to effectively manage all contracted services:

- Do an inventory of all the contracts in your organization.
- Establish a centralized process for managing them.
- Ensure that there's a formal approval process for all of the different kinds of contracts (**see box on page 39**).
- Have criteria for managing each type of contract.
- Create performance measures for each type of contract.
- Have a review and renewal process for each type of contract.

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• The Joint Commission requires a process for corrective action should a contract fail to meet required specifications and a contingency plan for contract termination.

Who should be at the table?

Troncone suggests:

• an expert panel to review the contracts;

• a legal expert to review the contract language;

• a privacy officer to approve business associate and confidentiality clauses;

• subject matter experts, "people who are familiar with the performance of that particular clinical or nonclinical service so they can approve the services and methodology of the delivery of services and establish performance indicators";

• an administrative authority who approves the contracts.

He also promotes using templates for your contracts and assigning responsibility for each contract to a senior lead, with the department head most closely associated with the particular service monitoring the contract day to day to ensure quality and delivery of services. That department head reports on the contract to the contract management group.

"By having that department head involved on a daily basis, problems are identified early," he says. Each department head may have up to seven contracts, but it's within his or her span of control, he says. They should have a checklist with the appropriate indicators, which could be supplied by the contract management company or by data already collected on that service line.

The contract management group should meet at least once a year to determine if a contract should be renewed or terminated, and if terminated where you are going to go to get the service. Troncone says you should be able to review 25% of your contracts at the meeting. The department head should make a recommendation for renewal or termination. The second item on the agenda, he says, should be any worrisome contracts and what you're going to do about them. And then look at whether you have identified a need for a new contracted service.

You also need to ensure your contracted services are oriented to your policies. For example, gardening services are spraying pesticides and fertilizers and using power equipment. Troncone says you should ask yourself: "Do they know where the oxygen lines are? Do they know where your air intakes are so they're not spraying pesticides in the air intake for the operating room? Are they following the appropriate infection control procedures? If you take anesthesiologists, he says, "What standards are they following? What are their outcomes? If an anesthesiologist call in sick, who do they provide as back up? Is it someone who's already been oriented and privileged by the hospital?"

With services accredited by The Joint

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and Patient Satisfaction Planner™ is published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals.

Opinions expressed are not necessarily those of this publication.

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Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

Associate Publisher: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Managing Editor/Writer: Jill Robbins, (404) 262-5557, (jill.robbins@ahcmedia.com).

Editorial Questions

For questions or comments, call Jill Robbins at (404) 262-5557.

Seven Types of Contracted Services

- accredited onsite clinical services;
- nonaccredited onsite clinical services;
- accredited offsite clinical services;
- nonaccredited offsite clinical services;
- nonclinical onsite services;
- nonclincial offsite services;
- administrative contracts.

Commission, you should be aware of their accreditation status. With those not accredited, you should do your own "tracer" of sorts, Troncone says. You should make sure they're fulfilling Joint Commissions standards. "So you need to do an onsite review. You need to review and approve their policies and procedures. You need to ensure that they're doing all the appropriate life safety things, and that means you need to get your infection control person, your safety officer, your privacy officer, and your clinical people to do an indepth review."

Medical staff should have the opportunity to review and comment on clinical services and performance data. Troncone says the corporate compliance officer should ensure that contract terms and bidding and awarding of contracts meet the organization's corporate compliance requirements.

Offsite services should meet the credentialing and privileging standards of The Joint Commission. "Clinical services require the most intensive orientation, and the organization has to ensure current competency, licensure, education, and continuous improvement of competency for contracted clinical staff," Troncone says. A personnel file for each clinical staff person should be maintained.

The Joint Commission is "not going to sit down and review individual contracts and [try] to identify a problem. If they identify a pattern or trend with contracted services, they will certainly start reviewing contracts," Troncone says.

They might ask to see a contracted person's competency and credentialing and privileging files. They might ask people on the floor if contracts are being monitored or if services are being delivered appropriately, Troncone says.

They might ask senior leadership if there is a process for managing contracted services, he says; or if someone is installing television, they might ask if he or she got an infection control and patient privacy inservice.

The most work-intensive part of the process is getting all the contracts together and creating your process for managing them. "Once the process is set up, ongoing compliance becomes easy," Troncone says. ■

Are you evaluating your contracted services?

Data sources for evaluation

So how do you evaluate the quality of your contracted services? **Frank Ruelas**, MBA, principal of www.hipaabootcamp.com and director of compliance and risk management at Maryvale Hospital in Phoenix, has some tips.

His first is that you use what you might already be gathering. "For example, in some states it says that contracted services and their ongoing evaluation need to be part of your quality assurance program," he says. That is a "built-in factor we so often overlook."

"What I often tell people is look at some of the easiest data-capture activities that you have within your organization that could lend themselves to providing you insight into the questions: Are there any issues, good or bad, related to these contracted services?"

Use incident reports in your evaluation, he says. You also can use findings from your grievance process. Many contracted services need to fulfill state requirements for things such as licensure or certification. For example, vendor A might get a renewal of their license with a statement "with issues."

"That needs to be something that should prompt a call to action. It could be as innocuous as the administrator paid vendor A's licensing fee two weeks late. Or it could be they are on some type of probation," Ruelas says.

He also suggests querying the licensing entity, which often has public information on that provider. General input from staff is a great measure, he says. For instance, you may ask bedside staff about the performance of a dialysis provider. It might seem at first like isolated information or inconsequential comments, "but if you look at trends and if you look at patterns, they can be very indicative of the level of service your patients are getting," he says.

Also see what quality metrics the contracted

service may already have in place, he says. "Once these are identified, place in the contract an expectation that the service provider is to show how it is meeting these metrics and to identify what options there are to address if the service provider should fail to meet these metrics," he says. ■

Readmission rates, LOS decrease with BOOST

Teamwork, accountability key

He believes it's the right thing to do for the patient and the right thing to do for the hospital. And with staff happier, patients happier, and length of stay and readmission rates decreasing, it seems as if it's working. In 2008, Piedmont Hospital in Atlanta chose to implement one of the myriad transitional care models out there today. Their choice: Project BOOST (Better Outcomes for Older Adults Through Safe Transitions) from the Society of Hospital Medicine.

Matthew Schreiber, MD, chief medical officer for Piedmont Hospital, says before adopting BOOST, the hospital was working on process improvement and lean techniques. At a meeting, he half-jokingly asked for his very own unit — one "where I could bring some new ideas and just see what happens." To his surprise, the chief nursing officer took him up on it. He was given a 20-bed general medicine hospitalist unit, 6 North.

Before adding the discharge model, the unit had asked and answered some very basic questions: "How do we restructure the patient's experience from door to discharge in a patient-centered way, in a way that makes sense and is most efficient, and how can we get rid of waste and all of that stuff?" he says.

Staff knew that discharge was going to be an integral component of improving quality care, he says. About three weeks after opening the unit and working on care processes, an administrative director told Schreiber about the BOOST project, saying, "This is something we need to do." The hospital was selected as one of the first six sites to pilot the project, which just recently went statewide in Michigan.

What distinguished 6 North was that it was primarily overseen by hospitalists dedicated to that unit, which Schreiber says removed the time doctors spend logistically moving around the hospital. "Almost an hour of their day was just spent going from one place to another, which is not value added for anybody." But for him the unit wasn't just about hospitalists; it was about the entire care team and creating an environment where teamwork melds with structuring responsibilities so that the team knows who is responsible for what and everybody is responsible for something.

"We got all of the participants, all of the ancillary services, nursing, respiratory therapy, physical therapy, all around the table, and we said, 'OK, if you were king for the day and you wanted to make the process better, what would you do? What could you offer? What jobs do you find yourself doing that you feel like you're not the expert in? What jobs do you see other people doing that you feel you are the expert in? How could we make this a better experience for the patient? And the only rule here is everybody has to contribute something.'"

Streamlining processes

The team looked at care processes and streamlining those to decrease inefficiencies. One process improvement project included "specialized testing triage." For example, Schreiber says, let's say you have three patients who need MRIs. One needs an MRI for spinal cord compression, a medical emergency. The second had a transient ischemic attack, in which case, he says, a normal MRI would mean he could go home. The third has osteomyeletis, which is not a critical need. The radiology department schedules the orders and puts the osteomyeletis patient first, the spinal cord patient second, and the brain patient third. But someone from the unit could call radiology and change the schedule to meet the most urgent need. That person would call the radiology department and say, "Move number two to number one. Number one to number three. And number three to number two.

"So the time slots have been assigned already. We're just retriaging the testing for the most appropriate orders. That also takes into consideration a patient's discharge readiness," he says. The team would also be able to work with radiology on reducing cases if the department is overbooked. For instance, the osteomyeletis patient could be booked for the next day, but the other patients need to be seen that day.

"So it really cuts down on the waste for everybody when there's good two-way communica-

tion; everybody knows what needs to be done. It gives you the opportunity to begin to negotiate. 'I want you to do this for me. I want you to do the acute cord study right now because that's what the patient needs, and what I'm going to do for you is I'm going to identify the guy you could bump until tomorrow without any pain and suffering,'" Schreiber says.

"We look for those win-win opportunities so that we can create a better environment, more efficient for the patients and quite honestly get more work done in less time. And we were very successful in that," he says.

Assigning clear responsibilities was a major focus of improvement. And Schreiber says it all starts with communication. For instance, the team noticed that patients were being delayed because sputum samples were not being processed in a timely fashion. "Then we start digging. 'OK, why aren't sputums done in a timely fashion?'" he says. The team found they weren't being collected. And when asked why, nurses looked at respiratory therapists and RTs looked at nurses and both said: "I thought you were doing it."

"So we said OK, from here on in RT is now responsible for doing all sputums." RT notifies nursing every time a sputum sample is being collected. If RT is unsuccessful in collecting the sample after three attempts, they place a flag in the chart notifying whoever is looking that a sputum sample was not collected.

The unit also has a whiteboard in the nursing station with patients' names, their main diagnosis, and specific barriers to discharge. For instance, instead of writing that patient Joe Smith needs three sets of cardiac enzymes and a stress test, it would note that patient Joe Smith's next set of cardiac enzymes is due at noon and if the results are negative, he needs a stress test. "So if at 10 past noon we don't have the results of the cardiac enzymes, we can be on the phone saying, 'Where are those test results?' And if the results are normal, then we're making sure that the stress test is done in a timely fashion. That's good for patients. It's good for the staff. It's good for everybody," Schreiber says.

At first, the whole team would huddle at the whiteboard. "It became abundantly clear very quickly that PT would tune in when we were talking about PT needs, and RT would tune in when we're talking about RT needs, and case management would tune in [when we're talking about case management], but otherwise they were just kind of politely standing around for 10 minutes." So they did away with the team huddle and instructed staff "whenever you set foot on the floor, just come in and check in with the board and the board manager. So this person, our nurse, is aware of the status of all patients at all times. And everyone can go to the board and see what's important to them to help them prioritize their work. And so people check in with the board 20, 30, 40 times a day to know where are we at with their patients, what's happening next, etc."

Implementing transitional care model

Piedmont's success with Project BOOST started before the model began because, as Schreiber says, the unit had already looked at process improvement, efficiency, and accountability. Those underlying processes should be in place, he says, before you implement the tools. "[W]e did the workflow process issues first and then we took these tools when we were primed and ready.

"For me, personally, it was like somebody just did the homework for me. I knew that we needed a new discharge form. I knew we needed a risk assessment tool for patients that are at risk for failed discharge. I knew we needed all of those elements and here comes this wonderful BOOST toolkit," Schreiber recounts.

Included in the toolkit is a risk assessment form called 7P that looks at issues such as polypharmacy, how many medications the patient is on, the patient's degree of sophistication, and his or her family support. There are also checklists for logistical issues. "Does that patient have their keys? Do they have steps in their house that they can get up and navigate? There are a lot of questions that are really important for patients having a successful discharge but don't really get up into the front of doctors' minds as a medical thing. We think about their blood pressure medicine — not how many steps they have at home," Schreiber says.

There's a discharge checklist similar to a preflight checklist, he says, with reminders: Before the patients walks out of the door, have you done all these things? And there's the patient Pass form — a discharge form written in patient-friendly language.

A big part of the BOOST intervention is communication using the teach-back method. **Christopher Kim**, MD, MBA, a hospitalist at the University of Michigan and director of the statewide collaboration using BOOST, says when

patients are given information they may say they understand. "But if you really probe them further, they might not have as good of an understanding. Using the teach-back method, the concept is to explain something to the patient and then ask them how well we may have done at explaining to them and ask them to repeat it back to us. And if they could teach it back to us then it helps us to be more reassured that we did a good job and that the patient has a good understanding. If they do not understand and they can't teach you back what you just said to them, then it identifies some gaps and perhaps it's another opportunity to intervene again."

At Piedmont, when a patient is ready for discharge, the clinician visits the patient with a blank discharge form and goes over elements with the patient before the form is filled out. So a conversation might be:

Clinician: "Ms. Smith, why were you in the hospital?"

Patient: "I don't know. The doctors were concerned about me."

Clinician: "Ms. Smith, remember how your legs were swelling and you were short of breath?"

Patient: "Oh yeah, that's right. That's why I came to the emergency department."

Clinician: "We call that congestive heart failure. Ms. Smith, can you tell me why you were in the hospital?"

Patient: "Oh yes, I was in the hospital for congestive heart failure."

Clinician: "Great. I'm going to write this down so you remember."

There is a section on the form for red flag symptoms. So a clinician may say: "Ms. Smith, remember how we were concerned about your legs swelling on you? If your legs swell on you then I want you to call your primary care doctor because they're going to need to make an adjustment in your water pills. I'm going to write that down for you. If you're short of breath, then you should call 911. And I'm going to write that down for you. Ms. Smith I'm going to write down all the care providers that you've seen here: your hospital doctor, your primary care doctor. I'm going to write down your pharmacy number. We've made all of your follow-up appointments, and in this section is your homework. You need to go over your echocardiogram with your primary care doctor. That's where you need to adjust your water pills and check your potassium again."

Schreiber says the form was created as a "memoir" for patients, something they would stick on their refrigerators at home. But he found that patients became so attached to the form that they took it with them to their visit with their primary care doctors, which is scheduled for the patient before he or she leaves the hospital.

"It's a big win for so many reasons. Even though the discharge summary may have been dictated, the primary care doctor may not have it in front of them when the patient shows up. So now they've got something that says, 'I was in the hospital because I had congestive heart failure. These were the major things that happened to me when I was in the hospital. These are the things that I'm supposed to follow up for today.' So now they have a much more productive, engaged visit with their primary care doctor, which is part of the essential theme to keeping people out of the hospital."

Results speak for themselves

On the unit are patients seen by the hospitalist group and others not in the group. Thirty-day all-cause readmissions for patients 69 and younger, Schreiber says, for the non-hospitalist patients was 25.5%, and their case weight was 1.16. For the hospitalist patients, the rate was 8.52%, and their case weight was 1.15. "So very similar populations, similar diagnoses, and dramatically different results," he says. The length of stay for the non-hospitalist group was 4.96 while the hospitalist group's length of stay on the unit is 4.09

Along with participating in the BOOST project, Piedmont had to provide certain data including patient satisfaction, length of stay, and readmission rates. "Readmissions were a big challenge for us as an institute, and I should tell you that our readmission rates are probably a lot better than even the numbers I've suggested because our readmission rate is anybody who is put in a hospital bed, whether they were on observation status or inpatient status. And if they even return to the ED even though they weren't readmitted, it counts in the 30-day readmission rate. And that's because while the government may be deciding how to pay you based on your readmission rate, you haven't won the game unless you've done right by the patient, unless you get them out of the hospital and you keep them out. If they to come back to the ED every three days but they never got readmitted, have you really done the right thing for the patient? So for us we took the broadest defini-

tion possible because that's the goal we want to achieve."

The team now does a root-cause analysis of patients readmitted within 72 hours. Everyone is called together at least once a week with the hospitalist nurse and home health to discuss possible interventions that could have helped. What were the primary issues? Was this something that was preventable? Not preventable?

"Anyone who comes back within 72 hours gets a very focused review on 'OK, something happened for that to happen. Was it they were discharged too early? Was is that their home health agent didn't get out to them? Did they not understand their instructions? Did we prescribe them something they can't afford or any of those elements so that we can learn those things and incorporate them so that it won't happen again?'"

The clincher in success? Schreiber says, "We created a team environment that's nonconfrontational, that's totally focused on the outcome. We've decided that nothing matters, not our egos, not anything, except for the patient outcome. So when they see that dot starting to move, it really revs them up." ■

Where research and reality collide

Measurement and science's role in QI

Checklists have become a ubiquitous term for the patient safety movement, which most recognize as being born with the Institute of Medicine's 1999 report "To Err is Human." With books like Atul Gawande's "The Checklist Manifesto" hitting bookstores' prime shelves, public attention on health care and errors has become heightened. And with health care reform on the political horizon, health care — from the inside and out — is being scrutinized like never before.

Checklists illustrate the need for standardization. But according to patient safety guru **Peter Pronovost**, MD, PhD, who has published a new book "Safe Patient, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out," the concept is not as simple as it sounds and represents a broader need for measurement, data, and standardization in health care. He says safety and real culture change in health care is not just about checklists

Pronovost is an intensive care specialist physician at Johns Hopkins Hospital; professor at the Johns Hopkins University School of Medicine in the departments of anesthesiology and critical care medicine, and surgery; and medical director for the Center for Innovation in Quality Patient Care. He created a five-step checklist for central line insertion that helped to curb infections not only at Hopkins and as part of the Michigan Keystone initiative but internationally — with other hospitals picking up on his work.

"The story of a simple checklist has eminent appeal," Pronovost says. "I really want to show that it's much more than that." He likens the checklist to the New Year's resolutions we all make, every year — lose weight, exercise more, make more money. How many of those well-intentioned goals move to the wayside as more pressing issues come to the forefront? He wants the health care field to understand that a checklist means nothing if you don't measure the success of the intervention at hand. "We're 10 years after 'To Err is Human,' and we don't have a lot of empiric data, virtually no empiric data, that patient outcomes are better. I think that's quite sobering, and if I think about what we've done, our efforts — and there have been a lot of them — have been more competitive than cooperative, more independent than interdependent, and far too focused on efforts than on results."

In addition to measuring quality improvement interventions, Pronovost says the health care industry must tackle the tendency to put "ego ahead of safe practices" and empower staff to hold each other accountable for following protocols and doing the right thing.

A checklist, he says, is not Harry Potter's wand. It's not a magical tool guaranteed for quick fixes. Yes, it stands for standardization, something the health care industry needs, but the necessary cultural changes are far harder to achieve. The checklist informs you of what to do, but Pronovost looks at the barriers to complying. What is most important to changing outcomes is measurement and empowering staff to speak up when things are wrong, he says.

He says he often hears the phrase "these data are for quality improvement, not research." But he says "do the data know any difference? You're making a public statement that care is better. There's certain rules of measurement that you have to adhere to, and I think the quality improvement field has been too loose."

But the Institute for Healthcare Improvement's director **Fran Griffin**, MPH, says Pronovost is a

researcher and that is a difference between being a quality improvement director in the hospital. What IHI is doing "is not research. We're not trying to create new knowledge," she says. "So for example, if you take the central line bundle, nothing in the central line bundle is new. The five elements of the central line bundle, four of them have to do with insertion and have evidence to back them up. So we're not out there trying to figure out what's the new technique for central lines that needs to be studied. We're just saying we want to learn how we're going to make that process work here. So the what has already been established. The focus is on the how."

Pronovost says, "To be fair, many of my academic colleagues are too rigorous. They would never get off the dime if we did every study the way they would want to do it because health care is often practiced in the messy real world where I can't control everything. So part of what I'm trying to do in this book and in my work is bridge the research world that often needs to loosen up a little bit and the quality improvement world that needs to tighten up a little bit and end up at some place in what I call the 'sweet spot,' the middle, where the measurement and science is good enough that I can look at a patient or you and say with confidence, 'Hey, things are better.'"

The problem he sees is that often national policies are made without a scientific understanding of their validity. He wrote a piece in the December 2009 issue of *Academic Medicine* — "Perspective: Physician Leadership in Quality" — showing that most physicians who become quality leaders "went into it because they had nothing else to do. It wasn't a destined career track where they had the formal training and the skills necessary to do this well. It was, 'Well, this is a nice guy or a senior clinician, let's give this to them.'" That's something health care quality needs to move away from, he says. Certain skills are required to be an effective quality leader, he says — measurement skills, leadership skills, and human factors engineering skills.

While Griffin agrees that you shouldn't say a measure is working without measuring compliance, she says quality improvement directors can obtain those skills, either by getting their organization to fund additional training or by going out and doing it on their own. She says she's met QI directors who were great in their role and QI directors who weren't, and she's sat in on quality meetings where the measurements were not in line with what the team was trying to measure. They recognized the need to measure, she says, but didn't know which variables to choose to get the answers they wanted.

Griffin, who worked in quality before joining the IHI, says QI directors "don't need to be statisticians. This is an area where I see people sometimes making it harder on themselves than it needs to be... [For quality improvement directors, they're] not designing a randomized control trial that you're trying to get published in the *New England Journal of Medicine*. It doesn't need that level of rigor."

She says there has been much debate about the data of quality improvement data vs. the data of the randomized control trial and acknowledges that it's tough for quality improvement directors to speak data with physicians who are schooled in the scientific speak of the randomized control trial. "If you put a run chart showing data over time up on the wall, you don't need to be a statistician to interpret whether it's going up or down or jumping all over the place... With data for learning, the thing [IHI] often tells people is you just need enough [data] to know. You don't need a year's worth of data statistically analyzed to know whether or not something is getting better. Go ask the frontline nurses. They'll tell you after a week. So we emphasize that."

Robert M. Wachter, MD, is professor and associate chairman of the department of medicine at the University of California, San Francisco; chief of the division of hospital medicine and chief of the medical service at UCSF Medical Center; and health care blogger. He says measuring a process before you fix it and then after you fix it is "fundamental to quality improvement."

"Organizations that don't build that in," he says, "who just do things because they seem like they may help, usually end up getting burned. Changes don't stick."

But he says quality improvement today is not "your father's quality improvement. It's a much more nuanced, interdisciplinary, iterative process where you begin by identifying all aspects of the problem in a new way and you focus on changing systems of care, not just shaming people for not doing something."

Though everyone, he stresses, is trying to do the right thing, "IHI has tended to have a philosophy in which anecdotal evidence may be enough to catalyze a recommendation to change a given process." This may move things along faster but means you may be doing things that make sense but don't work and you've committed

resources to it, he says. He, like Pronovost, supports balance between the scientific world of data and the quality improvement realm. Wachter says if a clinical study comes out saying tight insulin control is a good idea, it can take years for clinicians to implement it. "Whereas in safety and quality, because of the regulatory and accreditation environment, there often is a very, very short path between an organization like IHI or others coming out and saying, 'We think this is the right thing to do...' So the pressure to do it grows very quickly."

The checklist concept, he says, has become "useful shorthand" and often misunderstood. It's not just a list with boxes on it. It implies:

- collaborative and evidence-based efforts to codify and settle on certain best practices;
- standardization of those practices;
- thinking in terms of human factors engineering and deciding what elements should not and should be on the checklist;
- roles and accountability.

"Not only did I not learn anything about checklists, systems, process change, change management, human factors engineering in medical school, I learned things that actually set me back in these efforts," of looking at patient safety in a team environment, Wachter says. "I learned about being really smart and clever, an individual free agent who's practicing like House."

But in becoming involved with patient safety and quality improvement, he finds himself asking: "What is the role of standardization in a field that has resisted that? What is this thing called human factors engineering? What is the role of teamwork? What is the role of leadership and expertise?" The patient safety field is "still relatively new," he says.

Checklists involve "a level of teamwork and role allocation that's critical. It involves embedding a checklist in a culture that allows the checklist to do what you need it to do and sometimes conversely, the checklist is a culture-changing activity," he says. ■

Applying human factors engineering to QI

Reduce reliance on memory

What do high-reliability organizations, lean techniques, and Six Sigma have in common? First, they're all part of the discussion of modern quality improvement and change management in health care. Second, they all come from industries such as manufacturing, aviation, and nuclear power.

Barbara Wilson, PhD, RNC, assistant professor at Arizona State University's College of Nursing and Health Innovation, Center for Improving Health Outcomes in Children, Teens, & Families, began focusing on patient safety as a nurse manager and then as a director at Intermountain Healthcare in Salt Lake City. She recognized then that "we had to do something about standardizing care." For instance, within the system one hospital might differ in how it handles induction of labor. "I've really been interested in what are differences in terms of practice variables, and how do we figure out what's the ultimate process for patients and then try to streamline processes so we can consistently achieve that."

She says aviation had been onto this 15 years before health care really caught on. A plane does not take off until a thorough check has been completed. While health care, she says, has used checklists similarly, it was never as consistent or standardized a process. "I think physicians have been more resistant, quite frankly, in my experience to standardize processes because they're training for years and years not in a teamwork environment. They're soloists. And it was very hard when I was an administrator to tell a doctor, 'We're not letting you do it this way. We want to standardize it to this way.' That was hard for a doctor to hear because they called it 'cookbook medicine.'"

With so many variables, though, in the way medicine is practiced, costs and the chance of errors increases, Wilson says. What are practices consistent with human factors engineering? Wilson says:

- **Prepackaging and standardizing supplies.**

"Yet I think there's real hesitancy for hospitals because they don't want to upset the physicians for fear they'll pull their patients out," Wilson says. She recalls working with a physician who did a lot of volume and insisted on using something other than the standard C-section pack because he liked wiping his hands a certain way. "So here the hospital had prepackaged supplies to meet the needs of one physician out of 30. We can't do that kind of stuff."

- **Ensuring practices are based on evidence-based protocols and double-blind checks on high-risk medications.**

For high-risk medications, she suggests using protocols. For instance, stating "Mix this amount of fluid for this medication and run it at a set

number of cc's per hour." If a nurse gets a dose that she has to do a calculation on, she can say to another nurse, "this is the math problem. Would you figure it out and then let's see if we get the same results." This type of double checking, Wilson says, is an effective way of preventing problems with high-risk medications.

• Simulation training.

This, Wilson says, is an opportunity for staff to work on a manikin "so they can learn skills without posting the risk to real patients. It's a structured way to learn that's risk-free in terms of error."

• The use of checklists and preprinted order sets.

This reduces reliance on memory and establishes processes "to reduce the likelihood that someone is going to make a mistake." Her caveat: You should not forget the intent of the steps on a checklist. Don't just do it because it's routine. "Be consistent about it, and then when there is a variation, stop the procedure, stop the process immediately until that gets resolved," she says. ■

ACCREDITATION
Field Report

Midland Memorial happy with DNV shift

Frustrated with The Joint Commission, Midland Memorial Hospital (TX) made the shift to DNV this year, says accreditation specialist **Lisa Williams,** PT, MS, HACP. The hospital had already been looking at the Centers for Medicare & Medicaid Services' conditions of participation in order to keep up with Joint Commission standards that were coming in line with those. So Williams says there was no real preparation. She told the leadership team: "There's nothing we can do to prepare. We really should be ready all the time instead of trying to get a bunch of stuff done [right before the survey]. Whatever they find, we'll fix."

She says she attended several presentations on DNV and what she heard was "refreshing in that their standards are based on CMS conditions of participation, which as we all know don't change very much. And then those conditions of participation are integrated with the ISO 9001 quality

CNE QUESTIONS

13. According to Michael Troncone, FACHE, how many types of contracted services exist?
    A. 5
    B. 7
    C. 10
    D. 15

14. Frank Ruelas, MBA, suggests using incident reports to gauge the quality of your contracted service providers.
    A. True
    B. False

15. The teach-back method is an integral part of Project BOOST.
    A. True
    B. False

16. Which of the following would be examples of applying human factors engineering, according to Barbara Wilson, PhD, RNc?
    A. prepackaging supplies
    B. performing double-blind checks
    C. using checklists
    D. all of the above

Answer Key: 13. B; 14. A; 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

management system."

What drew her in was DNV's revelation that "you know your organization best, and you decide what's important to your organization. If you don't have trouble with X, Y, and Z, then you don't have to worry about them, but you should be studying them and know that you don't have trouble with X, Y, and Z."

Williams says that was a different take than The Joint Commission's. She points to the disruptive behavior standards. Leadership had spent more than a year defining disruptive behavior and what they were going to do about it. But, she says, "We don't have those problems here... We dealt with our disruptive people effectively. But we had to put all these things in place and jump through all these hoops because somebody else had a problem somewhere else in the health care world."

DNV, she says, is collaborative and "like an auditor that's going to come in and see that we're doing what we're supposed to be doing, what we say we're going to do as opposed to 'Are you doing what we're telling you to do?'"

She says she was almost floored when DNV came for its first survey in October and didn't get to every area and said, "What I don't see this year, I'll see next year. It's OK." DNV has annual surveys vs. The Joint Commission's triennial survey.

DNV also is "very good at sharing from one hospital to another. 'This is what works well for us here....' That's the difference with ISO is that there's a product on the end. There is a certain product that is being delivered and that's health care. And we want to deliver the best health care." She sees The Joint Commission's motive as fundamentally different. "With The Joint Commission, it becomes more about the process in the middle and how you're doing steps A, B, C, and D, as opposed to what happened at the end."

For the survey, four surveyors came for three days — one life safety surveyor who stayed throughout the survey, a clinical nurse surveyor, a generalist surveyor, and a team leader with a pharmacist background. Midland Memorial was praised for its work on HR competencies. Williams says everyone in the organization is required to have a competency and it's "done a very comprehensive review of employee job descriptions and what we consider to be competencies."

It also was praised for its infection control processes in cleaning equipment in areas such as endoscopy and the operating room. The surveyors did find some loose infection control processes in terms of consistent application of isolation precautions, she says.

Although the CMS CoPs don't touch on FPPE or OPPE, that is a policy Midland will continue to work on. But they are sifting through other Joint Commission requirements and deciding which ones they should continue working on. For example, reporting critical values was never a problem, but William says she used "to spend the better part of her day doing an audit of those critical values. And we've decided as an organization that we're not going to do that anymore because we've not had any issues."

Midland did get cited for updating H&Ps. "We were cited for lack of timely updates. Part of our corrective action plan, which is working, is that the circulating nurse checks for an update prior to the patient being taken back to the operating room and no patient is taken back without either a current H&P or an updated H&P.

"Prior to our survey, there was not a check for

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

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

COMING IN FUTURE MONTHS

- Complying with H&P requirements
- Decreasing ED wait times
- Using safety coaches for patient safety
- Empowering staff to speak up

an update, and the only thing looked at for H&Ps was if there was one there, not when it was performed. All circulating staff were educated, and all surgeons were also educated. We have been doing random audits of usually first cases of each room each day and have improved our compliance from a baseline of about 10% to 87% at our last weekly check. Our feedback to physicians is to fax them a letter indicating where they failed to update the H&P timely. Unfortunately, this feedback has not been very timely, but we are in the midst of implementing a compliance manager software tool that will greatly improve the efficiency of communication from the data collectors to me, who is responsible for faxing letters to physicians," she says.

DNV also found that light switches in the med gas storage room had not been installed with the proper specifications. Had a Joint Commission surveyor found the same thing, Williams says, the hospital would have relocated the switches, sent that information to Joint Commission, and been fine. But with DNV when a hospital turns in a corrective action plan, it must do a root-cause analysis of why it happened and all areas that could be affected by that. "So we had to look at how we were managing our construction and look at other med gas storage rooms in our organization. Just doing that root-cause analysis opened up a whole area of construction management," she says.

Since its survey, Midland has been looking at its grievance process and managing that in one area. Before, if a patient for example complained to the quality management department, it was logged. But if a person made a complaint with the radiology department, that department would handle it and no one else was aware of it.

DNV also focused heavily on restraints and the hospital's care plan.

Williams says The Joint Commission "wants you to have everything fixed when you turn in your information. What DNV asks is that you turn in either what you fixed and what you plan to continue to fix because things just can't done in 60 days." DNV, she says, is not solely concerned with processes but outcomes as well, and you can't look at that unless you have data. She says the board has been happy with the switch. "Our board understands ISO. The don't really understand The Joint Commission." But, she says, they won't cut Joint Commission out of the picture altogether. For those things the hospital identifies as necessary, they will keep. ■

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