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State-sponsored programs help PA hospitals reduce HAIs

Facility-specific initiatives complete picture of impressive QI efforts

In quality improvement circles, certain states have gained a reputation for excellence, and recent statistics out of Pennsylvania seem to indicate that this particular state's reputation is well deserved. A new report issued by the Pennsylvania Department of Health (DOH) shows a decline of 12.5% for overall health care-associated infection (HAI) rates at the state's acute care hospitals in 2009.

One of the reasons for this improvement is the number of programs Pennsylvania makes available to its hospitals. For example:

- Pennsylvania is a participant in the Agency for Healthcare Research and Quality (AHRQ) national quality improvement program, which is designed to implement Comprehensive Unit-Based Safety Programs (CUSP) in ICUs across the state and reduce central-line-associated bloodstream infections.
- Pennsylvania says it is the first state to create a patient safety organization, the Pennsylvania Patient Safety Authority. Advisories from National Healthcare Safety Network (NHSN) data produced by the Patient Safety Authority are being used by Pennsylvania's hospitals to help identify risk-reduction strategies around prevention of infection. The authority and the Hospital & Healthsystem Association of Pennsylvania (HAP) are collaborating with hospitals on CUSP.
- Pennsylvania's hospitals, along with the state's Blue Cross &

KEY POINTS

- Creating culture of safety seen as key to success in new CUSP program.
- State makes liaison advisors available to help identify opportunities to improve.
- Even with "packaged" programs, hospitals must address their unique needs.

Blue Shield plans, developed the Pennsylvania Health Care Quality Alliance (www.phcqa.org), which provides information about publicly available measures.

- Pennsylvania's hospitals also participate in several statewide and regional quality improvement efforts under the auspices of HAP and other organizations.

On the 'CUSP'

Pennsylvania hospital quality leaders recognize the value of initiatives such as CUSP. "Pennsylvania has been at the forefront of IHI bundling programs and CUSP, which is a Hopkins

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EDITORIAL QUESTIONS

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program," notes **Omar Rahman**, MD, medical director of the adult ICU stroke trauma unit at Geisinger Medical Center in Danville, PA. "They were part of a cohort of states that took the bold move to get onboard with what are extremely important issues. In the era of health care reform, addressing HAIs is essential."

Rahman's ICU is part of the CUSP program. "We have a team that I lead, and we have interactive meetings with all participants — state hospitals as well as those outside the state," he explains. "We started with regular weekly meetings, and now we still meet monthly to share ideas and safety initiatives."

Every CUSP team has a clinical leader (in this case, Rahman). "Then, the program asked us to include well-known nurses who lead by example; we have five," he says. "We also included our quality assurance person [the ICU has its own], and we included an executive member of administration, so each executive team member can help facilitate resources."

Rahman says he began participating in the CUSP program in July 2009, with the initial steps being education, orientation, and getting the teams together. "With Geisinger being a large academic institution with multiple ICUs, this was a decentralized process," he explains. "Each ICU was asked to create a team and implement CUSP guidelines, keeping in mind the uniqueness of each unit."

The basic goal, he continues, is to improve the safety culture. "For decades we have been trying to treat patients and fix sickness, but this new culture is moving toward an era of not letting anything else happen to the patient," Rahman notes.

The CUSP strategy, says Rahman, is multifaceted, and focused on improving the culture through the ongoing education of nurses, doctors, and residents. "It occurs on several different levels — group sessions, PowerPoint presentations, and one-on-one sessions with each of the 110 nurses," Rahman shares. "I've also e-mailed them regularly telling them why we're doing what we're doing, and sharing current data. We also have visual aids such as posters, monthly listings of current infection rates — a dashboard that shows how many lines we used and how many infections we got." In other words, he adds, staff can sit in the break room, look at the wall, and see all the information they need.

Rahman says he actually had a head start on CUSP because about 18 months earlier, he had started a program of his own to change the culture of the unit and make it more quality- and

safety-friendly. “We came up with the idea of a verbal rounding checklist where the doctor, nurse, and respiratory therapist will go over every single patient on every single day,” he shares. These discussions include most of the unit’s quality and safety goals and many National Patient Safety Goals. “We discuss why the patient needs a central line, why a Foley catheter is needed, whether or not they are on a DVT program, whether code status is designated, if we’ve met with the family, the patient’s mobility status — those things frequently overlooked in ICU patients that can lead to complications,” he says. “We made a rule that doctors cannot round unless a nurse is present, and we have 100% compliance with that, after having 33% compliance a year earlier.”

In addition, he says, the unit improved its rates of sores, the number of times lines were left in the body, and discussion of code status and advanced directives.

“When CUSP came along, we were happy it was something we were kind of already doing,” says Rahman. He notes that before the unit joined, despite the fact that its rate of line days was going down, infection rates were still higher than the national average. “Although CUSP started last July, the changes weren’t implemented until last December, after the education process,” he notes. “Still, in 2009 our infection rate was 4.1 infections per 1,000 line days; our most current rate was 1.9 per 1,000 line days.” In terms of absolute numbers, he says, there were 17 last year and a total of four so far this year. “We’re obviously moving in the right direction; we want to achieve a zero rate by the end of this year,” he asserts.

Among the specific benefits of CUSP, Rahman continues, was the suggestion that the unit create a checklist. “We now have a checklist as we put a line in; if there’s a problem, we interrupt and stop the process,” he says. “Our next venture is to have the checklist done electronically.” As for those regular meetings, says Rahman, “there’s never been a meeting where we did not add new a strategy.”

A different approach

The approach taken to CUSP by Greensburg, PA-based Excelsa Health demonstrates how different facilities can customize their own initiatives. “We’re participating at our Westmoreland ICU in conjunction with HAP,” says **Denise Addis**, RN, MSN, CPHQ, Excelsa’s chief quality officer. “Our goal is to improve our culture of safety within the ICU and reduce our central line-associated bacte-

remia, or CLAB rate, using the bundle from IHI. And, because our CLAB rate is so low in all our organizations, we decided to also reduce sepsis by implementing what is now called the sepsis bundle, which is just starting to get legs nationally.”

At the outset, says Addis, the AHRQ patient safety survey was implemented, which is a requirement of the project. “Another thing we’ve done is encourage staff to identify one defect a week and then work on that as a team,” she shares. “It could be as simple as where supplies are located, or how communication occurs.”

In addition, she says, the unit has instituted multidiscipline rounding led by an intensivist. “We have a 24/7 intensivist program at Westmoreland, which we know improves outcomes, and we have developed a daily report sheet that allows everyone to know the plan of care and expectations for every patient,” says Addis.

A representative from the Josie King Foundation provided an educational seminar to Excelsa’s physicians, caregivers, and the community on how they could work together to improve patient safety.

In 18 months, Addis says, staff participation has been good. “They participate every day in rounds,” she notes. Since the facility’s CLAB rate was already very low, “our main benefit has been teamwork.” The sepsis bundle, she adds, was implemented only a month ago.

CUSP is not the only state program benefitting Excelsa, says Addis. “I would say the resource of the patient safety liaison of the Patient Safety Authority has put us more in touch with the national literature,” she says. “And they have a website board where you can post questions and get a response from the authority. We use them very much as advisors; they’ve been invaluable in triggering us to look proactively at identifying opportunities rather than reactively after things happen.”

Numerous initiatives

Excelsa and other Pennsylvania systems and facilities have been participating in a number of initiatives beyond those offered by the state, notes Addis. For example, she says, “Hand hygiene is a No. 1 priority, and we’ve most recently been given more structure around compliance through the H1N1 scare. It allowed more attention to be placed on hand washing and put everyone on a level playing field because we all can relate to the flu, as opposed to other more technical microorganisms (i.e., MRSA).”

While the outbreak did not match the expecta-

tions, she continues, “It allowed us to increase education, observational opportunities (compliance) and force the hand of [administration] to put in more hand-washing stations,” says Addis. “We did a lot of community outreach with physician offices, providing them with resources on hand washing and prevention.”

As for compliance, says Addis, she used “secret shoppers” — future medical and nursing students — to observe compliance while appearing to do another task. “We also required every department to monitor hygiene compliance two to four times a year by direct observation,” she notes. “We empowered both staff and physicians to step up and tell someone they did not wash their hands, and we empowered patients or guests and taught them that they also needed to stop caregivers who were not washing their hands.” In addition, creative slogans such as “Boo to the flu!” have been used and T-shirts given out to publicize the effort. Addis says compliance rates have steadily increased and are now around 80% — well above the national average.

Another initiative Excelsa is participating in is “Quality Blue,” a pay-for-performance program sponsored by Highmark Blue Cross Blue Shield. “Highmark incentivized organizations to reach best practice outcomes for projects based on national standards and best practices,” says Addis. “We reached max reimbursement and outcomes at all campuses in the latest fiscal year, as we did the year before. It’s a good way to get an organization to do best practices when it is clearly established what a best practice is.”

In fiscal year 2010, she adds, Excelsa is working on surgical repair infection prevention; MRSA; UTIs; and CLAB, “and we continue work on the ventilator-associated pneumonias [VAPs].”

Piggybacking on success

Speaking of VAPs, Rahman says he is using lessons learned from his VAP initiative in the current CUSP efforts. “We want to achieve what we did with VAP,” he asserts. “In 2006, we started aggressively, and have brought it down to almost zero; in the last two to three years we’ve only had two infections, and in 2008-2009, we had 12 months where we had none.”

The key to this success, he says, “was that we not only set up a committee to look at the IHI bundle and make sure we were compliant, but we used our EMR and innovative IT tools to make sure compliance was being done.”

Most hospitals, he says, will commit to processes such as providing good oral care or having the head of the bed elevated, “but we ensured it; oral care had to be electronically documented through a pharmacy order,” Rahman explains. “This was a big step, because it meant care was standardized. Second, we only use a specialized endotracheal tube — it’s now the only one used in the hospital.”

Ongoing education is also crucial, he continues. “When we have a case, we sit down with infection control, analyze it in depth, and see what the breakdown was,” says Rahman. These discussions led to the discovery that “99% of the time” the patient was either not getting the right tube or not receiving proper mouth care. “If the cause was nurse care, we addressed it with the nurse; if it was the system, we addressed it with the supply department,” he adds. ■

Bar-code/eMAR combo reduces errors

Order transcription, med administration studied

A study of a patient safety strategy at Boston’s Brigham & Women’s Hospital that incorporated bar-code verification technology within an electronic medication-administration system (bar-code eMAR) showed a significant reduction in errors, according to an article published in the May 6, 2010, issue of the *New England Journal of Medicine*.¹ The study was funded by the Agency for Healthcare Research and Quality.

The researchers observed 14,041 medication administrations and reviewed 3,082 order transcriptions. Here’s what they found:

- There were 495 non-timing errors in medication administration on units that used the system (a 6.8% error rate), compared with 776 in those that did not use the bar-code eMAR (an 11.5% error rate).

- The rate of potential adverse drug events (other than those associated with timing errors) fell from 3.1% without the use of the bar-code eMAR to 1.6% with its use, for a 50.8% relative reduction.

- The rate of timing errors in medication administration dropped by 27.3%; however, the rate of potential adverse drug events associated with timing errors did not change significantly.

KEY POINTS

- Study covers usage of system in multiple hospital units.
- Make sure your system meets the specific needs of your facility.
- Compliance should be viewed as a journey, not an isolated event.

• There was a rate of 6.2% for transcription errors on units that did not use the barcode eMAR; units that did use it had no transcription errors at all.

“We are not the first hospital to implement the technology,” shares **Eric G. Poon, MD, MPH**, who is with the division of general medicine primary care at Brigham and Women’s and the lead author of the article. “The VA has done it for quite a few years, and we learned from them as we designed our own.”

Studies have been tried in other settings, but have not necessarily shown an impact. “This is partly, as I understand it, due to the fact that some users may not have embraced the technology, while others have done studies in a fairly limited setting — like one unit,” notes Poon. “We’re glad to be able to show how this worked in a larger hospital across multiple typical units.”

System developed internally

The Brigham & Women’s system was developed internally when the facility decided to embark on the technology about 10 years ago, says Poon. “We did not feel the vendors out there really supported what we needed,” he asserts. Since then, he adds, they also have looked at other vendors; some systems had what his did not, and vice versa.

“In general, having it internally developed allows us a lot more flexibility,” he declares. Still, he notes, vendor systems are “very much catching on” within Partners Healthcare (the system to which Brigham & Women’s belongs), and the system has implemented similar initiatives using vendor technology. “Many have an eMAR component and are looking to implement a bar-code scanning component; more and more vendors will be interested in this,” Poon predicts.

Since, as Poon notes, compliance may have been the cause of more disappointing results in earlier studies, how did he ensure a higher level of compliance at Brigham & Women’s? “The great

illustration of how to implement this is that it is not a single event, but more of a journey,” he explains. “At the beginning, not all nurses might have embraced it, but what we heard was as soon as it catches the first error they really embraced it, which is the traditional adoption curve.

“What we also found was a lot of times nurses wanted to scan, but there were technical issues; certain drugs had bar codes per the FDA and some were harder to scan than others, just as they are in the grocery store,” he continues.

There were some cases, he adds, where the hospital actually had to switch pharma vendors to get better bar-codes. “IV bags were particularly challenging,” he notes. “In another case we got around the problem by having an in-house re-packaging center; we were able to put those drugs in a little plastic baggie with their own bar code.”

An ‘invasive’ intervention

Poon continues: “This is a reasonably invasive intervention — particularly for the nursing staff. About a quarter of what nurses do is around administrating medications.”

For other organizations considering such an intervention, says Poon, “They should not think of this as just scanning a bar code at the point of giving meds, but as a whole process: how to make sure the pharmacy sends the right medication doses to units in a timely way; how we make sure there is good communication between the pharmacy and nursing staff when there is a question about a medication order; and that there is reasonable response time to approval of pharmacy orders.”

For instance, he points out, the Brigham & Women’s system says a nurse can’t administer a drug by scan unless the pharmacist has approved the order.

In addition, says Poon, “Other organizations need to understand this is not just about buying technology and training nurses on its use, but also about whether they are willing to take a critical look at what nurses spend a lot of their time doing. For instance, they may need to do work redesign in conjunction with the technology.

“That in my mind is where projects either fail or succeed,” he continues. “Do you have the leadership to say, ‘Gee, we need to come up with a way of giving meds that makes sense’ even if that means changing what you’ve been doing the last few decades?”

Finally, says Poon, “You need to keep working on this. There will be folks who may not embrace

it; in some ways it's just like CPOE.”

[For more information, contact:

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Medical home model can be complementary

Model has point person for DP to call

A health care model that seeks to improve quality while reducing costs is attracting more attention lately as the health care reform has made it a priority for pilot project funds.

The patient-centered medical home (PCMH) model, also called simply “medical home,” takes medicine back to a previous time with patient care that is focused around a primary care physician (PCP) team structure. The idea is that patients treated in medical homes have their care coordinated by one PCP, who handles all referrals and ancillary care.

The medical home model could avoid 25% of current readmissions, saving \$25 billion a year under a scenario in which it's used nationwide, according to a recent Microsoft Health Plan Industry Group monograph on the subject.

“The tenet of the medical home model is the patient would have a quarterback, a relationship with a personal physician and health team that would help navigate the patient through our complex health care system,” says **Marjie Harbrecht, MD**, CEO of Health TeamWorks, formerly the Colorado Clinical Guidelines Collaborative (CCGC) of Lakewood, CO. Health TeamWorks is a nonprofit collaborative that is working to redesign the health care delivery system.

“More importantly, it should keep them healthy and out of the system,” Harbrecht says.

From a hospital's perspective, the model ideally will reduce unnecessary hospital utilization, because it will prevent emergency department visits by patients with diabetes, congestive heart failure, or heart disease that is poorly maintained, Harbrecht and other experts say.

“The hospitals agree they don't want to give inappropriate care,” Harbrecht says. “They want the appropriate care where it should happen: right

KEY POINTS

- The medical home model could avoid 25% of current readmissions.
- The model also could reduce utilization.
- Some states have moved forward on the medical home model, using it for Medicaid patients or mandating its availability for all insured patients.

time, right place, right care.”

The medical home model's goal is to provide continuous, coordinated, comprehensive care for the purpose of improving quality and reducing costs, she adds.

In the siloed, uncoordinated health care system prevalent in the United States, patients see whichever providers they desire, making frequent changes, and no one provider knows everything about the patient's health status.

“Patients can go wherever they want, but no one helps them coordinate care,” Harbrecht explains. “So, the patient might show up in the ER with a condition that could have been treated in a lower-cost setting.”

Currently, nationwide, 13% of hospitalized patients require readmission within 30 days of being discharged, and one of the chief causes is delayed or inaccurate communication between hospitalists and primary care physicians around discharge, according to the Microsoft Health Plan Industry Group paper.

The medical home model seeks to reverse this trend, having patients think to first call their medical home office, which often provides after-hours access to a care coordinator, when they have a problem.

The model isn't a gatekeeping system like the old HMO model of the 1980s, says **Wanda Hanson, RN, MSN**, quality and chronic disease manager of Sanford Health - MeritCare in Fargo, ND.

“If the primary care provider (PCP) can treat the patient's diabetes, then that's where we want it treated,” Hanson says. “If they're having difficulty, then it's very important to refer to the endocrinologist, and it's the same for cardiology and other specialties, as well.”

It's difficult to say precisely how the medical home model will impact a particular hospital, because each type of medical home is handled differently, the experts say.

For example, each medical home patient seen at

one hospital after a congestive heart failure (CHF) diagnosis will receive education and follow-up telephone calls from a nurse specialist, says **Tina M. Snapp**, RN, BSN, CCM, continental division director of case management at Hospital Corporation of America in Denver.

Case managers also can provide discharge care.

“They make sure they have someone in the case management department who is coordinating care to make sure primary care visits are made in the first week of discharge, which is a significant factor in readmissions,” Snapp says. “It’s amazing how many people who don’t have a PCP visit billed after hospital admission are readmitted.”

Ideally, the medical home model leads to better communication and hand-offs between providers.

“We now have a home health provider that has very good discharge programs, risk assessments, disease management programs that we, in essence, will be handing off to,” Snapp says. “So, we’re creating a streamlined discharge process where the home care coordinator or liaison will see the patient before the patient leaves and within specific intervals, including within 24 hours of discharge.”

The goal is for the program to make sure high-risk patients are receiving support when they first return home and perhaps for the first 30 days post-discharge, she adds.

With the medical home model, this process includes the continuation of patient education in the home setting and sending information and updates to the PCP office.

“We want to make sure we’re all bridged in this, because we know communication is one of the biggest downfalls of this whole process,” Snapp explains. (*See story on how discharge planning best works with medical home model, page 104.*)

One of the drawbacks of the medical home model is that hospitals receive no financial incentives to provide better care coordination and communication, some experts note.

“The money still goes to the physician, so the devil is in the details of this,” says **Robyn Golden**, MA, LCSW, co-founder of the National Coalition on Care Coordination in New York and director of older adult programs at Rush University Medical Center in Chicago.

“There are no expectations for the hospital,” she adds. “It’s the medical home where the expectations sit.”

Still, there is potential for a good fit with medical home PCPs and hospitals, she notes.

“The medical home has a transition component of making sure people get more integrated into the com-

munity and never are admitted in the hospital in the first place,” Golden says. “So, there’s great potential for case management and a bundled payment.”

Some states have moved forward on the medical home model, using it for Medicaid patients or mandating its availability for all insured patients.

For example, the state of Minnesota passed legislation in favor of the model. The medical home rule went into effect on Jan. 11, 2010. Clinics certified in the medical home model will receive a fee per member per month for coordinating care, Hanson says.

Also, in North Carolina, the medical home model is used to improve health care outcomes among Medicaid patients who have chronic illnesses.

There are nearly 1 million Medicaid recipients in North Carolina, and there are 14 nonprofit networks that serve as their medical home, says **Denise Levis Hewson**, RN, BSN, MSPH, director of clinical programs and quality improvement for Community Care of North Carolina in Raleigh, NC.

These medical homes take care of sick Medicaid patients, but also look for people who have undiagnosed or untreated chronic diseases to provide them with disease management services, Hewson says.

“They hire care managers, who work with the highest-risk and highest-cost patients to bring them disease management,” she explains. “They follow them when they come out of the hospital, help with their medications, and make sure the medical home has the information and data needed to manage their population.”

For example, the medical home works closely with diabetes patients, following evidenced-based practices, such as having the physician examine patients’ feet for numbness, which could signal diabetic neuropathy, leading to insensitivity, ulceration, and even amputation.

“Research shows that if patients come into the exam room and don’t take off their socks and shoes, then the physician doesn’t see their bare feet or think about examining their feet,” she says. “So, the medical home staff make sure the patient’s feet are easily accessible and noticeable when the doctor conducts the exam.”

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Medical home model helps DP process with care

Point person or EMR keeps all providers informed

Here's a common hospital discharge scenario: The patient is ready to be discharged home, and the hospital has a discharge planner or case manager who is prepared to call the patient's primary care physician (PCP) to discuss the patient's post-discharge care. But who does the discharge planner call? And will anyone respond to the call?

"Everyone in a typical doctor's practice is busy; and they might be a little annoyed, because they don't have time for this; and they don't have a system in place to handle it," says **Marjie Harbrecht**, MD, CEO of Health TeamWorks, formerly the Colorado Clinical Guidelines Collaborative (CCGC) of Lakewood, CO.

This is where the patient-centered medical home model can greatly benefit discharge planning. With this model, there is a person to call — a primary care case manager or care coordinator. And chances are that the care coordinator might even call the hospital discharge planner first.

"The medical home sets up a specific contact system, so each person has been assigned to someone who can check this log to see who has been in the hospital and emergency room," Harbrecht says.

The hospital discharge planner can tell the medical home coordinator about the patient's dis-

charge, the hospital team's chief concerns, and the need to have the patient seen by a provider soon after he or she returns home, she adds.

Harbrecht and other experts discuss these ways the medical home model can enhance care transition and the hospital discharge process, and how hospitals can make the most of these transitions with or without assistance from medical home providers:

• Create tools to improve communication between the hospital and medical home/PCP.

Physicians sending patients to the hospital will want to communicate some specific details about the patient's case, but it's often unclear how they might do so, Harbrecht notes.

"Who is the patient, his or her demographics, histories, medications, allergies, etc.?" she says. "And how do you contact me and send information back?"

Also, there might be times when the PCP doesn't know the patient has entered the hospital, and the hospital doesn't know where to send results.

TeamWorks created some tools to help with these communication issues.

One is a wallet card for medical home patients. They receive a handout that says, "You're now part of a medical home, and here's what it means; here's how to reach us after hours, and if you do have to go to the ER, call us first to see if we can help you through that," Harbrecht says.

Patients keep these cards in their wallets or purses, so they'll have it to show hospital staff their PCP's name and their health coordinator's name and contact information.

Another tool is a fax referral form that is available for these care transitions:

- PCP to hospital - direct admit;
- hospital to PCP;
- PCP to ED;
- ED to PCP.

These one-page fax forms have spaces for all essential communication about the patient, including the following information:

- patient name;
- patient date of birth;
- dates of hospitalization;
- hospital name;
- attending physician/hospitalist;
- reasons for hospitalization;
- discharge diagnoses;
- key lab/imaging results;
- new medications/immunizations;
- procedures done;
- pending lab/imaging results;
- recommended follow-up (including specialists contacted);

- comments;
- provide discharge summary if available.
- **Provide electronic communication processes.**

“One challenge is how to get succinct communication back and forth between the busy emergency department and the primary care physician and back,” says **Tina M. Snapp**, RN, BSN, CCM, continental division director of case management of Hospital Corporation of America of Denver.

One method is to provide PCPs with access to the hospital’s computer system and electronic medical records for their patients.

This way they can check their patient’s lab test results at the time they have the patient sitting in the exam room waiting for them.

“Through our information system, we set up a remote access for the physician group, so they can go online for information,” Snapp says. “We have a website called healthonecares.com, and doctors can go online with access codes, and if these are tagged to their patient, they can see the test results.”

Insurance company nurses also can access this system when they’re primary payers, she adds.

- **Work with medical home care coordinators.**

Medical home care managers provide complex case management for patients, Snapp says.

“From the discharge perspective, we know the primary care office, and we can call different care coordinators in the offices, and information will go over to them,” she says.

“It’s set up in our system that discharge summaries and information is faxed over to the primary care office too,” Snapp says. “So, they know what happens in the course of hospitalization.”

It can be a relief to hospital discharge planners to have a point person to call about a patient.

“It’s still our responsibility, but the difference is we have somebody to call and say, ‘This person is very high risk and has been here several times, so would you please make sure you get the patient in your office right away,’” Snapp explains.

“Before, you might call the doctor’s office and leave a message that goes into oblivion,” she adds. “But now, there’s someone at the doctor’s office who’s responsible for this call, and that’s a huge difference.”

Case managers and social workers have a tremendous opportunity to be a positive force in care transition through the medical home model, notes **Robyn Golden**, MA, LCSW, co-founder of the National Coalition on Care Coordination in New York City and director of older adult programs at Rush University Medical Center in Chicago.

Medical home care coordinators regularly call

patients to make certain they are adherent to their medication and doctor visits and to see if they have any symptoms that might lead to an ED visit.

“They talk to patients all the time, making sure things are going okay,” Golden says. “They’re the contact person.”

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Physicians use checklists for quality DP

Tool helps hospitals meet quality measures

Mistakes happen even to the best clinicians. This is why hospitals increasingly are relying on checklists and other tools to assist clinicians in the discharge process.

One such tool, called a clinical decision support system, is an electronic checklist that enables hospital clinicians to meet all safety and quality goals every time they make a patient discharge.

The tool can assist hospitals with meeting quality measures used by the Hospital Quality Alliance (HQA) and Hospital Quality Incentive Demonstration (HQID) project.

A study comparing clinician compliance with heart disease treatment quality measures before and after use of an electronic checklist found significant improvement from the pre-intervention period to the post-intervention period. Clinicians’ compliance with delivery of discharge instructions increased from 37.2% to 93% for acute myocardial infarction.¹

Overall compliance with the cardiac discharge measures improved with the use of the clinical decision support system from 76.8% in the pre-intervention

period to 96.8% in the post-intervention period.¹

“It’s not like a doctor ever wants to do the wrong thing, but you need another safety mechanism to assure 100% quality,” says **Jeff Riggio**, MD, MS, physician advisor for information systems in the department of medicine, division of hospital medicine at Thomas Jefferson University Hospital in Philadelphia.

“We’ve realized the need to have systems in place, and having this as a computer-aided system has been helpful,” Riggio says.

The hospital instituted the checklist for discharge planning involving cardiac patients with the help of a staff focus group and physician leaders, he says.

The movement toward using checklists partly is drawn from the airline industry, which instituted such processes to improve safety, he notes.

“The airline industry has translated many of its initiatives to improve quality and safety, and now we’re taking advantage of their experiences,” Riggio adds. “We’re taking up their recommendations and adapting them for health care use.”

Hospitals already have access to best practice guidelines. For instance, the Centers for Medicare and Medicaid Services (CMS) and the Hospital Quality Alliance have national quality initiatives. And various cardiac societies also have national guidelines involving cardiac care.

“So, we know what appropriate care is for our patients,” Riggio says. “Unfortunately, to err is human, and people forget things; so we need a computerized system to help us achieve better compliance.”

Electronic checklists can be useful tools for all clinical staff involved in the discharge process, including medical students, nurse practitioners, and attending physicians.

They work by having a section called the national quality measures section pop up on screen whenever a clinician keys in a specific diagnosis relevant to these measures.

“Once the appropriate diagnosis has been selected, there is a required checklist that needs to be performed before you can complete your documentation for the patient,” Riggio explains. “You’re forced to say whether or not you’ve prescribed an ACE inhibitor or given the patient appropriate discharge instructions.”

The electronic system requires clinicians to answer a few questions before the discharge instructions are finalized.

“It takes an extra two minutes, if that long,” Riggio says. “It’s a mandated checklist. And for heart failure patients, there are two questions; and

for acute myocardial infarction patients, there are four questions.”

For a specific diagnosis, the electronic system will list patient instructions. These include having patients weigh themselves daily, follow their prescribed diet, know their activity recommendations, and understand their medication instructions.

“The program will require you to put in a follow-up post, and the program will have specific instructions for heart failure patients, talking about what to do if symptoms get worse and how to monitor weight,” Riggio says. “This is automatically included in what’s printed out for the patient.”

Physicians can use their desktop computers to create the discharge instructions, which are all Web-based and available on the hospital’s intranet, he adds.

“We’re looking at putting computers in every room, but that’s in the future,” Riggio says.

One of the big mistakes that an electronic checklist can prevent involves whether or not physicians have reminded patients to take aspirin or prescribed an ACE inhibitor, he notes.

“For heart failure patients, the electronic prompt will remind them that the patient needs to be on an ACE inhibitor,” Riggio says. “It reminds the discharging physician, because sometimes the discharging physician is not the physician who took care of the patient the entire time.”

These continual hospital hand-offs are windows in which mistakes can occur, so the checklist is helpful in making sure the necessary communication occurs.

“It helps to double-check on prescriptions,” Riggio says. “The physician might say that when the kidney function is better, we’ll start an ACE inhibitor, and this will remind them to prescribe the drug.”

The checklist also provides transparency in hospital care, and it’s printed out and given to patients, who can see the quality measures for themselves. The total discharge instructions might be five pages with headers and page breaks; they’re self-explanatory, listing medications and instructions about when to call a doctor. There are icons highlighting the various sections.

“Patients will be aware of quality standards for their disease process,” Riggio says. “Patients often are never involved or see the end result; but we actually give them a copy of it, because this is one of the few documents we give patients routinely.”

Some physicians and hospitals might debate the wisdom of sharing this information with patients, but from Riggio’s perspective, it is the right move: “We felt this was the future [of medicine], to empower patients and have them understand these

decisions we're making."

Typically, the physician will review the instructions with patients, although nurses might also be involved, Riggio says.

The other benefit to sharing the information is that the patient can take it to his or her community physician, who now will know why particular drugs were prescribed or not prescribed, he adds.

"Copies of these discharge instructions also could be sent to outside referring clinicians," he says.

The electronic checklist could be used by various health care systems as a means to improve clinical decision support at discharge.

"We've been working on rolling this out at an affiliate hospital in South Philly," Riggio says. "It has translatability to many different systems and hospitals."

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What does DP do at patient EOL?

Care continuity still necessary, expert says

Hospitalized patients with terminal illnesses often feel abandoned by their physicians at the end of their lives. Their physicians might experience a lack of closure that is unsettling.

While no physician plans to abandon a dying patient, this often is what happens, particularly when the patient's crisis leads him or her to the hospital.

Here's a case study example: a 72-year-old woman entered a hospital emergency room with complaints of acute pain caused by metastatic cancer. The woman had no family in her Arizona community, and she was admitted only after she claimed to be unable to care for herself at home. Her community physician was out of town and unavailable.

The hospital provided treatment for her pain

and begins to prepare for surgery, but it was soon discovered that the cancer is too widespread to warrant surgery. The hospital prepared to discharge the woman to a cancer specialty center that could identify the origin of her cancer, but the patient declined this transfer, saying she did not want to be transferred for further tests and could not withstand the pain or take care of herself if she were sent home.

Meanwhile, the patient expressed feelings of anger and abandonment by her physician and the hospital. The physician did not interrupt his vacation to check on her condition after she was hospitalized, and, from her perspective, the hospital seemed eager to get rid of her.

The solution ended up being a transfer to a residential hospice center that had inpatient, acute care beds. The woman's Medicare benefit paid for the acute care stay, and the woman did not live long enough to be discharged back to the community.

This type of situation is all too familiar to oncologists and other physicians who try to help patients make an end-of-life transition, according to a study about abandonment of patients at the end of life.¹

"The main finding of our study was that although physicians were conscious of not abandoning their patients at the end of their lives, the patients still could be abandoned because they were sent to hospice and there was no follow-up by the doctor," says **Anthony Back, MD**, a professor of medicine at the University of Washington, Fred Hutchinson Cancer Research Center and a gastrointestinal oncologist at Seattle Cancer Care Alliance.

"At the time of the patient's death, the patient might not hear from the physician, and that led family members to feel like they had been abandoned," Back says. "Physicians said it felt like a lack of closure for them, but they didn't recognize the effect it had on their patients."

For example, one family member interviewed by researchers was crying and saying, "Gee, I know he's

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busy and has lots of patients, but we had been through so much together that I was surprised we didn't hear from him at the time of death," Back recalls.

"The physician said, 'I was out of town when the patient died, and when I got back in town I wasn't sure if I should call because I might stir things up,'" he says. "It was a little poignant. The doctor wouldn't have stirred things up, but he could have helped the spouse heal a little by acknowledging her grief and everything they had been through together."

Clearly, when dying patients are transferred from the hospital to hospice care, the hospital and hospice nurses will do a good job of ensuring a smooth transition, Back notes.

"But it's not always clear to the patient how much the physician is involved," he adds.

What the study shows is that patients are very attuned to how doctors and nurses think of them as regular people, as human beings, as opposed to just diagnoses, Back explains.

"So, it's incredibly important to us that we make sure we're respectful with that part of our relationship, and we need to learn how to integrate the biomedical part of our work with the humanistic part of our work," he says.

From a hospital discharge planning perspective, it's important to automatically follow up on patients who are transitioned to hospice care, Back says.

Someone should assist them with making an appointment to see their community physician, which helps them return to a regular routine in their lives.

"It's very powerful for patients, and it's an easy thing to do," Back says.

"The other thing I would recommend is that when a provider finds out someone has died, then he or she should call the family member and ask how things went," he adds. "You can express whatever seems authentic to you, like, 'I appreciate how hard you worked on behalf of your husband, wife, son, daughter.'"

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