Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

November 2010: Vol. 17, No. 11
Pages 121-132

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Hospital has unique marriage of research center and QI team

Regular meetings spur new initiatives

What hospital quality manager wouldn't want to have a renowned research center that investigates the leading issues in quality and safety based right within his or her own facility? Certainly not **Jan Fitzgerald**, MS, RN, CPHQ, director of quality and medical management at Baystate Medical Center in Springfield, MA, which also is home of the Center for Quality of Care Research (CQCR).

"They really help give Baystate Health a place at the research table nationally, and they are into a great number of things that help our work here, which includes providing care to patients," she says. "We meet weekly, which allows for a lot of discussion and state-of-the-art presentation and review of not only what we've looked at here, but at other things going on in the research world that may relate to what we're doing. That keeps us ahead of the wave on research."

Part of her work, she adds, involves translating research into practice, "and making us aware of what's coming down the road in changes in clinical care or core measures enables us to do baseline or scout data where we know our strengths and weaknesses."

The rationale for the CQCR, which was established about two years ago, grew out of Baystate's mission, explains director **Peter**

KEY POINTS

- Two-way communications enhance the work of both teams.
- Translating research findings to the bedside: a key quality goal.
- Research center discoveries already have spurred initiatives.

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Lindenauer, MD, MSc. "As part of our mission around the advancement of knowledge, we felt there was an opportunity to build upon existing successes a group of investigators was having and formalize that into a full-fledged research center," he says.

"An even more central mission of Baystate Health is to be a national leader of quality of care and to be recognized for it," he adds. "One of the ways you can do that is by delivering great care, and we strive to do that, and we have a large QI program devoted to it. We can also contribute to that recognition by being a thought leader in the measurement of quality and safety." Along those lines, the center has published a number of studies in leading journals, including the *Journal of the American Medical Association* (*JAMA*).

Baystate, Lindenauer explains, is the western campus of Tufts School of Medicine. "Members of our center are faculty members who have an interest in pursuing research around quality improvement, quality of care, and patient safety," he notes.

Very strong linkages

"One of the exciting aspects of our center is that we are part of the division of health care quality at Baystate, so we have very strong linkages to the QI staff and physicians," notes Lindenauer. "Many of the faculty members within our center, in fact, have operational roles in QI at our hospital. For example, one of our investigators is the hospital epidemiologist in charge of infection control prevention. With her, we are studying *C. difficile*. I am medical director of clinical decision support and am intimately involved in leveraging our information systems to improve safety and quality of care — primarily around medication safety."

These linkages are not accidental, Fitzgerald notes. "Several years ago, Peter worked as one of the medical directors in the division of health care quality," she says.

All of this creates "a very fertile environment for identifying topics of study and for identifying important issues and then for feeding back the results of those investigations to our own institutions," Lindenauer says. "Members of our center attend regular divisional meetings where we hear about what the PI staff are working on this quarter, or what the latest Hospitalcompare data are, and, similarly, they hear about what we're working on. Our weekly research meetings for the center are attended by a significant number of members of our division of health care quality — everyone from the nursing director of performance measurement and improvement to the medical director of quality. Often, we will invite staff within the division to present some of the projects they are working on, with the hope we will turn some of that into scholarly work that can be disseminated."

"We have lots of different ways things get reported," Fitzgerald adds. "We have trigger tools to look through randomly selected cases; hospital-acquired conditions lists; and serious reportable events and our internal safety reporting system. We can analyze the data and come up with areas where we look for opportunities to improve. We send these along to generate baseline ideas

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices. USPS# 0012-967.

POSTMASTER: Send address changes to Healthcare Benchmarks and Quality Improvement, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $549. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $92 each. (GST registration number R128870672.)

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EDITORIAL QUESTIONS

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or opportunities for some actual formal clinical research."

The Wednesday meetings, she continues, "are almost like sounding boards. It's been a great opportunity for us as well as for them. Things that have historically been conundrums can be reviewed and sometimes put through the research process. It's a great marriage for us."

Already bearing fruit

This unique "marriage," as Fitzgerald puts it, already is bearing fruit. "There's a study we did looking at about 500 hospitals at the rates of use of potentially inappropriate medications among the elderly that are associated with a high number of side effects," Lindenauer shares. "We did this study and published it in the *Journal of Hospital Medicine*, and it showed relatively high rates of use of these medications, and as a consequence of that and follow-up data, we've been doing a project in our hospital in which we use CPOE to alert physicians to the potential dangers of those drugs. So here's a case where we identified a problem nationally and put it to work at Baystate. Hopefully, we'll learn from our intervention whether it works — to see if alerts in CPOE led to improvement."

Fitzgerald further explains the intervention. "We've actually linked the information back through our computers, so if I am older than 65 and have this co-morbidity and the doctor orders one of these drugs, it will give me an alert that by ordering this drug the patient is at increased risk for X, Y, or Z," she says. "So, we are actually taking Peter's work and driving it to the bedside."

"We've also done a lot of studies on COPD, and have published in *JAMA* and in the *Annals of Internal Medicine*," Lindenauer reports. "As a consequence of some of our learnings, Baystate is embarking on a care redesign initiative around that. I'm helping to co-lead those efforts, and we're looking at protocols we can use with the ultimate goal of better outcomes such as lower rates of readmission."

Some protocol changes already have been instituted, Fitzgerald says. "They had published a paper that said IV steroids are not any more beneficial than 'PO' steroids," she says. "Within the past 12 months, we have taken that evidence and translated it into a care change. We took out the IV option for steroids; the only option is PO."

With that change, she adds, the physicians were given "reference texts." "We used our MD bulletin and other vehicles to let the doctors know we made the change, but the reference text gives them the rationale," she explains.

In terms of the care redesign initiative, she continues, "we're having ongoing discussions about where we are and where we need to go. We're fortunate to have CPOE so we can translate information into order sets that drive care and leverage the capacity of the computer to do alerts, tasks, and prompts."

Fitzgerald is very positive about how this "marriage" is working out. "Just the fact that you think about and talk about these things puts the care you deliver in a different echelon; it keeps you right out there in front," she says. ■

Facility dramatically reduces pressure ulcers

Product changes, new processes achieves results

In 2008, the incidence of pressure ulcers in the ICU at Swedish Covenant Hospital in Chicago ranged from 11% to 13.6%. Today, a multidisciplinary task force has dispelled the myth that little can be done to prevent pressure ulcers in the ICU. "We were able to drop our rates to 1.8% in the ICU cumulatively over a six-month period, and the last four months we have seen 0% in the ICU while treating about 275 patients," reports **Nancy Chaiken**, ANP-C, CWOCN, RN, wound ostomy continence specialist and head of the hospital's skin breakdown prevention committee.

The committee, which has been meeting for a little more than two years, includes nurses and nurses' aides from every unit in the hospital, says Chaiken.

"Before I started here in 2004, we used an outside bed rental company to check incidence and prevalence of pressure ulcers once a year," says Chaiken. "When the committee formed, the administration decided to increase its importance and we started looking at pressure ulcer rates unit

KEY POINTS

- Every patient is checked for pressure ulcer development.
- Formal and informal education seen as critical.
- Despite success, wound committee continues to monitor progress.

by unit on a monthly basis." Floor rates, she notes, were only at 1%-2%, so it was clear the greatest challenge was in the ICU.

Several changes made

As a result of the committee's recommendations, a number of changes were made. For example, in 2008 the hospital purchased all new pressure reduction mattresses for the med/surg units, including the ICU. "They are low air-loss mattresses," notes Chaiken, who says that in the general medical units, the pressure reduction mattresses are not as high quality. The beds, she adds, come with pumps that assist with pressure redistribution.

Skin barrier products also were changed; creams were purchased that can be applied to the skin so moisture from sweat and incontinence does not damage the skin. "We also use incontinence collection devices that help bring fluids away from the skin — pads that go under the mattress to allow fluids to wick away from the body," Chaiken adds.

In terms of care processes, the nurses started monitoring the amount of times patients are turned. "You're supposed to do it every two hours," Chaiken says. "Compliance in the ICU is about 100%, and the rest of the hospital is about 95%."

In the ICU, pressure ulcer risk assessments using the Braden skin scale are done every day. If the score is low, Chaiken says, all prevention practices are initiated. "In the ICU, almost everyone is at risk for pressure ulcers," she explains.

Identification of pressure ulcers is emphasized, especially on admission. "We had cameras put in all units," Chaiken says. "If anyone came in and the nurse was not sure if they had a pressure ulcer, they were encouraged to take a picture, put the picture in the chart, and chart what they saw."

Education important

"We did a lot of formal and informal education," Chaiken says. The formal education included prevention, correct staging, and the definition of a pressure ulcer. "Because not all breaks in the skin are due to pressure ulcers, this is a really important piece to educate on," says Chaiken, who notes that the committee created several PowerPoint presentations and also brought in outside speakers.

As for informal education, she continues, "I was up there all the time with the nurses, turning patients and looking at skin. I can be a really good nagger."

There are unique challenges to getting staff onboard in the ICU, notes Chaiken. "You have critically ill patients who are sometimes at death's door," she points out. "So, for example, the patients' blood pressure is often dropping, and they are put on medications to raise it." But what that does is shunt blood away from the buttocks and heels and starts to cause more pressure ulcers, she notes.

"When staff are battling with these low pressures, they kind of think, 'Can we really prevent a pressure ulcer?'" she says.

Chaiken says she "had to get staff to buy into the concept that we can prevent them — that we probably couldn't get them down to 0%, but we could get them down dramatically."

The key to getting that buy-in, she says, was a formal institutional review board study that was conducted with the approval of the hospital. "We started using a silicone dressing on the sacral area of everyone who was admitted to the ICU without a wound," Chaiken shares. "Patients who were undergoing long surgical procedures also had the cream placed on them in the operating room."

In the past, she notes, the cream had been used only when skin broke down. "This was given right off the bat," she notes. "This really dispels the myth that pressure ulcers are inevitable."

Despite the impressive results, the committee remains active. "We still look at every patient in the hospital for pressure ulcer development," says Chaiken.

"We are part of the National Data Nursing Quality Index, and we submit data on a quarterly basis." While they formally benchmark quarterly, "internally, we watch data on a monthly basis and address any potential problems a unit is having," says Chaiken. "The committee members are out there making sure everything is right — this has really empowered the nurses." ■

Disclose mistakes that affect multiple patients

Harm/benefits analysis leads researchers to conclusion

A group of researchers from the University of Washington, Seattle, led by **Denise M. Dudzinski**, PhD, MTS, associate professor and director of graduate studies, has concluded that

KEY POINTS

- Staff must have a sense of duty to patients.
- Policies and procedures should be developed to address issue.
- Prion diseases present the greatest ethical challenge.

it is preferable to disclose medical mistakes affecting multiple patients — even if those patients were not harmed. Their findings were published in the Sept. 2, 2010, issue of the *New England Journal of Medicine*.[1]

"We were wondering about this dilemma concerning disclosure and recognized there was not much out there [in the literature] on this, and we wanted to really analyze the ethics of disclosure and give examples of different types of large-scale events," Dudzinski explains.

Why did the researchers conclude that in most cases these events should be disclosed? "We focused on ethical analysis," Dudzinski explains. "In other words, when you do a harms/benefit analysis and consider it carefully, would this [disclosure] actually be more harmful?" Hospital administrators, she notes, may be concerned that by disclosing mistakes, knowing that a small percentage of patients were actually physically harmed, the only potential harm is to worry people.

However, says Dudzinski, the analysis showed that the magnitude of harm for the few who were physically harmed is likely greater than the harm diffused over all the people who are informed and temporarily worry.

"In addition, we also said it's important to look at what duties we have," Dudzinski continues. "There is more of a trend to disclose to individuals than to a group. But why doesn't that same duty apply to a group? Based on those issues, disclosure should be the rule."

Although Dudzinski's group endorsed disclosure in all cases, the most challenging types of disclosure they examined were prion diseases such as Creutzfeldt–Jakob disease where there was potential exposure from surgical instruments in neurosurgery. "You have a low possibility of it being passed on, but sterilization procedures for non-prion disease do not work on prions," she explains. "The World Health Organization says we need to use more robust sterilization if we suspect potential exposure." What troubles people about these cases the most, she adds, is that there's no way to actually diagnose the disease before death, and in cases where it was not suspected, patients who died were found to have been treated with the same surgical instruments as several others.

"It's still your duty," Dudzinski insists. "The patient may want to know, and if they are going to have other neurological procedures, this may amplify the risk; and if a test or treatment becomes available later, the patient can get it."

Policies and procedures recommended

Large-scale adverse events, noted the researchers, "occur frequently enough to warrant thoughtful policies and procedures." Here are several they recommend:

• An institutional policy

"Organizations should have a clear set of procedures for managing the disclosure process, notifying patients and the public, coordinating follow-up diagnostic testing and treatment, and responding to regulatory bodies." Such a policy, says Dudzinkski, "should be sanctioned and endorsed by leadership." Quality leaders, she adds, "might be in a perfect position to write the policy, along with clinicians." In any event, says Dudzinski, she recommends a multidisciplinary approach.

• Plans for disclosure

"Institutions should proactively (rather than reactively) disclose all large-scale adverse events to affected patients unless a strong, ethically justifiable case can be made not to disclose," the researchers wrote. What methods of disclosure should be used? "If you have to notify 1,000 people and you want everyone to know around the same time, in that case, probably a letter makes sense — as long as you have a telephone call-in center," says Dudzinski. "With a smaller number, you might consider making phone calls."

• Communication with the public

"Institutions should assume that media coverage of large-scale adverse events is inevitable. Responses to the media should demonstrate the institution's commitment to honesty and transparency to build public trust," according to the article. Potentially, says Dudzinski, this could involve a news release. "Those patients at increased risk of being exposed should be told first, and then the information you provided them can go out to the media," she advises. "Since it takes a while to find out what happened, you might initially tell the public what you know now, and what you're going to do to get more information." In addition,

she says, let the patients know they will keep hearing from you as you get more information that is relevant to their health.

• Plans for patient follow-up

The article advises: "Institutions should provide follow-up diagnostic testing and treatment to patients affected by the large-scale adverse event and address anxiety produced by the disclosure." Organizations should provide follow-up diagnostic testing and treatment to patients who were affected by the event, says Dudzinski, and then address any anxiety they may have. "You need people who are well-trained to answers questions about what occurred and to address anxiety," says Dudzinski. "For patients worried about infectious disease, it may be sufficient to inform them that you will get them tested to address their concerns. For some who may be extremely worried, you may need people who are better trained."

REFERENCE

1. Dudzinski DM, Hebert PC, Foglia MB, and Gallagher TH. The Disclosure Dilemma — Large-Scale Adverse Events *N Engl J Med* 2010; 363:978-986. ■

ED quality performance moves into public arena

'Top performers' are named — What does that mean?

HealthGrades, a Golden, CO-based health care ratings organization that provides the public with ratings on more than 750,000 physicians and 5,000 hospitals, has just released a study it claims "evaluates hospital emergency medicine for the first time."

The report, which HealthGrades says is the first annual "HealthGrades Emergency Medicine in American Hospitals" study, examined more than 5 million Medicare records of patients admitted through the ED at 4,907 hospitals from 2006 to 2008. It identified hospitals that performed in the top 5% in the nation in emergency medicine.

HealthGrades then compared those top performers with the other facilities and found a 39% lower risk-adjusted mortality rate and a faster rate of quality improvement. HealthGrades postulated that if all hospitals performed at that higher level, 118,014 more patients potentially could have survived their emergency hospitalization.

KEY POINTS

- Be sure to share the good news with your administration, so they can use it to help market the hospital.
- When adverse rankings appear, you have two options: Seek additional resources to improve performance, or challenge the data.
- Use an automated system to access "real-time" data on your department's performance, so you will always be ready to defend your ED.

The study examined these 11 conditions:

- bowel obstruction;
- chronic obstructive pulmonary disease;
- diabetic acidosis and coma;
- gastrointestinal bleed;
- heart attack;
- pancreatitis;
- pneumonia;
- pulmonary embolism;
- respiratory failure;
- sepsis;
- stroke.

HealthGrades also ranked the states according to overall performance. Ohio, Arizona, and Michigan had the best rankings, while Mississippi, Alabama, and Hawaii ranked lowest.

What does it mean?

Emergency medicine proponents, even some whose facilities received high rankings, were critical of HealthGrades' methodology.

"HealthGrades basically looked at mortality on the inpatient side," says **Rick Bukata**, MD, clinical professor of emergency medicine at the Los Angeles County University of Southern California Medical Center. Bukata recently retired after serving as ED director at San Gabriel (CA) Medical Center for 25 years.

Although he says his facility ranked among the top 10% in the country, Bukata notes that "any ED doc who's honest with themselves knows that if we had a patient for two hours before admitting them, in most cases nothing could have been done to change the ultimate outcome." To take credit or blame for whether an admitted patient lives or dies after a six-day hospital stay "is absolutely nutty," he says.

Jon Mark Hirshon, MD, MPH, associate pro-

fessor in the department of emergency medicine, department of epidemiology and preventive medicine, the National Study Center for Trauma and EMS, Baltimore, agrees. "They call this an 'emergency medicine excellence award,' but it's not necessarily related to emergency medicine," Hirshon says. "The issue I have is the fact that they looked at in-hospital mortality and said that was a marker for how good an ED is."

The fact remains, however, that this study is just the latest in a growing number of public reports that include a focus on the ED. For example:

- The National Quality Forum (*www.qualityforum.org*) reports on quality improvement and covers care in the ED.
- Medicare's Hospital Compare service (*www.healthcare.gov/compare*) offers a condition-by-condition rating of how hospitals care for their patients, and it recently began adding data on ED care.
- The Physician's Quality and Reporting Initiative (PQRI, *www.cms.gov/pqri*) offers doctors an opportunity to earn payment incentives by reporting on and meeting specific quality measures, including some that apply to the ED.

Bukata argues that in many cases, the methodology used can be questioned, but ultimately that might not matter. Administrators are paying more and more attention to these reports, he says. "My most candid view is that the methodologies are generally poor," Bukata says, but adds that "CEOs love this stuff when your marks are good and use it to promote the hospital and give themselves 'attaboys.'"

When the numbers are bad, of course, they become concerned that the facility will be perceived by the community with less favor than they would like, he says.

Responding to the rankings

If your ED receives a poor ranking, you have two options, Bukata says.

"I would tell the administration that we need more resources to achieve higher rankings, because one of the ongoing stresses of being a medical director of an ED is the inordinate emphasis that the hospital administration puts on keeping the staffing lean in the ED," he says.

The other option, which Bukata does not favor, is to challenge the numbers. "Most people are not going to take your challenge very seriously, even if it is totally legitimate," he says. "It looks like sour grapes to criticize the methodology, even though it is absolutely legitimate in the majority of these cases."

Hirshon takes a different tack. "If someone came to me and asked why we did not get an award of excellence, I'd say this is an in-hospital metric," he says. "You may call it emergency medicine, but the bottom line is: What are you doing to do to improve the metrics in your hospital?"

To support any criticism of methodology, he says, "have an epidemiologist or statistician look at your data, or someone who understands how to do research — someone who understands the population being studied, where the data came from, how it was analyzed, and whether the results support the conclusion." (*For more on the importance of data collection, see the story below.*)

Of course, if you receive a favorable ranking, the path is much clearer. "Frankly, when I like our numbers, I think the surveys are terrific," Bukata says. "However, we should have no delusion that what is being measured really matters." If administration doesn't know about the report, he will let them know, he adds, "but they subscribe to most of them, like the patient satisfaction surveys."

Hirshon says the overall message for ED managers is this: "We need to recognize that we live in a time when a large amount of information is being disseminated, and that gives attention to real problems." While he has an issue with how HealthGrades performed its study, he says, "it's a good thing that people are paying attention to emergency medicine." ■

Managers paying attention to data

In light of the growing trend toward public reporting of performance, an increasing number of ED managers are seeking better ways to track their data, says **Mark D. Crockett**, MD, FACEP, president of the emergency care division at Picis, an information solutions provider based in Wakefield, MA, and an attending ED physician at Morris (IL) Hospital.

"From my perspective, we have a large number of EDs that report anything from wait times to their latest performance," he says. "We see requests from customers to put those kinds of metrics into our software."

With the growing emphasis on reporting quality

performance, "you'd better have data," Crockett says. If you don't understand the data behind your ED's processes, the time to understand them is *not* after you've been questioned by administration, he says. "You can't say, 'I'll go look into that and see what is going on,'" Crockett says. "You need a ready answer."

This preparation is particularly important for "global" data such as time in the department or door-to-doc time, he says. "It also applies to PQRI [Physician's Quality and Reporting Initiative] measures like time to antibiotics," he says. "And this is tied to better outcomes. It's not just administrators being annoyed for no reason."

Having an automated system to collect such data is becoming a "must" for EDs, says **Jon Mark Hirshon**, MD, MPH, associate in the department of emergency medicine, department of epidemiology and preventive medicine, the National Study Center for Trauma and EMS in Baltimore. "Personally, I think you *need* some form of automated system," Hirshon says. "With government requirements for electronic health records going forward, that may allow us to have a more automated system for collecting information."

While the fact that these metrics are reported on publicly by private and government organizations frequently can put other areas of performance in the background, it's important that an ED manager maintain focus on all areas of patient care, cautions **Rick Bukata**, MD, clinical professor of emergency medicine at the Los Angeles County University of Southern California Medical Center, who recently retired after serving as ED director at San Gabriel (CA) Medical Center for 25 years.

"The emphasis others put on specific measures does not mean we should not concentrate on those things that are not measured," he says. "After all, those measures are very limited. They shouldn't distract us from other things." The real issue, from a medical point of view, is that "all we can really measure is our processes," he says. "We can't measure outcomes." ■

Many EDs noncompliant with asthma guidelines

ED nurses should take a lead role

Many ED nurses are apparently not following guidelines for pulmonary function testing and asthma medications, according to a recent study.[1] Of 1,078 adults with an acute asthma exacerbation, less than 60% received guideline-recommended therapy with a bronchodilator, corticosteroid, and supplemental oxygen. Also, at discharge, 18% of patients did not receive a prescription asthma medication.

Felicia Allen-Ramey, PhD, one of the study's authors and associate director of global health outcomes at Whitehouse Station, NJ-based Merck & Co., says, "The suboptimal adherence to treatment guidelines observed in this study could be reduced by enhancing the partnership between nurses and physicians and other allied health professions, especially respiratory therapists, in the ED."

Allen-Ramey recommends that ED nurses:

- work collaboratively with physicians to develop clinical pathways that triage asthma patients according to exacerbation severity *(To download a copy of the Global Initiative for Asthma's Pocket Guide for Asthma Management and Severity, go to www.ginasthma.org. Select "Guidelines & Resources" and "Pocket Guide for Asthma Management and Prevention.")*;
- lead quality improvement projects to improve compliance with recommendations for periodic assessments and use of objective measures;
- assist patients with arranging post-ED care before they are discharged.

To improve care of asthma patients in your ED, use these approaches:

- **Start treatment immediately.**

Sue Hilderbrand, RN, CEN, an ED nurse at Providence St. Vincent Medical Center in Portland, OR, says, "early assessment and intervention are key to the management of the asthma patient."

Hilderbrand says your assessment should include auscultation of breath sounds, measurement of the heart rate, respiratory rate and effort, skin color, and the patient's level of anxiety.

"Continued reassessment of these parameters, while remaining alert to sudden decompensation in the patient's respiratory status, is paramount," she says.

Hilderbrand adds that ED nurses use nurse-initiated orders to start treatment once asthma

KEY POINTS

- Triage based on exacerbation severity.
- Tailor treatments to specific age groups.
- Assist patients with arranging post-ED care.

patients are assessed in triage. These orders include peak flow measurement and treatment with bronchodilators.

Kerri Helm, RN, BSN, an ED nurse at Hendrick Health System in Abilene, TX, says the biggest change her department has made with asthma patients is getting them treated more quickly. "We initiate nebulizers the minute they get through the door. The kids get oxygen, treatments, corticosteroids, or arterial blood gases, according to their severity," says Helm. "By getting to them quickly, we can head off a bigger exacerbation and, hopefully, an admission."

• Tailor treatment to age-specific groups.

ED nurses at Providence St. Vincent use colorful nebulizer masks that look like toys when caring for an asthmatic child. "We allow greater participation for the child and adolescent in the delivery of treatment," says Hilderbrand.

Plain masks that allow 4-6 liters of oxygen flow are used for patients who can't hold a hand-held nebulizer, such as a young child or an elderly patient with dementia. "The masks have a base that allows for the attachment of the nebulizer directly to the mask," says Hilderbrand. "This then allows the mask to be fitted to the patient's face and the treatment delivered."

• Give education on medications, peak flow devices, or aerochamber delivery devices.

"We send the patient home with preprinted instructions regarding their medications and the asthma care devices," says Hilderbrand. "Teaching by demonstration and return demonstration are also employed."

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1. Fitzgerald JM, O'Byrne PM, McFetridge JT, et al. Pulmonary function testing in the emergency department and medications prescribed at discharge: results of the Multinational Acute Asthma Management, Burden, and Outcomes (MAMBO) study. *Prim Care Respir J*. 2010;19:155-162. ■

TJC suspends 'auto' adverse decision

The Joint Commission has suspended its policy that triggers an "automatic" adverse decision if an organization fails to complete an acceptable root-cause analysis in response to a sentinel event or its related measure of success within a specified time frame. The change is retroactively effective as of Jan. 1, 2010.

Under the new policy, if an organization makes "measurable and observable" efforts to improve and mitigate a risk of recurrence, The Joint Commission will consider the organization's efforts before changing its accreditation status.

"It is no longer automatic that an organization will be placed into provisional status, which puts them on the path to other actions — up to and including an adverse accreditation decision — based on some part of the process on which they did not completely hit the mark," explains **Anita Giuntoli**, BSN, RN, MJ, associate director of the office of quality monitoring at The Joint Commission. "So, for example, if they have done a really good root-cause analysis, but when they implemented and measured their new processes it did not hit the thresholds that were set, we will work with them on what the obstacles are and what steps will make this process more effective for them."

In the case of an ED, for instance, the remedy might have been education of the ED staff. "That's something you can measure, like the percentage of nurses for whom education had to take place within three months," Giuntoli says. In that example, perhaps the ED had set a target of 95% of the nurses being educated within three months but they had only reached 85% because the educators had not yet educated the night shift, she says.

"We'll ask what they're going to do now to tweak their plan, and we look to them to be responsive," says Giuntoli. "Perhaps they'll decide to assign two more nurses to cover the night shift or have a 'learn at breakfast' session."

If the changes seem to give them a reasonable chance of meeting expectations, The Joint Commission might suggest they touch base again in a few weeks or a couple of months "to see if things are moving along a constructive path." If, on the other hand, there had been no substantive effort toward implementing the plan and measuring what occurred — i.e., "we scheduled a lunch and learn but nobody showed up" — "then we would say that might trigger a cascade of more serious discussions," Giuntoli adds.

Who does the reporting?

The direct reporting of an adverse or sentinel event to The Joint Commission is not handled by the ED manager, even if the event occurred in the

ED, notes **Mary Anne Morris**, MS, RN, senior director of accreditation services for Cincinnati Children's Hospital Medical Center.

"That responsibility resides in a position like mine, or it may be done through the legal department," Morris says. "You're required to report an event if it becomes public knowledge, for example, if something appears in the paper."

She adds that because The Joint Commission uses a service that saves news reports, the agency certainly will know about it. In that case, even if the event occurred in the ED, someone in her position would make the report directly. However, if an ED patient is given the wrong dosage of a medicine and there is an adverse outcome, it might not be immediately apparent to people outside the ED, Morris says. Then, she says, it is the ED manager's responsibility to "notify the internal stakeholders" as to what occurred. "There should be an internal incident reporting policy, and you would probably want to escalate the knowledge you have and participate in a root-cause analysis," Morris suggests.

Giuntoli says, "If the event happened in the ED, what we've seen is the root-cause analysis process involves the individual at the bedside and also the people who oversee that area." However, there is a point person in the organization who is the identified "owner" of how the facility does root-cause analyses, she says. ■

Most experts predict higher ED volumes

Many strategies available to minimize logjams

The bad news: Most ED experts believe that health care reform will only exacerbate the steady growth of volume in the nation's EDs. The good news: ED managers have several weapons in their arsenals to help keep patients flowing through and out of their departments.

There are two forces at work that indicate crowding will become an even greater problem in the future, says **Charles L. Reese** IV, MD, FACEP, chair of the department of emergency medicine for the Christiana Care Health System in Newark, DE.

"There is a gradual reduction in availability of primary care services of all kinds, with fewer medical students choosing primary care and very few internal medicine people going into primary care, while those who are in it are retiring and getting older and have a much more difficult time making a living than in the past," Reese says. "Combine that with an aging population and increasing complexity in their medical problems, and both those forces favor more patients going to the ED."

The final dynamic, he notes, is empirical evidence coming out of Massachusetts, which passed health care reform of its own. "We've seen a very substantial increase in the number of patients going to their EDs," Reese says. "This indicates to me substantial pent-up demand being unleashed by people having the ability for their health care to be paid for."

David C. Seaberg, MD, FACEP, dean and professor of emergency medicine at the University of Tennessee College of Medicine in Chattanooga and an ED physician with the Erlanger Health System, also in Chattanooga, agrees with Reese. "Reform was about insurance, not access," Seaberg says. "We don't have enough primary care doctors." He says the true impact of reform will start to be seen once the health exchanges are set up.

"If you look at what's happened in Massachusetts, it's a microcosm of what may happen in the country," Seaberg says. "With 97% of the people having some form of insurance, you see ED visits going up 7%-9%, while the average for the rest of the country is 1% to 1.5%."

Reimbursement rates under reform also could impact ED crowding, says **Lynn Massingale**, MD, FACEP, chairman and CEO of TeamHealth, a Knoxville, TN-based clinical outsourcing firm that provides ED services to more than 400 hospitals nationwide. "For the currently uninsured, it will probably be nothing above Medicare and perhaps more like Medicaid," notes Massingale, who points out that there are so few doctors in communities now who will take Medicaid and not a lot who take new Medicare patients. "So those who have 'insurance' will not have access because there's not enough capacity in primary care practices." Impact also could be felt from subspecialties, he adds. "We know from seeing patients in the ED that many women are not getting pap smears, breast exams, or mammography because there's no place for them," he says.

What's more, the nurse practitioners in drug store clinics are not really adding net new capacity because "they're just in a new location," he says.

Another challenge under reform is how, and how aggressively, to address the issue of acuity, observers say.

"Low-acuity patients are not our problem; sicker patients are," says Reese. "In our own

institution we see 25,000 a year, but we designed a very good low-acuity care model using two or three rooms to process those people." The real issue, he says, is patients with Emergency Severity Index scores of 1, 2, and 3, which he predicts will increase.

The recently released "National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary," from the Centers for Disease Control and Prevention (CDC), supports Reese's contention by showing that only 7.9% of all visits were non-urgent — down from 12.1% in 2006, says **Angela F. Gardner**, MD, FACEP, president of the American College of Emergency Physicians (ACEP) and assistant professor, division of emergency medicine, department of surgery at the University of Texas Southwestern Medical Center in Dallas.

"One of the concerns ACEP has is that the administration may have based all its assumptions on a faulty premise: that they can decrease the amount of ED visits by improving primary care," Gardner says. "What we're predicting will happen is that EDs will grow busier and busier, and the CDC data support that based on its preliminary report for 2008."

However, Seaberg says that Erlanger was sufficiently concerned with non-urgent pediatric patients that it established a federally qualified health center (FQHC) on campus to relieve the burden on the ED at T.C. Thompson Children's Hospital at Erlanger.

Other strategies can free space

There are several strategies ED managers can employ to combat the anticipated volume increases that reform will bring, Gardner says.

"The biggest thing we have to promote in the college is to ask the ED manager to get admitted patients out of the ED, which allows us the flexibility to see more patients," she says.

One strategy is to take those patients to a floor even before a bed is ready, Gardner says. "Floor nurses don't like that. They want the patients all tucked in their bed. But the patient probably gets better care on the hospital floor than in the hall of the ED," she says.

Of course, such a policy requires the agreement and backup of administration. How can the ED manager "sell" it? "You get more patients through your ED," says Gardner. "Obviously, you do not want to do that if you don't have a waiting line to get into your ED, but that's a rare occurrence." She points out that if there are 10 patients taking up half the ED's beds, two each can go to five floors (one on each wing). Not only will that movement relieve the ED, she says, but "if you put a patient on the floor in a bed, they will find a way to take care of that patient. They will find a bed."

Gardner recommends having a strategy in place for when your ED becomes too crowded. "Just that act brings attention to the issue and helps people resolve the problem," she says. "I've seen a number of hospitals develop these full-bed protocols."

Such protocols involve administration, nursing leaders, and the ED medical director, Gardner says. "The protocol is triggered at a certain point, and they come down to the ED and determine who needs to be admitted and where they can be put," she says. "You consider which patients can be discharged or can wait in another area. Just shining the light on it will cause solutions to come up."

ED managers need to make their hospital administrators aware of how they can help reduce boarding and crowding in the ED, adds Seaberg. "ACEP put out a paper a couple of years ago on solutions to ED boarding, and three of the main ones don't even involve the ED," he says. Those solutions include moving patients into floor hallways, smoothing the elective surgery schedule, and discharging admitted patients before noon, he says. (The ACEP publication on boarding solutions can be downloaded for free at www.acep.org/WorkArea/downloadasset.aspx?id=37960.)

How do you get administration on board? "Show them the Massachusetts data," Seaberg suggests. "Ask them to think about what a potential 7%-9% increase in volume would do." If they care about their customer services and patient safety scores and metrics, they will have to look at how to deal with these issues, he says. ■

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1. Publication Title	2. Publication No.	3. Filing Date
Healthcare Benchmarks and Quality Improvement	1 5 4 1 - 1 0 5 2	10/1/10
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$549.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Robert Mate, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Jill Robbins, same as above

Managing Editor *(Name and Complete Mailing Address)*
Russ Underwood, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Healthcare Benchmarks and Quality Improvement

14. Issue Date for Circulation Data Below: September 2010

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			186	172
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	111	111
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	4	12
	(4)	Other Classes Mailed Through the USPS	12	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			127	123
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	4	4
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
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f. Total Free Distribution *(Sum of 15d and 15e)*			24	24
g. Total Distribution *(Sum of 15c and 15f)*			152	147
h. Copies Not Distributed			34	25
i. Total *(Sum of 15g, and h.*			186	172
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			84%	84%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2010 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: President and CEO — Date: 9/27/10

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