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New accountability measures could mean sea change for QI

Joint Commission spearheading effort to stress outcomes

With a coordinated double-whammy, The Joint Commission and a group of quality experts, including current president, **Mark R. Chassin**, MD, MPP, MPH, have served notice on the QI community that they'd like things to change — in a major way.

In a paper first published online in June by the *New England Journal of Medicine*, Chassin and his co-authors outlined four criteria for accountability measures that would have "the greatest likelihood of improving patient outcomes."[1]

The four criteria are as follows:

- "A measure must be based on a strong foundation of research showing that the process addressed by the measure, when performed correctly, leads to improved clinical outcomes";
- "The measurement strategy must accurately capture whether the evidence-based care has been delivered";
- "The measure should address a process quite proximate to the desired outcome, with relatively few intervening processes";
- "The measure should have minimal or no unintended adverse consequences."

At the same time the *NEJM* article was published, The Joint Commission released the June 23, 2010, edition of Joint Commission Online, in which it announced these four criteria. In fact, the paper's authors wrote: "For its part, The Joint Commission is incorporating

KEY POINTS

- Research, evidence-based practices are emphasized.
- Measures should address a process proximate to desired outcome.
- Changes should strengthen the hand of quality managers.

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this framework into its programs."

"We wanted to indicate that while the paper itself is not a Joint Commission policy paper we are calling on all stakeholders to adopt these concepts — and we wanted to say The Joint Commission is doing that," Chassin explains. "The way The Joint Commission is embedding these ideas into its programs is in that publication."

The reaction from quality experts has been mostly positive. "I most definitely agree with them," says **Kathy Schumacher**, MSA, CPHQ, director of quality, safety, standards, & outcomes and director of the Surgical Learning Center at William Beaumont Hospital in Royal Oak, MI. "One of the things I underlined in the paper is that the measures must be based on a strong foundation of research; I couldn't agree more." In fact, she adds, she plans to pass the paper along to others in her department.

"I think this is a wonderful step in the right direction," adds **David B. Nash**, MD, MBA, dean of the Jefferson School of Population Health in Philadelphia, who served on the inaugural ORYX steering committee. "I applaud The Joint Commission because, in part, hospitals had all started to appear as though they were living in 'Lake Woebegone,'" he says. "Everyone was way above average on all the core measures, so after awhile we all recognized the core measures needed greater granularity or a level of transparency. I think these four criteria will go a long way in that direction."

"My bias is to be suspicious of literature, such as this article originating from The Joint Commission, coming out of the compliance/regulatory world, but I think this is really a good move," says **Martin D. Merry**, MD, CM, a physician in Sanbornton, NH.

But **Patrice L. Spath**, of Brown-Spath & Associates in Forest Grove, OR, was not quite as quick to jump on the bandwagon. "In some ways, these are 'mother and apple pie' until you dig into them," she observes. "The problem is that in order to apply these criteria, you need some hindsight. In the rush to create accountability in health care, measures have been chosen that in hindsight did not necessarily have strong evidence that such care led to improved outcomes; but we only know that in hindsight. So consequently, when we apply these criteria now, how are you going to know the answers to some of these questions?"

Chassin responds: "We certainly have to be sensitive to the possibility that unanticipated adverse effects will creep in when measures are put into the real world, but there are some characteristics of these process measures and the way they are constructed that leads one to be suspicious of certain kinds of measures."

Chassin cites the measures governing the timing of the first dose of antibiotics for patients with pneumonia. "The real problem is that the way we construct these measures is based on identifying groups of patients using a principal diagnosis, which is not determined until weeks after they leave the hospital," he notes. "Much of the time the diagnosis is not clear at the time the patient is admitted to the hospital, so you do not know who will end up with that label three to six weeks later. The pressure to improve on measures may lead us to give antibiotics more quickly than good clinical

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EDITORIAL QUESTIONS

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judgment might deem appropriate. So, understanding how these measures work in the real world can lead to anticipating where 'unanticipated' adverse effects are likely."

Development of the measures

Where did these criteria come from? "This effort goes back on my part a long way — to when I was responsible in a big hospital for overseeing efforts to improve on core measures and found there were a number of them that really did not contribute much to improving outcomes," recalls Chassin. "And a lot of my colleagues in similar roles felt the same way. That experience on the front lines, together with my first year or so in my current role with The Joint Commission hearing from thousands of hospitals with very similar observations, led me to conclude that we needed to do a better job now.

"There are measures in the 'accountability spotlight,'" he continues, "that cause hospitals to do a tremendous amount of work and expend lots of resources and energy; we really need to meet a higher standard where we can be very confident that improvement on measures will mean improved outcomes. Then there was the matter of looking carefully at the experiences of measures and understanding what good measures have in common, and using that as criteria for getting rid of some measures and how to replace them with others that were superior."

Schumacher, for one, thinks they've done a good job. "One of the things we struggle with often is the linkage of process to clinical outcome measures; we can certainly measure process, but we can't marry the two together. It's frustrating when you try to get clinicians to change processes or put new things in place and they want to know how it will affect outcomes. I think they are measuring in the way the physicians want to do it. The third criteria — that the measure needs to address a process proximate to the desired outcome — is very, very important."

Merry agrees. "Some measures have been ineffective and frustrating; doctors have resisted them, and hospitals have said 'Trust us,'" he notes. "One of the things I like is that it validates the notion of external measures — how we compare providers on a number of measures. This paper is a real contribution; we're beginning to become more granular, and asking which measures we need to plug into accountability."

The criteria dealing with more downstream processes, he adds, "is a real advance; I've never seen that in print before."

Nash agrees with the need to replace some measures. "We all recognize, as an example, that the smoking cessation measure doesn't really tell us anything," he notes.

Is broad adoption ahead?

The publication of these criteria raises the question of whether there will be broad adoption across agencies such as the Centers for Medicare & Medicaid Services (CMS). "I think CMS will get on board," predicts Merry.

"I cannot predict how the politics are going to align, but I do believe eventually all the major groups will get behind a 'no outcome, no income' approach, and as a result these four criteria will actually help that journey," adds Nash. "To me that is the main message."

"I would hope the likelihood would be great," says Schumacher. "Hospitals need that alignment. Oftentimes we get mandates from The Joint Commission, CMS, and NQF (The National Quality Forum), and they hit us all around. Any opportunity for them to align would help immensely, and I do think that is coming."

"CMS and NQF are right at the top of the list," notes Chassin. "These criteria really should influence, if not dominate — and at least serve as a filter for getting rid of measures that do not meet the criteria."

Chassin notes that The Joint Commission has already "worked very hard and successfully to make sure our detailed specifications for those measures we have in common with CMS are identical." In addition, he says, "We publish together a manual of specifications; we review it constantly with CMS to make sure all the measures we have in common are the same. Eliminating non-accountability measures from public reporting will not help hospitals much if Medicare still requires them. We're trying to persuade CMS; and NQF needs to recognize that part of the process of bringing new measures forward is understanding and having a way to assimilate the tremendous experience we have with what happens in the real world. As of now, we do not have a way of systematically assessing that experience and drawing the appropriate lessons and taking them back to measure development and the endorsement process. We must have that if we're going to be more successful in the future."

Meanwhile, says Chassin, The Joint Commission is moving forward with its own plans. "We are starting a process by which we will

require a certain level of performance on accountability measures as part of accreditation," he shares. "Hospitals currently report those data to us, but we do not judge their accreditation worthiness based on performance of those measures; that's going to change."

"I think that's wonderful," says Schumacher. "When we have people here doing their Joint Commission visit, we can meet every standard they want us to meet, but this means looking at that data set they asked us to collect — 'What did you do and how did you do it, and how have outcomes changed? Have you seen a decrease in your mortality or morbidity? Show us that.'"

Good news for quality managers?

Schumacher believes the broad adoption of these criteria would be good news for quality managers. "I think personally it may help clarify things and give us a better sense of direction," she offers. "It's wonderful that we've had process measures for years, but to be able to look at the outcomes of these measures is extremely important. From a quality perspective I'm very excited. I want to marry process and outcome together."

"It's going to have a great impact," adds Nash. "Your readers will be the frontline troops for promoting accountability."

"No. 1, it will make their jobs much easier in terms of getting their local physicians, nurses, pharmacists, and other clinicians to engage in this work of improvement," says Chassin. "The evidence that improvement on accountability measures results in improved outcomes is incredibly solid and The Joint Commission will play a much more central role in seeing that that evidence is available to quality managers; so if skeptics doubt them, they will have that kind of information at their fingertips. It will also make it much easier to get resources from management if the measures really are connected to improved outcomes."

This approach, he continues, is "real quality management and health improvement, and should put hospitals in a much better position. Also, as we get broader measures (for example, The Joint Commission just launched a new measure set for perinatal care), it gives the quality manager a much broader range in what they can work on in terms of improved outcomes and very reliable sources of really good measures. There are a lot of bad measures out there, and what we'd like to say is, 'You do not have to look farther; here are the best measures for hospitals.'"

Merry, however, does not believe the criteria will get the entire job done. "I think it will improve the field, especially if we begin to base payments on percentage of compliance; we will see a lot of improvement in a lot of these quality measures," he predicts. "But will it improve to things to the degree the health care system needs to? Absolutely not."

The true drive to excellence, he asserts, will never come from regulatory agencies. "The compliance industry has never been the motivator of the truly great organizations," he says. "They don't look to The Joint Commission because they are so far ahead of it. They are into genuine excellence and the highest levels of performance."

The Institute for Healthcare Improvement, he notes, talks about the "theoretical ideal," which is 100%. "The [*NEJM*] article talks about 90%-95% being good compliance with quality measures," he notes. "You'll never get there by accountability if inspectors come and encourage you to improve 2%; true quality/excellence leaders are already beyond 95%.

"We should measure ourselves in both percentages and Sigma units," he continues. Six Sigma, he explains, means 3.4 defects per million. "If you have 90% compliance, out of one million patients, 100,000 are not getting the care they are supposed to get," he says. "Even 95% compliance equates to 50,000 defects per million opportunities."

REFERENCE

1.Chassin MR, Loeb JM, Schmaltz SP, and Wachter R. Accountability Measures – Using Measurement to Promote Quality Improvement. *NEJM* 10.1056/NEJMsb1002320, June 23, 2010, at http://healthpolicyandreform.nejm.org/?p=3580&query=home. ■

Electronic tablets help provide information

Sensitive questions not always answered face-to-face

Patients at Duke University Hospital's cancer clinics have begun using electronic tablets to complete questionnaires about their health situation, and staffers are extremely pleased with the results. For one thing, they note, patients are less reluctant to answer sensitive questions, the answers to which can provide physicians and nurses with important information about the care

KEY POINTS

- Opportunities for improvement discovered through questionnaires.
- Use of e-tablets boosts patient satisfaction, say leaders.
- Color-coding of symptoms quickly alerts staff to any problems.

they require. As a matter of fact, they note, the e-tablets have actually helped uncover new opportunities for improvement.

"For example, sexual distress had been sort of a hidden problem; we had no idea," recalls **Amy P. Abernethy**, MD, director of Duke's Cancer Care Research Program. "It was one of their main concerns, and they had no way to deal with it."

This led to new research, and a number of published papers, says Abernethy. Nurses were brought up to speed and patient education needs were addressed. However, the level of patient distress had still not changed.

"So we went to a psychologist and asked what kinds of interventions were needed," Abernethy continues. "They suggested some coping interventions, and we got funding for providing those interventions if a patient reached a certain level of stress; if the patient agreed, they got randomized to research a type of coping intervention."

Once she knows that an intervention is working, she says, "we will put it back in the system as a standard. Meanwhile, the knowledge also allowed us to engage a urologist and gynecologist — who had never before engaged in my cancer care. We were able to show an influence on quality of life."

"I'd say it's a really nice added bonus and tool for taking care of very sick patients," adds **Susan Blackwell**, MHS, PA-C, senior physician assistant, thoracic oncology and sarcoma, Duke University Medical Center. "These oncology patients have lots of issues going on; it makes our dictation more complete, and we can refer back to it. We do not have to write down all the patient says, but we can add to it — and when it's time to do dictation, I dictate from it and my notes may be more complete than by just talking to patients and trying to remember all the questions I asked them."

The greatest benefits, she continues, have probably been in the psychosocial area. "That's where we're likely seeing the biggest improvement for our patients; we find out how many people really are having a lot of distress and worry," she explains.

Of course, she continues, many cancer patients note they are in pain or experiencing nausea, but they also indicate depression and anxiety. "Now, this enables our therapists and counselors to become more and more involved," Blackwell notes. "Some of these issues we may have missed because a lot of these are things people do not like to admit."

"It enables us to approach patient triage more smartly," adds Abernethy."By dividing people up by level of distress, we have all these different types of social care services; we never before had a way of matching up the service to the person."

How the tablets work

When patients check in at the front desk, they are greeted either by team leaders or undergraduate students who are well trained in the tablet and how it works, Blackwell explains. "If they are new, they get an explanation of what it is and why we're using it," she says. "Patients who are more familiar are given a tablet and asked if they would mind filling out the questionnaire."

After the questionnaire is completed, it is transferred electronically and a printout is created. "It immediately tells us which cases are having high distress or symptoms, because they mark them on a scale; they are then color-coded as severe or moderate or low," Blackwell explains. "So if we see orange, for example, we know that's not good; it only takes a second to see if patients are having a lot of problems."

The primary nurse sees the printout first, she continues. "A lot of times they will initiate a call to our counselors or therapists if the patient reports a lot of anxiety or depression; that happens automatically, which we never did before," says Blackwell.

The color scale works like this: five or six is coded yellow, while eight or higher receives an orange. "There is also a very complete list of symptoms the patient can look at — pain, nausea, vomiting, constipation, rash, and so forth," notes Blackwell. "If we get a printout and everything is completely white, we know that the patient either didn't fill out the questionnaire or they are doing fine and not having any problems."

When the provider sits down with the patient face to face, she continues, they are shown the document and what they wrote, and then "a more directed conversation" can begin.

Another benefit of the printout, Blackwell adds,

is that "you can look at the printout from the previous visit so you see if the interventions have helped."

'Nominal' training required

Abernethy says that "nominal staff training" was needed for the tablets, which have been in use in some Duke clinics for about 18 months (they have been rolled out gradually). "We have one person, who is usually a student, who troubleshoots any computer problems," she says. "The biggest part of the training was teaching nurses how to interpret and respond to reports — and we're still figuring that out. There are many things people complain about that the nurses need to be addressing.

"We've actually adapted the tablets and are working with the government to create an open-source version that will have most of the same features," she adds. Abernethy says that Duke purchased about 100 units for about $200,000.

She adds that she is very pleased with the results so far."I see the need to upgrade from where we are to the next level, but that's OK — I always knew we would," she says. (For example, Blackwell says she used the e-tablets at a previous position that enabled patients to indicate the need for prescription refills.)

"There's one thing I'd like to stress," says Abernethy. "Make sure your system is secure and trustworthy." In addition, she notes, it's important to survey patients often on how to improve the system.

For other facilities considering using e-tablets, she adds this is a "critically important" point. "It's education," she says. "After the patient has finished doing the survey here, they are actually matched into an electronic patient environment that includes videos, PDFs, and so on, and I can choose what information and education they should get. If they have a specific problem, like insomnia, I trigger specific information." Educational materials, she adds, "are what patients want most." ■

Hospital uses service for follow-up calls

Patient satisfaction rises

Calling patients after hospital discharge is a good quality improvement and patient satisfaction strategy, but it is often difficult to implement because of resource restraints.

San Juan Regional Medical Center in Farmington, NM, found a solution that has worked well for its facility: using an outside contractor to make the calls.

"We had our own in-house call center, and the nurses who did the Ask A Nurse line made the follow-up calls," says **Catherine Zaharko**, vice president of marketing at San Juan Regional Medical Center. "But there were a number of reasons why that wasn't working," Zaharko says. The chief problem was the hospital couldn't keep the nursing coverage it needed for the call center because of a nursing shortage in the region.

"So, we contracted out for the Ask A Nurse line, and we asked them to do the discharge follow-up calls, too," Zaharko says.

This provided consistency for the services. The Ask A Nurse line could be operated on a round-the-clock basis, and the discharge follow-up calls were reliably made within 24 to 72 hours post-discharge.

The discharge calls help the hospital identify areas that need improvement and help provide care continuity and safety to patients once they've left the hospital.

Patient safety is the top priority, Zaharko notes.

"We want to know if the patient is OK, if patients are taking their medications, if patients have someone at home to help them if they need assistance." she says. "The most important thing is patient safety."

These post-discharge calls also can have the side benefits of reminding patients to see their community physicians and identifying obstacles to their continuing medical stability, she adds.

"We can identify other things that might make it difficult for the patient to follow their discharge instructions and maybe find ways to help the patient be more compliant and avoid a readmission or emergency room trip," Zaharko says.

Another benefit is the information can help the hospital identify trends.

"Is transportation a problem for people in our community after discharge? Is access to 24/7 pharmacy an issue?" she says. "We could find a way to address these issues."

First, the hospital had to change its questions to make them more specific.

"We had been asking a lot of questions we thought were pretty soft," Zaharko says. "So, we changed our survey to make it far more specific: 'Do you have transportation? Do you know how to use your medications?'"

For example, San Juan Regional Medical Center

KEY POINTS

- San Juan Regional Medical Center contracted nurses to make discharge follow-up calls 24/7.
- Hospital identifies trends through calls.
- Calls escalated to hospital nurse if there are medication or clinical problems.

has identified two trends from the discharge follow-up calls. The first involved whether or not patients could identify who their nurse was vs. other caregivers, Zaharko says.

"We found that patients did not distinguish between caregivers," she explains. "So, we put a new process in place, so that the patient does know who the nurse is."

A second trend involved hand-washing.

"We found that patients and their families were not aware when caregivers washed their hands upon entering or leaving their room, so we began hand-washing instructions by caregivers to patients to raise awareness," Zaharko says.

From the hospital's perspective, the post-discharge calls work, because these are seen by patients as a seamless part of the hospital's health care service.

"We will make a call to a patient who has been discharged from the hospital or emergency room within 24 to 72 hours after their stay," says **Mark Williard**, senior vice president, product management, at Beryl Company of Bedford, TX, which provided the post-discharge calls for San Juan Regional Medical Center.

"We look to see if they were satisfied with the services they received, how they were treated by nursing staff, and what they thought of their room and food services," he says. "We also give them an opportunity to highlight any good services they have received, such as a particular nurse who treated them well."

Hospitals use the kudos to recognize staff members found to be doing an especially good job.

These first calls are made by non-clinicians, but they can result in a referral to a nurse if a problem is discovered, Williard says.

Called "escalations," these complaints might result in the call center staff notifying a nurse or the hospital for follow-up calls or treatment, he adds.

If something arises, typically it will occur in the first 24 to 72 hours, so if a patient has a fever that won't go away or a new pain or some new condition that wasn't apparent at discharge, then nurses escalate those back to the hospital for treatment, he says.

"We find that fewer than 2% of all calls wind up with an escalation, so it's not a huge issue for the hospital," Williard says.

Often, a patient might need more information or have a minor complaint, and all of these are transcribed and recorded for the hospital to review if necessary.

"These would be issues that do not need to be handled right away," Williard says. "Emergency service issues are rare, but on every call we have information that will help with future changes in care."

The call service also provides a second type of call — called a clinical call — that is made by a nurse, also within 24 to 72 hours post-discharge, he adds.

"These are placed to higher acuity level patients and to those with higher risk of readmission," Williard says. "With those calls, our focus is on trying to identify whether patients have a situation that could lead to a readmission."

Hospitalists at San Juan Regional Medical Center identify patients at risk for readmission, and then all of these patients are called post-discharge by a non-clinician, Zaharko says.

The patients are asked these questions:

- How do you feel today?
- Have you gotten your prescription filled?
- Are you taking your medication as prescribed?
- Do you understand your discharge instructions?
- Did you make an appointment with your primary care physician?

At San Juan Regional, the patient calls are escalated to a hospital nurse if there are any medication or other clinical questions, Zaharko notes.

"We want those kinds of calls escalated to our clinician, so we can identify if we're being clear enough with our discharge follow-up instructions," she adds. "We want to make sure our nurses are providing enough information for the patient."

Other health care facilities may choose to have a contractor's call center nurse handle those calls.

"Our nurse is logged into the medical record of the client, and so if the patient has any questions about the discharge, then the nurse can clarify those for the patient," Williard says. "We accept this call for those facilities that have electronic records, but we have faxed solutions for those without an electronic record."

As increasing numbers of hospitals move to electronic medical records (EMR), the discharge follow-up process will be more seamless, Williard predicts.

"Our vision is that anything that happens on this call will go on an EMR, so there will be a history of all points of care, including what happens on the discharge call," he says.

The post-discharge services result in higher patient satisfaction, according to data Beryl collected as part of pilot studies. In one case, the survey showed that patients who were called after discharge reported satisfaction with their hospital stay 76.4% of the time vs. 72.5% for patients who had not received the call.

On some measures, the difference was more striking. For instance, when asked if nurses listened carefully to them, patients who received the post-discharge call expressed satisfaction 81% of the time, vs. 69.1% for those who did not receive the call. Also, when asked whether the staff did everything to help with the patient's pain, patients who received the post-discharge call were satisfied 83% of the time vs. 75.2% for those who did not receive a call.

Post-discharge calls to patients are the right strategy and should be routine, Williard says.

"One of our clients said, 'You know, I get a call from the vet after my pet has been seen, and it's the right thing to do after our patient has been seen,'" he says. "Discharge calls can provide a warm touch and collect any information that might improve care."

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Provide better ED discharge planning

Use resources to assess home environment

The health care system benefits when unnecessary hospital admissions are avoided, and sometimes the best place to impact that trend is by focusing discharge services on the hospital emergency department (ED), an expert says.

"If you can avoid an admission in the hospital, it's good for the patient, as well as for the health care system," says **W. June Simmons**, CEO of Partners in Care Foundation in San Fernando, CA. The nonprofit organization focuses on innovations in delivery-system design through early intervention and prevention.

One way it's good for the hospital is that many patients who use the emergency room for care are the same patients who lack adequate health care resources, as well as community support. So, they might become a compassionate care admission to the hospital, simply because hospital providers do not know where else to send them, Simmons notes.

"Hospital [providers] don't know what to do with these patients and will admit them to the hospital, even though they probably don't need an acute care level of care," Simmons says. "Admitting these patients to an acute care hospital is an expensive and sometimes a risky move for patients, because it's better for people to avoid hospitalization whenever they can."

What are needed are new models for ED discharge and hospital discharge planners who help providers improve these transitions.

"If a social worker could mobilize immediate private duty care in the home, then an ED patient could be discharged home," Simmons says. "Or the hospital social worker could help a patient transfer to a psychiatric unit or some other alternative site."

These types of ED discharge planning need to be explored, she adds.

Hospitals need to look more closely at an integration of community resources and mental health resources when working with care transition of ED patients, Simmons says.

"Some people say 80% of care for chronic conditions occurs in the home, so you have to mobilize the community," she explains. "Transitions are all about making sure someone who has a health challenge or frailty challenge remains at home safely and makes maximum use of the medical care offered to them."

This includes extending hospital/ED discharge planning to environmental assessments. For instance, someone should make certain patients have the necessary wheelchair ramps, elevated toilet seats, and other home adjustments needed to accommodate someone with limited mobility and chronic health issues.

Patients who are admitted to the hospital after an ED visit, or who are frequent fliers in the ED, often have home environment issues such as an untidy home, improper nutrition, floor tripping

KEY POINTS

- Hospitals need to look more closely at an integration of community resources and mental health resources.
- Extend hospital/ED discharge planning to environmental assessments.
- One of the most common medication problems in therapeutic duplication.

hazards, low lighting, substance use, or medication complications, Simmons says.

A hospital discharge planner should know of community resources that might assist with making a home environmental assessment or visit.

Other questions discharge planners should ask about patients are as follows:

- Does the patient have access to food and a safe environment in the home/community?
- Does the patient have transportation to community providers?
- Does the patient have access to medication and any necessary assistance with taking drugs?

This last issue is very important, because older ED patients discharged home often have multiple chronic conditions and a variety of medications to take. Plus, they might have several different doctors who each see only one part of patients' health picture and do not communicate with each other, Simmons says.

Another issue is whether the ED patient has Medicaid or some other payment system that will cover in-home care management.

"The Medicaid waiver is Medicaid with permission to provide ongoing care management in the home," Simmons explains. "You can buy things Medicaid usually doesn't cover like heavy-duty cleaning, putting in ramps and grab bars, and bringing in someone to give the patient a bath."

If patients can't find reimbursement for these services that might make it possible for them to stay at home, then they likely will be ED frequent fliers and end up hospitalized or transitioned to a nursing home for the long term, she adds.

"We've been looking at the Medicaid waiver program in California, and we've found that almost 50% have flagged up on electronic screening for medication alerts," she says. "These patients have signs and symptoms that might reflect a medication problem, including dizziness, confusion, and a history of recent falls."

Half of these patients had a combination of conditions and medications that would suggest the need for a pharmacist to review their medication history, and more than one-third of the patients had medical problems that needed to be brought to the attention of their doctor, Simmons says.

One of the most common problems is therapeutic duplication, in which patients are on three different medication prescriptions, and all of the drugs are in the same class, Simmons says.

"In the Medicaid waiver program, the care manager goes into the patient's home and does a complete assessment, looking at all medications," she adds.

"We developed an electronic system for screening for patients who have concerns, and then a pharmacist reviews these to see if there is a problem," Simmons explains. "So, medication reconciliation is a huge issue in discharge planning."

Discharge planning that spans the hospital continuum, including the ED, likely will be a more common practice as the Patient Protection and Affordable Care Act of 2010 results in philosophical and, eventually, payment shifts in the national health care industry, she predicts.

The Centers for Medicare & Medicaid Services (CMS) has already begun aligning incentives by announcing that it won't pay hospitals for readmissions within 30 days of certain medical conditions, Simmons notes.

Plus, health care reform bill's emphasis on prevention and evidence-based programs will drive a lot of the change.

"There is a whole lot of effort and resources being put into finding better ways of delivering care, and all of these efforts are promising to help us look for something that is more tailored to address where people fall out of the system and close these gaps," Simmons says.

If patients have medical crises, often the root cause of their emergency is related to inadequate discharge planning, she adds.

The goal is to provide rapid follow-up care when patients are transitioned from the ED or hospital to home — and then to assess their situation and follow them closely, Simmons says.

"We need to put the resources in place to keep them stable at home and provide good continuity with their medical care," she adds.

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Collaboration on capacity management

Helps with discharge delays, waits for beds

When a hospital in downtown Knoxville, TN, closed and volume soared at other nearby hospitals, two hospitals in the Covenant Health System joined forces to develop a systematic approach to capacity management that allows each hospital to create variances in the process to meet its individual needs.

The process reduced discharge delays, increased discharges early in the day, and reduced waiting time in the two hospitals.

"Patient flow is a huge process that needs to be managed every day in real time. We developed a process for ensuring good patient flow, but it's also about relationships and communication. The success of the process depends on a 'trifecta for patient flow'— the physicians, the nursing leadership, and the case managers," says **Sheila Gordon**, RN, MS, director clinical effectiveness/ nursing administration at Fort Sanders Regional Hospital.

The volume at Fort Sanders Regional spiked to 1998 levels last year after the downtown hospital closed.

"All of a sudden, we were having 90% census days. ParkWest Hospital took some of the volume we couldn't handle, but we knew that we had to improve on our capacity management process," Gordon says.

The hospitals replicated a best practice in patient flow from the Institute for Healthcare Improvement, according to **Lori Myers**, RN, MSN, capacity management manager at ParkWest Hospital.

"To achieve good patient flow, hospitals need an open conduit that goes from the administration down to the person who sees the patient first, and spreads out across the hospital from the charge nurse, to the primary nurse, to the case manager, to the ancillary units, and everyone else who touches the patient," Myers says.

Representatives from both hospitals formed a multidisciplinary team and developed a systematic approach to capacity management that allows for each hospital to create variances to meet its individual needs.

For instance, the process they developed calls for daily huddles between the nursing manager and the case managers on each unit and a daily hospital-wide capacity management meeting, but each hospital handles the practice a little differently.

KEY POINTS

- Representatives from two hospitals developed a systematic approach to capacity management that allows for each hospital to create variances to meet its needs.
- Huddles vary by hospitals.
- The hospitals track time frames at different points of care.

At Fort Sanders Regional the first meeting of the day is the huddle during which the nurses and case managers identify what should happen with the patients during the day. That meeting is followed by the hospitalwide capacity meeting to discuss patient flow, any potential new patients, and which patients are expected to leave.

ParkWest holds the hospitalwide meeting first, followed by the huddle.

At Regional, if the hospital is approaching capacity, the team meets again, in the emergency department at 3 p.m.

"We look at how many patients have moved in the past six hours. At 3 p.m., most of the patients waiting for a bed are in the emergency department. We collaborate with the staff there to help us think through what we need to do to get those patients in a bed," Gordon says.

Fort Sanders Regional has designated specific overflow areas when patients need a bed, such as the catheterization lab recovery area. The hospital can shift critical care staff to the step-down unit if critical care beds are needed.

"When we are approaching capacity, there is a lot of creative thinking and critical thinking and a lot of dialogue between the physicians and the rest of the staff," Gordon says.

For instance, if the emergency department is full and holding acute care patients and the hospital is being called to accept transfers from outlying hospitals, the team looks for ways to accommodate the new patients.

"We look at how many patients we have on a unit that have not been discharged, and the staff concentrate on getting them moved so the hospital can put patients holding in the emergency department in a bed on the unit and receive patients from the outlying hospitals," she says.

The staff at ParkWest have three daily bed

capacity huddles regardless of census, Myers says.

The shift leaders and case managers from throughout the hospital meet at 8:30 p.m. and 4 p.m., and the shift leaders meet again at 4 a.m. when the day crew starts work.

Then each unit holds a daily huddle at 9 a.m.

If it appears that the census is going to be high, a 7 a.m. bed alert goes out all over the hospital.

"The administration, nursing managers, hospitalists, emergency department staff, charge nurses, and case managers all receive the bed alert and they know that they need to start looking at their part of capacity management first thing," Myers says.

For instance, when the bed shortage is significant, the 7 a.m. alert cancels all meetings for administration and management to free up their time to concentrate on the flow. It alerts surgeons to go to the floor and discharge patients before they start their surgery.

When Regional has a high census, the team is alerted at the original bed huddle and meets again at 12:30 p.m., 3 p.m., and 8:30 p.m., depending on the capacity issues.

"We call down to the areas that are having a high census and try to involve them in improving patient flow. At Regional, we tend to have bottlenecks in critical care and cardiology, and less frequently, the pulmonary floor and oncology," she says.

"We identify areas where there are flow issues and call the nurse manager, shift leader, and case manager to the extra bed-control meeting," she says.

Keys to the success of the process are a discharge flow board that tracks all of the regulatory requirements for patients, as well as procedures that have to occur before the patient can leave, and a computerized case management system that allows management to track glitches in the patient flow, Myers says.

For instance, Myers can determine if a patient was late leaving because the physician was rounding late in the day or if the insurance company took a long time to precertify post-acute services.

Case management drives the flow board process that informs the entire multidisciplinary team about what is going on with patients, Gordon says.

When a case manager believes a patient is likely to be discharged the next day, she lists him or her as an "intent to discharge" and enters it on the flow board.

Each morning the case manager and nurse manager on the unit use the flow board to determine which patients are labeled "intent to discharge," who can be discharged that day, who cannot be discharged, and the plan of the day for each patient.

"The intent-to-discharge list is what case managers look at first thing in the morning and work on throughout the day. They work to make sure that these patients get everything they need for discharge," Gordon says.

The team discusses any obstacles to discharge and assigns someone to take responsibility for overcoming them. For instance, if a patient's discharge depends on the results of an X-ray, the charge nurse alerts the primary nurse to let radiology know that the test is a high priority. The case manager makes sure that home health is ordered for patients who will need it.

The nursing and case management staff start holding conversations with post-acute facilities earlier in the day. If discharges depend on home health, they call the agency to let them know the hospital is on bed alert and they need to process the referral quickly.

Gordon and Myers track the reliability of the process to determine how many patients designated as "intent to discharge" are actually discharged and what kept them in the hospital if they are not discharged.

The hospitals track time frames at essential points, such as how long it takes from the time the patient arrives until the patient is in a bed, and use the information to develop targets for getting patients admitted and for housekeeping turnaround times.

"If we are efficient in our admission process and get patients admitted and the beds turned around in a timely manner, we can focus on discharge issues, such as physician orders and referrals for post-acute services," Gordon says.

The hospitals have collaborated on process changes that one or the other hospital piloted before the other rolled it out.

For instance, ParkWest added environmental services milestones to its flow board. These include add-

COMING IN FUTURE MONTHS

- VA rapid response team reduces cardiac arrests
- Campaign seeks to increase health care worker flu vaccinations
- What changes should be made to accommodate obese patients?

ing when housekeeping arrives and when the bed is ready for the next patient to its flow board. Following the success of the project, Fort Sanders Regional is adding environmental services to its flow board.

The increased communication and awareness of patient flow needs has cut 20 minutes off the time between when a bed is empty and the room is clean, Myers says.

"We took two solid processes and combined them. Environmental services had their benchmarks and processes, and we had ours. By having conversations between the two areas and combining the benchmarks, we were able to improve efficiency," Myers says.

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AHRQ issues quality, disparities reports

The Agency for Healthcare Research and Quality (AHRQ) on April 13 released the 2009 National Healthcare Quality Report and the National Healthcare Disparities Report, which are used by a variety of health care stakeholders to evaluate quality and access to care.

Lt. Karen Ho, lead staff at AHRQ, says the findings were fairly consistent with previous years; however, since the reports have only been published since 2003, it is difficult to detect trends in the data. The reports are mandated by Congress.

"Despite promising improvements in a few area of health care, we are not achieving the more substantial strikes that are needed to address persistent gaps in quality and access," said AHRQ Director Carolyn M. Clancy, MD, in an AHRQ news release. "Targeted AHRQ-funded research in Michigan has shown that infection rates of HAIs can be radically reduced. We are now working to make sure that happens in all hospitals."

For example, rates of postoperative sepsis increased by 8%. And according to the press release, although rates are improving incrementally, blacks, Hispanics, Asians, and American Indians are less likely than whites to receive preventive antibiotics before surgery in a timely manner. ■