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## IN THIS ISSUE



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# How will health care reform affect hospitals, quality, and payment?

*Prospective models pull hospitals and other providers together*

Quality and utilization are going to be inextricably linked as the health care industry moves forward with the health care reform legislation. How the legislation will shake out is a matter of speculation at this point. But hardly anyone denies that a new payment model for health care services, moving away from the current fee-for-service type payment model, is necessary for improved quality and the economic health of hospitals. The legislation hints at some models such as accountable care organizations and health savings accounts.

"There seems to be a real thrust in this health reform toward quality improvement and quality and efficiency being tied together," says **Stuart Guterman**, MA, PhD, assistant vice president for The Commonwealth Fund's program on payment system reform. "And there's been a lot of discussion about the health care reform legislation in terms of whether it bends the curve enough. It's clear that in order for all of these health care reforms and coverage and those kinds of policies to be sustainable over time, there needs to be attention paid to the amount we spend and what we get for the amount we spend, and quality is a big component of that."

**Harold Miller**, executive director for the Center for Healthcare Quality & Payment Reform and president and CEO of the Network for Regional Healthcare Improvement, agrees: "I think there's going to be a lot more focus on quality improvement that reduces utilization. I think the focus is on how do we reduce cost without rationing." And just how does he see that being accomplished?

One way is keeping people healthy so that they don't have chronic conditions in the first place. Secondly, if they develop a chronic condition "you keep them out of the hospital so you reduce preventable admissions, and then when they do end up in the hospital that you eliminate infections, you eliminate complications, you eliminate readmissions, and you deliver that in the most efficient fashion possible."

The law allows the Centers for Medicare & Medicaid Services (CMS) to begin cutting reimbursement for preventable hospital readmissions. Guterman says there will be more moves in this direction but also points out that "there's specifically a lot of space in the law devoted to describing a

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shared savings pilot that's supposed to focus on the accountable care organization."

The accountable care organization (ACO) model is not new. In 2006, lead author Elliott S. Fisher, MD, PhD, director for The Center for Health Policy Research, professor of medicine and community and family medicine, Dartmouth Medical School, published an article in *Health Affairs* titled "Creating Accountable Care Organizations: The Extended Hospital Medical Staff."[1] An ACO is a local health care organization and set of providers (at least, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care.

The experts *Hospital Peer Review* spoke with all pointed to models such as the Mayo Clinic, Kaiser, and Geisinger Health System. The last, praised even by President Obama, is a physician-led health care system in Pennsylvania, which offers its own health insurance plan and has been using electronic health records for more than 10 years. The system's ProvenCare model focuses on using evidence-based practices, a fixed price for certain procedures such as open-heart surgery, and patient engagement. Accompanying the fixed prices is a guarantee: If a patient has complications or needs to be readmitted, the health system eats the cost. Most employed physicians are salaried and share in incentives when the system does well. And it has.

President and CEO Glenn D. Steele Jr., MD, PhD, in an address to the Senate committee on finance on April 21, 2009, said: "The innovations we have instituted at Geisinger that bundle payments for acute care procedures, enhance support for primary care physicians and their care teams, better manage chronic disease and the transitions of care for patients from caregiver to caregiver, have produced significant cost savings and improved quality. Admissions for our patients with multiple chronic diseases have been reduced by as much as 25%, and readmissions following discharges decreased by as much as 50% in community sites." Incentives for staff are built into the system, and staff are rewarded for reaching certain quality measures.

**Jugna Shah**, MPH, president and founder of Nimitt Consulting in Washington, DC, says the idea behind Geisinger is "analogous" to and draws from the ACO model in that it crosses sites of care and types of providers. With models such as Geisinger, Mayo, the Cleveland Clinic, and Intermountain, she says, "the doctors are working differently with nurses. They're working differently with home health services or after the patient is discharged with follow-up care.

"This is now really what we're talking about with continuity of care, and everybody's incentives are the same. 'Let's make sure this patient does not get readmitted. Let's make sure this patient has no further complications' because they internally allocated how much this case ought to cost. And if they come in under that, whatever money is 'saved,' I think these profits are shared among all the caregivers."

She says that's where health care should be

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## What would Berwick as CMS administrator mean?

Media already are pegging him for the next administrator of the Centers for Medicare & Medicaid Services. If in fact President Obama nominates Donald M. Berwick, MD, MPP, FRCP, president and CEO of the Institute for Healthcare Improvement, to that position, what would it mean for the health care industry?

• **Jugna Shah**, MPH, president and founder of Nimitt Consulting in Washington, DC, says, "The one thing about Berwick is everybody is really excited about him being the administrator. The other thing is Berwick definitely comes from the model of having worked with a lot of payers. Berwick is definitely about bundled payments. I think if Berwick is the administrator, we are definitely going to see activity around more and more bundled payments, a transformation of how health care services are paid, less fragmentation across care settings. And I think he has an eye toward quality. A lot of the work that I think he's been involved in has looked at the payment side and the quality side."

• **Stuart Guterman**, MA, PhD, assistant vice president for The Commonwealth Fund's program on payment system reform, says, "Berwick is going to have to make sure that he has people lined up to help run the agency. There are a lot of details that the agency has to take care of... His big job as administrator is to set the tone for the agency, and he's the kind of person who will make it oriented toward action, and I think that's certainly not a bad thing for a bureaucratic agency to have. When Mark McClellan started out at CMS, one of the first things he said was, 'I want CMS to be a primary public health agency. That that's the function I see.' And I think that's great because that basically set the tone for CMS. 'We're not an insurance company. Our primary purpose is not just to pay bills. It's to make sure that the health care that our beneficiaries get is as good as it can possibly be, and that affects the health care that the whole population gets in a positive way.' That's a great tone to set, and I think that's a big contribution for an administrator to make. And I think Berwick is the kind of person who is a visionary. He's going to say, 'OK, this is where we're headed' and then his staff are going to need to figure out how to get the agency to head in that direction, and I think that's a good thing."

• **Kurt Patton**, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission, says, "At first I would have been concerned about quality [with the health care reform legislation]. With a large influx of new patients into the system, which has fixed resources, the bill had the potential to diminish quality. However, I see the pending appointment of Don Berwick as perhaps making a statement that quality must be enhanced. I don't see him allowing the feds to just hack at budgets aimlessly. His presence is a very good thing... I expect Don Berwick will help prevent aimless cuts, allowing for more focused cuts, which should not be as potentially harmful. Not paying for bad care can be a good thing. Small and rural [hospitals] should be helped because they have congressmen that can't afford to see them close. They fulfill an important role in their communities and must be a protected entity."

Asked if CMS will really be nickle and diming hospitals or really getting at quality, he says, "Some of both today, but I truly believe Berwick can help them get at real quality issues." ■

heading and where it may be beginning to go. The common thread about the aforementioned health systems, she says, "is that the physician and the hospital reimbursement is aligned in the sense that there in one payment that is made out of which comes the hospital part and the physician part."

Guterman says the definition of an ACO is rather flexible but that there's "going to be more and more pressure and incentives to move in that direction. To be able to work together, to be able to take more of a team approach to health care, and to understand providers should be more mutually accountable for the outcomes of the health care that they provide."

Miller and Shah acknowledge that the moves toward value-based purchasing, such as no reimbursement for hospital-acquired infections, have so far been just a "drop in the bucket" financially for hospitals. Shah characterizes the measures thus far as "pay for performance lite" and says it will be interesting to see what this year's OPPS brings. She says there will always have to be a "delicate balance" by not penalizing providers for the natural variability that occurs in health care. "I think the reason we're

slow with coming out with some of these health care-associated infections and the never events is the same tricky balance. You want to be really careful not to penalize hospitals for what could be truly patient-specific complications. I appreciate that [CMS is] moving very methodically and not penalizing hospitals for what's not in their control."

She says the "train really left the station" with the American Recovery and Reinvestment Act (ARRA) and the move toward more universal health information technology and electronic records. "There's a lot happening with money already being spent and allocated to promote the implementation of an electronic medical record. That legislation has teeth in it and then the regulations that have come out this year related to quality indicators, EHRs, all the incentive payments to hospitals and physician practices — all of that is on the pathway. There's no way we're going to promote, essentially pay for all this, if not trying to get toward value-based health." Once CMS is able to abstract data more easily through electronic transmission, it's going use it, she says.

As far as more standards from regulatory agencies, Miller says, "I think it's actually an interesting question for the future in terms of how much focus there should be on accreditation standards vs. outcomes across all of health care. Because that's I think a key issue as we move away from process measures to more outcome measures. Do accreditation standards impede that?"

An example he gives is the "whole medical home movement." He says "NCQA jumped in immediately with very elaborate accreditation standards, which then a lot of payers immediately adopted as being the requirements for primary care practices to get medical home payments, and now the bloom is sort of off the rose on that. A lot of people who've been trying to work with medical home practices have found that a) a lot of those standards are very difficult for particularly small primary care practices to meet, and b) it's not clear that those things, a lot of those standards, are the kinds of things that are really necessary or even desirable in some cases for them to actually improve performance in terms of keeping patients out of the hospital, keeping patients well, etc.

"I think there's sort of — I'm not sure I want to call it obsession — in health care with evidence. And we shouldn't do anything unless there's evidence. Well, how do you get evidence unless you actually do something?"

There is a risk, he believes, in setting standards and penalizing hospitals for not complying. What if a hospital found a better method than what the standard calls for? "So if CMS puts into place, as Congress has mandated, some kind of penalties for readmission reduction, that's what the hospital is really being held accountable for now is not having readmissions. So what's the best method of achieving that outcome, and if [hospitals] can find a better way to do it you shouldn't end up putting them between a rock and a hard place. 'Oh, no, you can't implement the program that reduces readmissions because that's not the standard that we've said there's evidence for even though it ends up working for you.'"

If hospitals focus only on 30-day readmissions and after that period patients "are on their own," then we may be only pushing the problems into the 31- to 90- to 180-day period, he says, "as opposed to saying, 'What can we do to strengthen primary care in the community? What can we do to make sure those people are actually linked to their primary care provider? What can we do to make sure patients can afford their medications when they come out?'"

Miller says the "hospital ends up being the convenient entity to point the finger at, but that doesn't necessarily mean that it's right or that what they will do to respond to that is the best long-term solution." Having a hospital-driven system, he says, is not the answer.

But the health care reform legislation, particularly the ARRA, appropriated funds to governmental agencies to look into evidence-based practices and establish hospital standards. The ARRA, according to the Association of American Medical Colleges web site, "set aside $1.1 billion for comparative effectiveness research [CER] in the next decade. The Agency for Healthcare Research and Quality and the National Institutes of Health will receive $700 million for CER, and the Department of Health and Human Services will receive $400 million to accelerate the development and dissemination of CER data."

Miller thinks hospitals are going to begin to see a new patient population, "potentially fewer patients than they did before" and higher-acuity patients, which in turn may change hospitals' "internal quality improvement initiatives."

"I think what is working better and has a long way to go are the regional health improvement collaboratives that are actually developing quality information and cost information locally with the engagement of providers and then having mechanisms for sharing information amongst them about why is somebody better than another one and what did they do differently as opposed to simply

having a national site that nobody can understand," Miller says.

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# Hospitals tackle MRSA with high reliability

*Safety coaches monitor hand hygiene*

When your board calls for an improvement initiative, it carries some weight. In 2007, VHA Central Atlantic's board "decided it wanted to work together on a clinical quality initiative, and it chose MRSA reduction," says **Terri Bowersox**, FACHE, director, performance improvement at VHA Central Atlantic. "And we immediately started a data collection process with the members, and once they had a few months of data, the board decided that it wanted to set the goal to reduce hospital-acquired MRSA infections by 80% in three years. And so we've been working on that ever since, and 2010 is actually the last year of the initiative."

Through January, the system was at a 44% reduction. "We have 57 hospitals in the initiative, and so we feel good. Not sure if we'll get to 80%, but we feel good with where we are," Bowersox says. "It's really about CEO and leadership-driven support and they are supporting this through the organization instead of it just being a project that's in the infection control department."

Bowersox says that along the way, CEOs of each hospital helped to overcome barriers, and they assigned an executive champion from within their facility. Collaboration was essential to reducing MRSA rates. "It has to be an organizational issue because some of the most fundamental work around MRSA reduction or any hospital-acquired infection reduction are things like hand hygiene and proper isolation policies and use of personal protective equipment for isolation patients. Those are really organizational issues. They have to be led by the organization, supported. Many of these hospitals have these types of things in their corporate goals so it's looked at all the way up to the board."

She coaches each hospital and talks to them at least once a month. The "basics" are covered — compliance with hand hygiene, isolation procedures, and personal protective equipment guidelines. "Then we start going into what we consider more advanced strategies, which include things like active MRSA surveillance screens. Many of the hospitals are working on using things like CHG baths (chlorhexidine baths) to treat certain populations prior to surgery." They also talk about things such as making sure device bundles for bath and central lines, as well as established checklists, are used.

Working with consultant HPI, Bowersox says she learned the fundamentals of getting to high reliability and high rates of compliance:

**• Reduce the work burden for employees.**

"What's the burden, and how do we make sure we minimize it as much as possible? For example, for isolation patients, it is quite a burden to every single time you go in that room you're going to have to put a gown on. That is a burden. There is no doubt about it," Bowersox says.

"So how do you make it be less of a burden? Partly by making sure the supplies are always there. So making sure you have a good process to keep it stocked. Making sure that the staff have some say in where these things are going to be stored, what kind of gown they're going to use, that sort of thing."

**• Increase risk awareness.**

This means education — "a lot of education about why this is so important. Why is it so important to wear the gown? What are we trying to do? It's trying to prevent this transmission from patient to patient or even patient to your staff member, who then maybe will take it home. So how to make it become real to them," she says.

**• Use peer-to-peer coaching.**

HPI consultant **Shannon M. Sayles**, RN, MA, says this step can't be reached until you have built a culture of safety. "What's important, at least from our perspective, that gets reflected in this is that this is a very useful strategy, but it's less useful if you aren't clear with people at the outset about what the expectations are and you give them the tools to do that. That's the approach that we take," she says.

The idea behind it is, "I'm going to encourage a coworker to do the right thing and I'm going to discourage them from doing the wrong thing. And we do that at a ratio of five to one. Five positives

(Continued on page 55)

# Using safety coaches to change behavior

Calvert Memorial Hospital in Prince Frederick, MD, which is part of the VHA Central Atlantic, chose to use safety coaches to monitor hand hygiene compliance. The safety coach program was piloted on the med/surg unit with two coaches per floor, and the hospital monitored pre- and post-implementation MRSA rates and then decided to move forward with the coaching program.

**Ginger Everton**, RN, BSN, director, risk management, says coaches, who still work only as part of the MRSA reduction program, receive an eight-hour class on observing employee work behaviors. One of the tools they're taught is ARCC. "They're taught to speak up, ask a question, make a request, voice a concern, and if there's no success then use the chain of command," Everton says. Coaches also were educated on proper hand hygiene — not simply running your hands under water and drying them off.

**Terri Bowersox**, FACHE, director, performance improvement at VHA Central Atlantic, says first the coach approaches "a physician who's not wearing the gown when they need to. First you ask, 'Dr. Smith, would you mind putting on your gown?' And if they ignore you, then you go the next, where you request, 'Dr. Smith, I need you to put on this gown.' The theory is that most of the time, 90% of the time, if you just ask, people will comply. So it's kind of like an elevation that you use that you start with the most simple, basic, least intrusive approach. And then you elevate it if it's not working.

"I did hear an example from a CEO where he talked about how a physician was approached by a staff member about washing his hands and he got all upset about it, furious about it, went to his chief of staff and everything. And the chief of staff, which we just love him for this, said, 'So you're complaining to me because a nurse told you to wash your hands? You should be thanking that nurse. We've known for over a 100 years that we're supposed to wash our hands,'" Bowersox says

"So leadership support is so important because the staff member who is going to coach has to know that that physician cannot go to the chief of staff or the CEO and complain. They've got to know that those leaders are going to support this work," she says.

Everton says they've spent a lot of time getting safety coaches comfortable to approach people and how to do it. One thing they've done to make the communication less confrontational is establish a code word staff members can use to alert someone to wash their hands. This functions well, she says, especially in front of patients. Using the code word, the doctor is not embarrassed in front of the patient and the patient is not alarmed. The hospital also uses reminder cards.

In selecting coaches, Everton says the goal was to have two coaches per department and not just clinical ones but ancillary services as well. She looked for willing volunteers, team members in good standing and admired by their peers, as well as those with strong communication skills. They also should "demonstrate a personal commitment to outcomes and know the expectations, practice the expectations, and make them personal work habits."

"Right now, their responsibility is to identify when people are doing the right thing and promote that good behavior and then identifying when we're not doing the right thing and addressing that and giving them the tools and techniques in reminding them of the right thing to do. We haven't really used them to empower everyone else. The idea behind the safety coach and the whole culture change and the high reliability organization idea is that if you can eliminate that culture of being defensive and not being receptive to when people speak up, then I think we can slowly hopefully change that," she says.

Coaches are expected to do at least 10 observations a month — whether they find noncompliance or comment to an employee that he or she is doing the right thing. They also come together monthly to continue to share hurdles and create more incentives or ways to encourage staff.

To staff, she explains, the safety coaches are "looking out for you to make sure you're doing the right thing. They're not there to point out that you're doing the wrong thing. They're trying to help you and make sure you're doing the right things to keep people safe." Notes congratulating and thanking compliant staff are put on the hospital's intranet. ■

(Continued from page 53)

to one negative. We have this mindset of, I should at the end of the day feel like, 'Boy I've given a lot of positive encouragement; that's the right thing to do, and I don't remember too many of that was the wrong thing to do.' I'm looking constantly for opportunities to encourage coworkers, peers, and a peer is anybody.

"So that is an extremely useful error prevention tool because it helps build the culture. Most organizations teach and expect that of everybody. But the idea with the safety coach is to identify one, two, or three people within the department at the staff level who become partners with the leaders in building that environment of focus on our safety culture, what we're trying to do, how we want to make safety a core value, how we want to build habits in all the people that work in this department around these error prevention tools."

But she cautions that introducing safety coaches before your organization is ready could make the program fall flat on its face. "It's because you don't start a safety coach program until most of the people in the organization have gone through their training. So that's my point. If you just put a safety coach program in, that's probably what it will look like — a safety police program."

Among the hospitals in the program, some use safety coaches. Others use secret shoppers. "Transporters are really good to be secret shoppers because they're everywhere. And even when they're everywhere, they're looking for these things but no one really knows that's what they're looking for. And they are tracking people's compliance on things like hand hygiene and PPE," Bowersox says.

"Rounding to influence" also has led to success. This type of rounding is used to address a singular issue, such as MRSA, and a minute-long script is used. Often, Bowersox says, leaders now will be a part of rounding, but this rounding to influence is more focused.

Beyond helping with buy in, leadership's interaction with the project has helped it have staying power. "It's amazing the competitive nature of the CEOs. They each want to be the best. And I think that has really driven a lot of this performance, because oftentimes hospitals get in projects and they kind of die off or they don't have the results that you unexpected but no one's paying any attention anyway. This is getting so much attention that I think that had a big part of the success, but I also think the other part is we have taken a multi-prong approach. So we do the coaching, we have the organizational structure with the CEO, the executive champion, and the MRSA team leader. We do lots of coaching. We do sharing calls where hospitals that are doing something really good tell the rest of the hospitals what they're doing and we have networking calls. We have a listserv. We have an awards program for people who have been really successful," says Bowersox.

"So I think it's a combination of all the different things. We definitely consider it a multi-prong approach. And certainly the high reliability work we've been doing with HPI is part of that." ■

**ACCREDITATION**
***Field Report***

# Surveyors educative, more collaborative

Demonstrating that you're prepared is important when Joint Commission surveyors knock on your door, says **Susan Bukunt**, RN, MPA, CPHQ, senior director of clinical quality and patient safety at El Camino Hospital with two campuses in Los Gatos and Mountain View, CA. "Being able to give them what they're asking for shows them that you're ready and you take this seriously," she says.

Prior to El Camino's most recent survey, Bukunt had readied all the documents on The Joint Commission's survey prep guide in binders. "We had our team on alert so that when we called, we mobilized everybody, and by the time of the opening conference I had all of my escorts ready. I had every binder that they could ask for in terms of committee minutes. Everything that was on that list we had into that room by 8:30 in the morning. And so that showed them that we were prepared and we were organized."

She also had a PowerPoint presentation ready for the opening meeting with the surveyors, who came seven months prior to their tentative "due date." "I've heard some surveyors do not let you [use presentations]. We decided to have it ready for those things and then just keep our

data updated so that even if they said, 'We don't want a PowerPoint, we just want you to talk,' people would have discussion points in front of them." So if a surveyor said, tell me what you've been working on that you've had success or not so much success with, "we had those examples there for people in the room to sort of rattle their brains to think about. And that made people feel more confident."

In preparation for the survey, Bukunt says there are 23 "surveyors" at the Mountain View campus and about 10 at the Los Gatos campus. Those are managers or directors within the organization who have been trained to do monthly surveys. They are outfitted with a checklist of about 75 items, and then the information is put on the hospital's dashboard. "So on the dashboard, if you miss one item it's red for the whole hospital. Everyone has to be perfect for it to be green. We post it on our internal web site and all the managers, they can drill down to their own unit level. They can drill down to a service line level or they can look at the entire hospital," she says.

When she surveys a unit, she takes the checklist with her and interviews staff while walking around the unit. She pulls a patient's record, a physician record, and a competency file. "And then before I leave the unit, and it usually takes about two hours to do a survey, we make a copy of it and I do a debrief with the manager of that unit and tell them what they missed and why they missed it," she says.

The surveyors arrived in March. Bukunt says that in California, the Institute for Medical Quality (IMQ) accompanies The Joint Commission on its survey and provides the physician surveyor. She says the surveyors were more collaborative, thorough, and educative — "a big difference in their approach from our survey three years ago."

"They put the staff at ease more so than I've seen them do before," she says.

They also were willing to look at clarification. "So if they had a question about something, it was 'Show me,' and I could produce a document. I could produce an audit. They were willing to look at that and take that into consideration."

Surveyors focused on patient safety, the National Patient Safety Goals, and especially life safety compliance. The system received no direct findings, only five indirect ones.

"I think one of the things that the surveyors were very complimentary of was our quality program and our use of data. And they liked the fact that they could trace the data through committee minutes and see closure where things had been looked at, talked about, and we said, 'This went up the chain of command or it went through the process,' they were able to trace that. One of the things they really liked was when we showed them some data. The surveyor could immediately see where we had a problem and asked us about that and then we were able to show him that that was one of our performance improvement projects. So he was impressed that our data were easy to read and understand," she says.

The hospitals use dashboards and a quality steering committee comprising board members, chiefs of staff, hospital administration, and the quality team. "They set the goals for the organization and what we will look at. And then they review the dashboard to make sure that we're on track with what we're trying to do," she says.

The report includes all of the quality measures the system is looking at. Bukunt says the national benchmark is included but is not the measure they use. The measure is getting to zero for things such as pressure ulcers and falls and getting to 100% for measures such as patients getting to the cath lab under 90 minutes.

She says surveyors talked about the Centers for Medicare & Medicaid Services (CMS) and the conditions of participation more than in the past, and if they cited a standard they would also site the corresponding CoP.

Surveyors asked to see the grievance policy and any grievances filed within the year. The hospital has scorecards in which data on physicians are fed. Although she says the process is still in progress, she says the surveyors were pleased.

One of the indirect findings related to timing, dating, and signing of H&Ps. The surveyors observed three instances in which physicians did not time entries in the medical record. "And so we did a clarification where 30 days prior to the survey, we looked at 70 records and did an audit of those records, and we found that we were 98% compliant with everything in the record being dated, timed, and signed. So we sent that back to The Joint Commission as a clarification to say, 'We think that we were in alignment with that.' And they may come back and say no. Or they can say, 'OK, we accept that and we'll take that finding away,'" she says.

She says the hospitals use an EMR system in which CPOE and nursing documentation are recorded for some units. "H&Ps and consultations are dictated and go directly into our electronic record so they get electronically dated and timed

when they're entered. And then the physician signature. Where we have the most problem is physician progress notes because those are still written by hand. So we've added a time column to the progress note, which was never there before. So we have a date and time column on the progress note, and that has really helped improve compliance for our physicians."

The hospital does audits of records, and when a lapse is found, the chief medical officer sends a note to the physician with the problem. It also goes on that physician's credentialing file and ultimately on the OPPE. If there is one miss, a physician gets the letter. "We're still trying to establish the threshold for how many times you can get a letter before it becomes a problem. So it's a work in progress for us," she says.

Other indirect findings were in the area of life safety, and all were corrected on site. There were issues around fire doors that didn't close completely and crash cart placement. The carts needed either to be locked or out of sight. "And they did not consider the breakaway red locks as being locked," she says.

Because they had just moved into a new hospital in November, almost all patients rooms are private and the units are bigger so they're struggling with having the carts closer to patients' room rather than to the nursing station.

"I have to say the team we had was very open and willing to talk about things and giving suggestions — 'Maybe you could do this' or giving us a reference, 'This is what I'm talking about, this is where you can go look for it.' It was so much better than we've had in the past," she says. ■

# Bay Medical improves ED throughput via ICU

Frustrated patients, core measures that require timely intervention, and optimizing house beds. Those are the issues Bay Medical Center in Panama City, FL, decided it was going to deal when it hired a consultant in 2008. Since then, patient satisfaction in the emergency department has increased by 14 points, throughput has improved, and mortality has dropped from 3.4 at the end of 2007 to 2.1 at the beginning of 2010.

**Robert Campbell**, PharmD, director of performance improvement, patient safety, regulatory compliance, and director of pharmacy services, attributes that drop to all the successes of each intervention, not just one.

The hospital's work began with developing a steering committee comprising staff up to the VPs and the CEO. Then subgroups were devised around issues such as core measures, patient satisfaction, and patient placement. Teams present their goals and subsequent barriers or hurdles, and with senior leadership involvement, "you have all the players at the table that could make the decision and move forward without having to have all the time it takes to go through a system in a hospital," Campbell says.

One of the main areas of review was wait times in the emergency department. Campbell says the team began by investigating the answer to two questions: How fast are staff moving patients who can be treated and released, and if patients are admitted, how long are they staying?

They found there was a direct correlation between the ICU transfer time and the hold time in the ED. So "if the ICU transfer time went up (and that is patients being transferred from the ICU not to the ICU), then there would be a longer wait time in the ER," Campbell says.

Campbell shared with staff an important statistic and a motivator for ramping up ED throughput: Patients who sit in the ED for longer than six hours have a 27% increase in mortality. "We explained to our staff if you have a family member who comes in here and they're right there at the 50/50 chance of making it and they have to sit in the ER for six hours, the odds are against them," he says.

He says the overriding goal became "pulling" patients out of the ICU rather than "pushing" them. "So the idea is that the med/surg floor will pull that patient from the ICU so ICU can pull patients from the ER instead of the ICU calling and saying, 'I'm sending this patient. I hope you're ready for them.' Or the ICU calling the med/surg floor and saying the same thing. The idea is we create an environment where we're working together to pull the patients through the system and get them out the door. And as efficiently as they need to be."

Campbell closely tracks the ICU transfer times — tracking from the time the request is made to the time the bed is ready on the floor and from the time that bed is ready to the time it takes for the patient to be transferred. The total time is recorded and then that can be broken down to bed request to bed ready and bed ready to patient transfer.

The goal, Campbell says, is that patients are transferred and in a bed on another floor within 60 minutes. On initiation, Campbell says some barriers were uncovered. For example, nurses would wait to transfer a patient at shift change so they wouldn't get a new patient. The other thing is that there is a button in the rooms to alert environmental services when patients are discharged or transferred from a room, and compliance on pushing that button was low. "[T]hat stopped the whole process. Environmental services' point is, 'If I don't know it's dirty, I don't know to clean it.' So we had an issue there." So a process fix was implemented. Now, when transport comes to get a patient, they are responsible for pushing that button. If a patient is leaving the hospital, he or she is given a piece of paper, which specifies whether that button was pushed, and told to carry the paper to the front desk at check out. When front desk staff see that, they can confirm the button was pushed. As another check, when environmental services comes to the room, they're equipped with a check-off list where they record whether the button was pushed. They also mark the current shift, and nursing managers check compliance by floor and shift.

In making the ED more efficient and making patients happier, Campbell says scripting was created for physicians and nurses to communicate to patients what was going on and, if there was a hold-up, why that was. So patients are told, for example, "Yes you're going to be admitted. These are the steps we've got to do just so you know what's going on behind the scenes and expect to be up there within this time frame."

Campbell says for busy staff members, 30 minutes may seem like nothing, but to patients, those 30 minutes could turn into two or three hours waiting for a bed or the frustrating realization that they don't know exactly how long it could take. "When you continue to say, 'I don't know, I don't know' it builds on people's frustration. And their tension," he says. Communicating with patients about what's going on and when they can expect to be put in a room has made a huge difference in patient satisfaction, he says.

Bay Medical, beyond its traditional ED, has a rapid response department for lower-acuity patients. The ED staff, he says, are responsible for monitoring the utilization of that department. "Our goal is that 30% of all patients who go through the department go through the rapid response department. And the way we determined it was we took historical data for a year, looked at the triage levels for the patients, and determined

## CNE QUESTIONS

17. Terri Bowersox, FACHE, director, performance improvement, suggests which of the following for getting to high reliability?
A. Reduce the work burden.
B. Increase risk awareness.
C. Use peer-to-peer coaching.
D. all of the above

18. Ginger Everton, RN, BSN, director, risk management, says using a code word has helped employees alert coworkers to wash their hands while not alarming patients in the room.
A. True
B. False

19. One of the indirect findings The Joint Commission found at El Camino Hospital dealt with H&Ps.
A. True
B. False

20. Since Bay Medical Center implemented process improvements for throughput, patient satisfaction of ED patients has risen how many points?
A. 7
B. 10
C. 14
D. 20

Answer Key: 17. D; 18. A; 19. A; 20. C.

## 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. ■

that this percentage could easily go through the department and not create any issues and actually improve throughput and improve patient care and outcomes," he says. "So we monitor that. Plus, we say, 'OK, given the acuity of these patients and given what we normally see based on our data, the turnaround time should be 90 minutes for this room.'"

In a spreadsheet program, he tracks how many times a room was used in a day, how many times a room was left empty, and how many times a room could have been used but wasn't. "We found that they were meeting their 90 minutes but they were not meeting their goal for volume. Well, what we found was they were only using five of the eight rooms. And they were using the rooms closest together to save footsteps. So we actually started monitoring utilization of each of the rooms in rapid and making sure that it was plateaued out. And it made a difference," he says.

Another process helped meet the core measure on 90 minutes to percutaneous coronary intervention. All of the hospital's ambulances are equipped with 12-lead EKGs. So when the team responds to a call they can do the EKG in the patient's home and send the information via cell phone to a physician in the ED, who can notify the cath lab to prepare for a patient. Oftentimes, Campbell says, the team is ready before the patient even gets there.

"The other thing that was interesting was we had some issues with the 90-minute window core measure for PCI, and what was interesting was that part of it had to with simply differences in times on clocks," he says. So atomic clocks were put in the ED and cath labs.

"When the cath lab gets a patient who's going to qualify for the core measure, we have a worksheet they fill out that has time stamps on it where they fill in the times. So they know when that case ends if that patient passed or failed automatically. And then we get that information and then we review that with the staff the following week to go over what we could have done differently and then the physician-related stuff we give to the appropriate physicians," he says.

The hospital also added a discharge lobby, so patients don't have to wait in their rooms to be discharged and thus opening more beds for other patients. The lobby has places for patients to read or watch television and a coffee shop. The hospital also is using its old ED to move patients when they are ready to be discharged and then can leave from there. ■

# Make learning about patient safety fun

It was a "room of horrors" replete with blood (corn syrup plus food coloring) and spiderwebs. And it was the theme of West Valley Medical Center's (ID) patient safety week. The display room was open 24/7 Monday through Friday and available to all staff — from housekeeping to nursing.

The week started with a kick-off party and a video demonstrating the importance of thinking about patient safety, says **Tammy J Sanchez**, RN, BSN, clinical quality specialist. Sanchez says it brought many in the room to tears. The video, she says, demonstrated "why it's important that we embrace quality in our practices every day and to put a human face to the reason we incorporate patient safety." *(To see the video and find out more about the Josie King Foundation, visit http://www.josieking.org/.)* A quiz was handed out after the video, focused on

## 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

- Joint Commission's revised med rec goal
- The Swiss cheese model and types of errors
- QI for multi-hospital systems
- What Geisinger does that's different

"errors and what kind of errors are skill-based and rule-based errors and how errors are made. We tried to incorporate a general safety theme into it."

The room was set up to illustrate safety errors, mostly related to the National Patient Safety Goals and risk management. There were things that didn't meet life safety or fire codes. There was a patient with only one patient identifier on the armband. A chart was left open to illustrate a HIPAA violation. "We had a CPR dummy, and we dressed him up and made a scenario. We said, 'You're walking into the room for the first time to see this patient. They were involved in a car accident and they were suicidal' so there were things around the room that you wouldn't want in a suicidal patient's room," she says. Unlabeled medications lay on the patient's bedside. Syringes were just lying around. "We even had a mouse with the mouse trap. We had a lot of fun. We really went to town with it," she says.

Staff had to go through the room and identify as many violations or concerns as they could, and the one who found the most won an iPod. Sanchez says staff were very engaged.

On Tuesday, there were games — Jeopardy, Wheel of Fortune. An employee's husband made a model to replicate the Wheel of Fortune board. "We had a whole lobby full of people who were participating in it and with Wheel of Fortune you just guess the letters so people from housekeeping and nutrition services, all of those people were involved without feeling real intimidated about maybe not knowing the National Patient Safety Goals. It just brought a lot of attention to the terminology, and all the words we used had to with the National Patient Safety Goals."

Jeopardy categories included performance improvement & patient safety, leadership & medical staff, misc., environment of care, information management, medication management, and provision of care/infection control.

Staff could win "West Valley bucks" with pictures of administrators — the highest amount, of course, showing the CEO, who "really liked it." Staff could turn in money to enter a prize drawing for MP3 speakers, flash drives, and iTunes gift cards. "We didn't spend a lot of money, but we got some really nice prizes, which also helps people want to play."

On Wednesday, staff were given a word scramble puzzle also highlighting the NPSGs and Joint Commission standards. She also handed out pocket guides of standards that were created.

On Thursday, staff played "Are you smart enough for the surveyor?" And Friday, the drawing was held for the staff member who found the most concerns in the "room of horrors." ■




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