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IHI releases guidance on disclosing adverse events to patients, families

Are you ready to deal with a crisis?

"The good news is, I see hospitals all over the country, and a lot of them are doing a dramatically better job in disclosures. I think the first thing we need to do is celebrate that people are dramatically more open about what happened than they were even five years ago," says **Jim Conway**, senior vice president at the Institute for Healthcare Improvement (IHI), senior consultant at the Dana-Farber Cancer Institute, and lead author of the IHI's new white paper — "Respectful Management of Serious Clinical Adverse Events."[1]

He tempers his statement by adding that it's not happening everywhere, that leadership must set the tone, and disclosure is not just about disclosing, but providing ongoing support to the family, bringing the situation to resolution, and learning that leads to clinical, systemic or operational improvement.

In talking to people who have been "at the sharp end of a tragedy," he says he consistently hears three questions:

1. I want to know what happened.
2. I want to know why it happened.
3. I want to know what's happening to prevent it from happening again.

The white paper encourages hospitals to have a plan and team in place so that when an adverse event occurs, you are working with an existing clinical crisis management plan.

"In the spirit of 'never worry alone,' organizations should establish a standing Crisis Management Team (CMT) that can assemble immediately in response to a serious clinical event," the authors of the white paper wrote. That team should be under the direction of the CEO and include "the chief operating officer, chief medical officer, chief nursing officer, chief public relations officer, legal counsel/legal advisor, patient representative, representatives from risk management/quality improvement/patient safety, the relevant service chief or clinical leader, and others as appropriate for the incident (such as physicians, nurses, pharmacists, mental health professionals, etc.)."

According to the white paper, the team should:

- "check in daily, even multiple times a day;

• maintain highly disciplined documentation and a daily log;

• engage outside help through colleagues and consultants who have developed or helped develop effective crisis management plans;

• listen and be prepared to hear things they don't want to hear, possibly seeking the advice of an objective facilitator;

• embrace speed and flexibility;

• stay close to conversations internally and externally;

• consider implications for hospital and professional billing;

• imagine the worst and mitigate as possible;

• communicate internally and externally;

• be prepared for inquiry from or the arrival of external accrediting and regulatory agencies; and

• ensure knowledge management and improvement."

According to the paper, key steps in creating a crisis management plan include:

1. Take stock of plans that you already have within your organization, such as internal and external disaster plans, as models to draw from.

2. Analyze the last two serious events that happened in your organization:

A. What worked?

B. What didn't work?

C. What could have gone better?

D. What did you learn?

3. Prepare a high-level outline of your plan based on that assessment (see Appendices A and B of the white paper).

4. Test the plan with either an actual or hypothetical near miss, an adverse event with minor temporary harm, or an event that happened in another facility.

5. Refine and build your plan based on what you learn in your test.

6. Continue to test the plan through drills, including unannounced drills, using cases noted in Step 4.

7. Use the plan to respond to clinical crises, and look at what worked and what could be better.

8. Revise the plan.

Involve patient/family in RCA

Conway says affected patients and families should "absolutely" be involved in your root-cause analysis following an adverse event because "there's nobody who knows more about what was going on in the hours and days before an event than the family that was sitting at the side of their loved one for the last 24 hours." Some organizations have them in the room with the RCA team but Conway says there are different ways to involve them, such as interviewing patients/families and bringing their perspective back to the team. "Whether they're sitting as part of the RCA team really needs to be figured out on a case-by-case basis," he says.

The person doing the disclosure, most impor-

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tantly, should be someone the family is familiar with, Conway says, even if they had nothing to do with the event. That may be the primary care physician or the attending physician. The disclosure also should never be done with one person, he says.

The first meeting is about expressing an empathetic apology — '"I'm sorry. Something has happened. We want to let you know we're doing everything we can,'" Conway says.

Support staff

The first priority in managing adverse events involves patients and their families. The second is staff. This is an area, Conway says, most people in health care have not had a lot of experience with.

Your institution should support staff. As part of your hospital's crisis management plan, you should have a "swat team that surrounds staff and helps staff deal with what's happened, but also to prepare for the actual disclosure," Conway says. Never should staff be thrown into a room to disclose "without having gone through the process of having them be supported."

The hospital, too, has to support the staff member after the event. "Debrief with them, talk with them, see how they're doing, because any time you are involved in a disclosure, it's a moving experience," he says.

The long-term goal, of course, is to eliminate adverse events, "but until we eliminate them, the overarching principle is that all parties who were engaged in these events would say they were respected," Conway says — the patient, the family, the staff, and the community.

Very few organizations, he says, have a comprehensive approach to support staff after an adverse event. "That could be everything from hugging them, to listening and responding to them, to making sure they're safe," he says.

He says he's surprised by the number of hospitals that still do not include staff involved with the error in the RCA. "What we know is the vast majority of adverse events are the result of bad systems, not bad people." The RCA process promotes healing for everyone involved, he says.

Quality improvement staff have a huge role to play in planning an approach to disclosure. "At the end of the day, this is about learning and improvement." That must be communicated to patients and family, staff, and in all the organization's communications, both external and internal.

"When serious clinical adverse events occur, communication priorities should include the following: those most directly affected; employees, as sometimes they can be victims, too; those indirectly affected — families, relatives, neighbors, friends; customers, suppliers, government, regulators, third parties; and the news media and other channels of external communications," the authors of the white paper wrote. "Core constituencies should never learn anything from the news media; they should receive the information directly. E-mail, Twitter, and other social media have changed everything — most obviously, the speed and content of communications. Many people want and need to believe in you; make that possible."

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1. Conway J, Federico F, Stewart K, Campbell MJ. Respectful Management of Serious Clinical Adverse Events. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2010. (Available on www.IHI.org.) ■

Criteria-based privileges: What, why, and how

(Editor's note: In this issue, we will deal with determination of the scope of services that an organization decides to provide. Future issues will deal with steps 2-4 of privileging.)

According to **Vicki Searcy**, vice president, consulting services at Morrisey Associates Inc. in Chicago, most Joint Commission-accredited health care organizations "are aware that the processes related to defining and granting clinical privileges are under intense scrutiny." Why? No. 1, the Centers for Medicare & Medicaid Services (CMS) "is focused on criteria-based privileges and has mandated that clinical privileging systems in hospitals (and other health care organizations required to privilege practitioners) be carefully surveyed to assure that when CMS pays for health care services, those services are provided by qualified and competent individuals," she says.

In discussing privileging systems, Searcy defines four relevant terms:

1. **Clinical privileges:** "The specific clinical duties that may be provided by practitioners at a health care organization."

2. **Criteria-based privileges:** "A group of privileges (i.e., pain medicine privileges) or single privileges (i.e., the privilege to administer deep

sedation), matched with criteria that must be met in order for a practitioner to be eligible to apply for the privilege(s). Criteria may include any/all of the following: education, training, clinical activity, board certification, other certification, contractual relationships, meet qualifications for other related privileges, behavior, etc."

3. **Practitioners:** "Health care professionals who are licensed independent practitioners (i.e., they provide care without supervision or direction) and additionally, advanced practice allied health professionals who are required by The Joint Commission to be privileged. Those advanced practice allied health professionals include physician assistants and advanced practice registered nurses."

4. **Competent:** "Knowledge, skills, behaviors, etc. that provide a practitioner with the capacity to perform. Having suitable or sufficient skill, knowledge, experience, etc.; properly qualified."

Looking back, Searcy says hospitals have been granting privileges for about 40 to 50 years, "but for most of that time period, privileging systems have not addressed current clinical competency in any meaningful way. The emphasis of CMS on criteria-based privileges, and subsequently, The Joint Commission, has forced hospitals and their medical staff organizations to search for effective ways to design and implement criteria-based privileges.

"In the past, a discussion of clinical privileges would bring to mind a privilege form on which a list of procedures would be arrayed in some fashion (sometimes grouped by body systems, sometimes simply alphabetized) with checkboxes for practitioners to request specific privileges. Some privilege forms have also included cognitive privileges (i.e., perform the history and physical examination, treat and manage diabetic patients), but the emphasis over the years has clearly been on the procedures performed," she says.

"Now, most hospitals and their medical staff organizations have come to realize that the processes associated with clinical privileging are much more complex than creation of a simple form. There are four basic components of clinical privileging:

1. Determining the scope of services that an organization will provide.

2. Determine the criteria (training, experience, behavior, skills) necessary in order to provide a specific service (or grouping of services) or procedures. Establish how exceptions will be handled.

3. Allow applicants to apply for privileges and determine if they meet criteria. Make a decision and communicate it.

4. Monitor the individuals who are granted privileges to ensure their competence and practice is within the scope of privileges granted."

An organization's specific scope of service is determined by the governing body. "For example, will the organization provide obstetrics services, level IV emergency services, services to patients with burns, neonatal intensive care services, etc.? In addition to these broad decisions, the governing body will also decide whether or not robotic surgery will be provided (which is a large expense due to the costs associated with purchase of the equipment) or whether or not a bariatric surgery program will be established (costs of equipment, training of staff, provision of ongoing services to bariatric surgery patients, etc.)," Searcy says.

"In the past, many organizations have not been thoughtful enough about making these decisions and often reacted to requests from practitioners for equipment and other resources in a somewhat haphazard fashion. Now, however, The Joint Commission requires that organizations clearly establish that new services can be added in a way that provides safe and competent care to patients. Many times, the addition of new services is requested by practitioners." When this happens, she suggests the following steps:

• "If a practitioner requests privileges for a service that is not currently provided by the hospital, that request should first be forwarded to hospital administration to confirm that the hospital is prepared to initiate and support the new service prior to being forwarded to medical staff leadership for development of the associated scope of privileges or privileging criteria. Hospital administration and the governing body will make a determination based on the following factors:

— The community and patient need for the new privilege(s). Will there be enough demand for the technology or service to justify its approval?

— The capacity of the organization to support the new privilege(s) requested, including whether appropriate equipment, space, supplies, trained staff, scheduling and other necessary resources are reasonably available.

— Quality of care issues.

— Whether the new technology or procedure is of proven efficacy and effectiveness and whether it carries a greater risk than existing conventional therapy.

— Patient convenience.
— Reimbursement issues.
— Any other business and patient care objectives of the organization, which the board believes are relevant to consideration of the request." ■

Multi-step bundle eradicates VAPs

Build evidence before checklists

Before Crozer-Chester Medical Center (PA) engaged in a four-year study to eliminate incidents of ventilator-associated pneumonia (VAP) from its surgical unit, the medical director of Crozer Regional Trauma Center, **Riad Cachecho**, MD, MBA, FACS, admits he was a naysayer.

"I thought, like any other surgeon with an ego, that you're giving the best care, and no one is going to make you give better care," he says. But now he's a believer, and the numbers prove him right. After the four-year study period and the introduction of the VAP bundle, the pneumonia rate dropped to 1.5 per 1,000 ventilator days compared to 7.9. And, Cachecho reports, the hospital has had no VAPs for almost a year.

When he began the study in 2005, he says guidelines were nowhere near standardized. So the team looked for the strongest evidence "and then we went to chlorhexidine every six hours, and it worked. In the beginning, about 60% of patients were getting mouth care every six hours, or it might be that nurses were giving it, but they were not documenting it so it was difficult to figure out. Was it really lack of care or lack of documentation?"

Cachecho says when he started at Crozer, they had a checklist. He says, clinicians walked into a room, checked the boxes but "no one understood the importance of it, no one really put any thought into it." Improvement, he says, doesn't start with a checklist. "You start out with finding out what your problems are... What does it mean for me to look at something every day when I don't believe it makes a difference? First, you have to build your team, you have to build the culture, and then the checklist comes later."

Now, the hospital has two bundles — the VAP bundle and the central line-associated bloodstream infection (CLABSI) bundle — and they're intertwined. The VAP bundles includes:

- all intubated patients should be in semi-recumbent positions unless the patient is in shock or it's specifically contraindicated;
- mouth care by nurse every six hours with additional checks within that period;
- gastrointestinal bleeding prophylaxis;
- DVT prophylaxis;
- daily assessment of weaning and daily drug holidays. (Every morning without an order, the nurse stops all sedation until the patient awakens. Once awake, the nurse restarts the medications at the lower rate if the patient was too sedated for assessment. "Obviously we won't do that if the patient is in the extreme, like hypoxic and needs high airway pressure," he says.);
- blood glucose control.

The blood glucose measure, he says, began before any of the bundles. "When I came to Crozer, I was concerned about blood glucose levels in the shock trauma unit." Working with a committee comprising a pharmacist, an endocrinologist, nursing, medical critical care, internal medicine, and nursing leadership, Crozer developed an evidence-based protocol. Cachecho says it was one of the hospital's first culture-changing moments. It was tough, he says, "to get nurses to accept the idea of sticking a finger every hour and getting sugars, and adjusting insulin levels without physicians all day."

Though the sell was tough, it made the adoption of further bundles easier. "Now it's part of daily care. No one questions, no one complains. Everyone is literally proud of the results."

Now the daily progress note in the ICU has all the components of the bundles, which the resident is supposed to check on early morning rounds. The attending physicians sign the sheet after their rounds and double check what the resident checked.

During rounds, he says, staff — including the primary nurse, the charge nurse, the resident, the attendings, and the performance improvement coordinator — used to use laminated cards, which had the same elements as the progress note. The team discussed each item and served as reminders to each other. "By Wednesday of the week, you know all your patients. You don't have to literally go over, 'Well, do I need that line?' We know. Yesterday we discussed why that patient needed a line. But we have to have a mind-check that we discussed it. We discussed the Foleys, we discussed the air lines, we discussed the labs.

"Everything that someone misses, someone else on the team brings up. And we have a pharmD

with us who would bring up the medication-related issues. And the social worker brings up family issues. This is part of the checklist, not part of the bundle, so there are things on the checklist that are beyond the bundle and we discuss every day, too. We got so good at it that we don't look at those laminated cards any more. It's just part of our subconscious to talk about that stuff."

The QI coordinator checks documentation and patients, documentation for the drug holiday, that the respiratory therapist is weaning patients in the morning, and DVT and GI prophylaxis is in the patient's medication list. Glucose and insulin values are hung on the wall, and she checks that the insulin is within the appropriate range.

A newer initiative the hospital has added is limiting the amount of blood drawn for routine labs. "Personally, I have always had issues with routine daily labs, and I always give people a hard time when they just get labs because they need to get labs," Cachecho says. He says he used guidelines from two journal reports in 2005 to back us his "personal bias," and the critical care committee is on board. "So now, part of our checklist every day is a discussion about whether the patient needed a complete blood count the day after, whether they need electrolytes. We really now have a much lower threshold for blood transfusion, a lower trigger value for a blood transfusion."

Cachecho plans to look over the next two years if the trend of blood usage and the number of labs ordered has decreased. The lab also uses pediatric tubes or smaller adult tubes when it's appropriate so less blood is drawn.

No longer a naysayer, Cachecho says the goal of the four-year study was to decrease hospital-acquired infections, "but my bigger goal is just to give better care." ■

Is mismanaging patient flow a medical error?

RRTs used to often to fix flow problems

ED wait times have been the traditional headline grabbers. But more and more, people are looking at throughput and seeing a different monster altogether — the OR. And more and more people are saying the solution for wait times is to smooth your OR scheduling, and wait times and the patient safety implications therein will go away.

"There are two sources of medical errors. One source is clinical. The other is due to the peaks in patient flow. And if you ask which number is greater, I don't know anybody who can answer that question. Yet, the second cause is completely overlooked," says **Eugene Litvak**, PhD, president and CEO of the Institute for Healthcare Optimization and adjunct professor in operations management in the department of health policy & management at the Harvard School of Public Health.

Litvak recently penned a commentary in the *Journal of the American Medical Association* "Rethinking Rapid Response Teams" along with Peter Pronovost, MD, PhD, an intensive care specialist physician at Johns Hopkins Hospital; professor at the Johns Hopkins University School of Medicine in the departments of anesthesiology and critical care medicine, and surgery; and medical director for the Center for Innovation in Quality Patient Care.

The takeaway from the commentary? "Let me be very specific," Litvak says, "because people were trying to misinterpret our piece in different ways. You ask whether a rapid response team is needed. The answer is yes. I want to be very clear about that. I also want to be clear about something else. That the frequency of using the rapid response is a reflection of our ability to manage patient flow.

"What does that mean? It means that very frequently we are using rapid response teams to correct our own mistakes in patient misplacement," he says.

He says the suggestion that hospitals don't have enough beds is incorrect because there is not a "steady-state pattern." "In the vast majority of cases, we don't have the right bed periodically... Why on Wednesday do we have a shortage of ICU beds that you don't have on Tuesday? Is it that God makes patients sicker on Wednesday?"

The reason, he says: the scheduling of elective admissions. If there is a peak in those admissions, then beds are held up and patients are diverted and rapid response teams are sent "to correct the mistakes" of suboptimal bed placement, Litvak says. "So we are frequently endangering patients' lives and then successfully correcting our own mistakes." Suboptimal placement, he says, occurs when the bed is not in the unit where the patient

should be or staffing is not optimal.

Scheduling predictable admissions evenly, he says, can fix the problem of poor bed management. The ED is in "a more or less steady-state manner," he says. Ask any ED physician if there is a significant difference in patient volumes between Tuesday or Wednesday, or whether he or she expects that four weeks from now it will be different on that Wednesday.

"Now, you go to the operating room and ask how many surgeries are going to be performed four weeks from now, and the answer would be, 'Who knows?' That's exactly upside down," he says.

The approach Litvak proposes is the "variability methodology" created by the Institute for Healthcare Optimization (see box, this page). In working with several hospitals, most centers saw about 700 surgical bumps a year — that is, a scheduled surgery is cancelled because of an emergent situation. After implementing the methodology, the bump rate decreased to a total of about 60, instead of 2,100.

"Part of our methodology," he says, is "separating scheduled and unscheduled surgeries physically. We're using mathematical tools to determine how many rooms we need for urgent and nonurgent surgeries so that the waiting time would not exceed the waiting time that clinicians believe is right."

The biggest portion of OR scheduling is elective — about 80%-plus, he says. "They now may have a very high utilization rate because they are no longer being interrupted by urgent cases, which would be done in a different room."

In this way, he says, you can control wait times for urgent and nonurgent surgeries, increase your throughput of elective scheduled surgeries because you can afford higher utilization rates, and floors don't have to be left open in case an urgent case comes through the doors.

Litvak worked for six years with Cincinnati Children's Hospital. The results? The hospital reported a boost in capacity that equated to a $100 million, 100-bed expansion, and increased income from treating more patients. (To see a detailed account of the changes made by the hospital, visit www.ihoptimize.org, select "knowledge center" and then case studies, and click "Cincinnati Children's Hospital Medical Center.)

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1. Litvak E, Pronovost PJ. Rethinking rapid response teams. *JAMA*. 2010 Sep 22;304(12):1375-6. ■

Variability Methodology

The following three-phase implementation approach is recommended for hospitals and other healthcare delivery organizations:

Phase 1
- Separate homogenous groups, i.e. elective vs. non-elective and inpatient vs. outpatient flows in order to,
- Reduce waiting times for urgent / emergent cases, increase throughput in the operating room and cath lab, decrease overtime, and decrease delays for elective scheduled cases

Phase 2
- Smooth the flow of electively scheduled cases in order to,
- Decrease the competition between unscheduled (e.g. ED) and elective admissions, increase hospital-wide throughput, achieve consistent nurse-to-patient staffing, increase patient placement in appropriate units

Phase 3
- Estimate resource (e.g. beds. ORs, MRIs, staff) needs for each type of flow to ensure right care at the right time and place for every patient

Benefits

Phase 1
- Increased throughput, i.e. volume or access, particularly in services such as the operating room and cardiac catheterization labs
- Reduced waiting times for urgent / emergent cases
- Decreased overtime
- Decreased cancellations and delays for scheduled patients

Phase II
- Further decreased competition between unscheduled (e.g. ED) and elective flows
- Increased system-wide throughput
- Achievement of consistent nurse-to-patient staffing
- Increased patient placement in appropriate units
- Decreased delays in the ED, and in recovery areas in the OR and cath Lab
- Further decreased overtime

Phase III
- Ensure right care at the right time and place for every patient

Source: Institute for Healthcare Optimization.

ED tracks criteria, ties quality to credentialing

Nurses surveyed about physicians

"We look at a variety of things as most departments do, but I think we're trying to collect some data that there aren't good benchmarks for and can have significant variability from institution to institution or at least trying to look at our [department] numbers... to compare ourselves to our colleagues here at the hospital. That's kind of the first step as we work toward more national and regional benchmarking," says **Bruce McNulty**, MD, chairman of the emergency department at Swedish Covenant Hospital in Chicago. As chairman, he tracks physician performance on specified criteria, establishing aggregate benchmarks and uncovering outliers.

"We're fortunate that we have and have had for a long time an electronic medical record here at Swedish so our ability to get information is fairly simple. So we're ahead of the curve in that respect. It's fairly simple for me to be able to have both numerators and denominators on total patients seen and then the rates at which my physicians are ordering things that have the potential to impact quality and utilization," he says.

McNulty tracks a variety of measures for efficiency and quality, and those data are used in turn by the hospital's credentialing committee for recredentialing.

He tracks, for instance, per physician how many patients are seen, how quickly they are taken to a bed, and their length of stay in the hospital. Admission rates, deaths in the ED and within 24 hours, X-ray reading discrepancies, and utilization of CT scans are also collected.

"Certainly one of the things you may have heard and read about is that rates of CT scans have really gone up exponentially with the ER being a leader, if you want to look at it that way, in the use of those imaging modalities. They obviously provide incredible amounts of information and are making our diagnostic skills far superior to what they were 10 years ago. The down side is radiation exposure is far exceeding what our physicians did 10 or 15 years ago and the potential risks that go along with that," he says. So it is both a measure of utilization and patient safety, and the department has been able to create benchmarks to use to identify possible outliers.

McNulty says he wanted to be careful in collecting data on imaging tests so as not to belittle their importance or to discourage physicians from using them when necessary. "[W]hen I decided I was going to start looking at utilization rates, my concern was I don't want to by doing that create a situation where I might be encouraging physicians to not do appropriate testing or not admit patients appropriately because they're concerned that their rates may be higher than their colleagues.

"So at the same time I looked at both gross rates of return to the ERs within 48 hours and then we also specifically pull those cases and look at them individually to see what patients who we sent out come back and why and how many of those can we attribute to the fact that we maybe should have admitted them at the first visit or we decided not to do a CAT scan of abdominal pain for instance and we messed up and they came back a day later. I'm doing my best to correlate those 48-hour returns with those rates to see if we have anyone who is potentially an underutilizer and by doing that is potentially affecting patient quality. So that's the kind of two-sided look at utilization," he says.

Nurse feedback shared with physicians

McNulty also tracks less measurable, less tangible things. Annually, the nursing staff, including ED technicians and secretaries, complete a confidential, anonymous survey assessing the ED's physicians. "A lot" of the questions, he says, are on the "touch-feely" side, such as: Are you a nice per-

Sample nurse survey questions

Staff can answer strongly agree, mostly agree, agree, mostly disagree, strongly disagree, N/A.

- works collaboratively with staff
- is a team player
- easily approachable and responds to nursing queries
- sees patients quickly and efficiently
- I feel confident when this physician is caring for my patients
- easy to find in the department
- easy to communicate with
- efficiently dispositions their patients
- Dr. McNulty is effective as department chairman
- Dr. McNulty is available and responsive as ED chairman

Source: Swedish Covenant Hospital.

son to work with? Do I feel comfortable working with you? Do I feel like you see patients quickly and efficiently? Are you easy to find? The survey also includes a free text area in which nurses can comment. *(See box, page 128, for sample questions.)*

He combines the survey results with the tracked data to create the year-end review with all physicians. Physicians see both their individual scores and the aggregate scores for the department. Data are sent out monthly so McNulty can identify opportunities that may need attention before or outside of the annual physician reviews. For instance, he says, it could be a "brand new physician out of residency who is going to have a higher admission rate because they're not as experienced and not as confident and they're going to have higher CT rates for the same reasons and it's a matter of understanding the reasons why that might be and then watching for improvement." The department meets monthly to discuss any quality improvement issues as well.

He says it's been a "powerful motivator for change for physicians." They don't want to be outliers. They want to be liked by the nursing staff. Sometimes the physicians are surprised by the results of the nursing staff survey but McNulty sees it as motivation for improvement. A practicing ED physician for 21 years, he says he's certainly seen individual cases where the data have had an impact. "Probably the most powerful one," he says, "is admission rates. I've had a few physicians who clearly were above their peer level in terms of admission rates and realized that probably their criteria for admission was a little soft, for lack of a better term. And that the rest of us would try to arrange outpatient or observation admissions or be a little more creative. Second is X-ray discrepancies. I've had physicians coming out of residency who didn't have a ton of experience doing this and based on getting that feedback they've become outstanding X-ray interpreters and they've done that by learning from their own mistakes." ■

Transition focus results in large readmit drop

Project builds on success

One path that leads to better care transitions and reductions in hospital readmissions is to break down the silos where care traditionally is delivered.

"We know from research that any time you have a patient hand-off, there is an opportunity for less quality and increased costs," says **Julie Schilz**, BSN, MBA, director of community collaborative and practice transformation at Colorado Beacon Consortium in Grand Junction, CO. The consortium consists of leaders from four not-for-profit, Western Colorado-based organizations, including the Mesa County Physicians Independent Practice Association, Quality Health Network, Rocky Mountain Health Plans, and St. Mary's Regional Medical Center.

The Colorado Beacon Consortium received an $11.8 million federal grant to participate in a three-year demonstration project that will improve care transitions, care coordination, and efficiency among providers across the care continuum.

"We are at the outset of our project, and we're very intentionally working to improve the strength of processes and the level of integration in primary care and hospitals, in particular," says **Patrick Gordon**, executive director of the Colorado Beacon Consortium and the director of government programs at Rocky Mountain Health Plan, also headquartered in Grand Junction.

"We are investing in health information exchange to support those processes," he adds. "Going forward with health information technology will enhance the level of communication between those points."

Rocky Mountain Health Plan already has electronic data collection and care transition processes in place to help reduce hospital readmissions and health care costs. The health plan's adult and disabled members have lower readmission rates than the state's benchmarks.

For instance, the readmission rate benchmark for adults in Colorado is 2.400. The Rocky Mountain Health Plan members' readmission rate within 90 days in 2009 was 1.348. Among the disabled population, the comparison is even more striking: The Colorado readmission rate benchmark is 6.420, while the health plan members' readmission rate within 90 days for 2009 was 2.907.

"We continue to have some of the lowest Medicare hospital readmission rates in the country," Gordon says. "That is related to the transitions of care both pre- and post-hospital stay that we're able to do in a sustained manner."

With the federal grant, the consortium could extend this type of success to reach even more people.

"By focusing on readmissions, we're focusing

on care transitions," Schilz says. "The best way to stop a readmission is to have a place where the patient feels well and care is coordinated."

The consortium will begin the work to improve transitions by first rebuilding relationships with hospital systems, Schilz says.

"When you get a group of hospitals and primary care providers together, you realize everyone wants to deliver effective patient care," she explains.

Then, the next step is to improve or replace the existing systems that are not successful in delivering the best patient care.

"If you have a hospital system that has a care transition program, then the goal is to build those links to the primary care practice," Schilz says. "What we have with the Beacon community grant and others is the opportunity to maximize technology as a tool."

Here's how the care transition project will work:

• **Improve transition communication:** Hospitals and others involved in the consortium grant project will commit to working with each other, discussing, and clarifying patient care information, Schilz says.

"They'll have healthy hand-offs that will house the information that talks about patients," she explains. "Everyone will be working toward the same goal."

Transition communication will be patient-centered, asking these questions:

— How does the patient live?

— How do we engage the patient in a way that encourages the patient to participate in information-gathering?

— How will privacy be maintained?

— "What are potential unintended consequences?

Providers will meet to discuss how to improve care transitions.

For instance, if a patient shows up in the emergency department (ED), how will the patient's illness and hospital care be communicated to the patient's community providers?

"They'll develop common communication and messaging for patients and make a commitment to share information from the ER to the primary care practice," Schilz explains.

This communication could include the use of tools, such as giving patients' wallet cards with their medical information or educating them in primary care settings with brochures that talk about the consortium's work to improve care transitions, she says.

These could say: "We want to make sure our hand-off with you is effective. Here's what you can

CNE QUESTIONS

17. Jim Conway suggests that when a disclosure is made to patients and families, only one hospital staff member be in the room.
A. True
B. False

18. According to Vicki Searcy, who decides the organization's specific scope of service?
A. the CEO
B. the community
C. the governing board
D. physicians

19. Which of the following are part of Crozer-Chester Medical Center's ventilator-associated pneumonia bundle?
A. all intubated patients should be in semi-recumbent positions unless the patient is in shock or it's specifically contraindicated;
B. mouth care by nurse every six hours with additional checks within that period;
C. gastrointestinal bleeding prophylaxis;
D. all of the above

20. Eugene Litvak, PhD, says smoothing your OR schedule will improve throughput.
A. True
B. False

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

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

do for us: When you go into the ER, make sure your primary care physician knows about it," she adds.

• **Assess improvements:** Each time a new process is initiated, providers in the group will collect data on its outcomes.

"We see who did what and how it worked from your end and my end," Schilz says. "We use quality improvement principles to continuously work on that process."

The assessment phase is crucial to maintaining efficiencies and best use of resources.

"The idea is, if you don't measure it, you don't know if you're improving it," Schilz says.

For instance, the Rocky Mountain Health Plan's success with reducing readmission rates provides tangible evidence that its processes are succeeding.

"One example of where we have a tangible outcome of this type of integration is our Medicaid program," Gordon says. "We've cut in half the readmission rate of some of our most complex cases, the people who need extensive support, and those who are the most costly group of patients."

• **Address clinical process and outcomes:** "Look at the clinical process and, more importantly, clinical outcomes," Schilz advises. "We need systems in place where we're looking at measures every month."

The systems and processes help health care providers deliver on evidence-based care. These systems might include electronic primary care dashboards, financial data collection, customer service improvements, and care models, such as the medical home care model.

"You set up practice tests for the systems and then use data to see if you were successful in your goals," Schilz says.

The most effective way to measure outcomes is to use electronic data collected across a care continuum.

"Rather than manually collecting data through very basic and simple processes, we now can collect and aggregate data through a much more robust exchange solution," Gordon says.

"We make sure we're not just working with islands of data and very intensive data sets we've sown together manually," he explains. "But, rather, we have a systematic solution for collecting data at practice level and sharing it."

The Rocky Mountain Health Plan's experience with data collection will serve as a leadership model as the consortium's seven-county care transition work begins.

"We'll work with leaders in each community to allow them to own and drive this process," Gordon says. "We bring technical assistance, expert resources, technological tools, data collection tools, and a financial incentive that will incentivize participation at the outset."

Also, the health plan is working on interfacing the electronic platforms that are created at the practice level with a health information exchange, he adds.

"Most of the funding we receive from the government will go into the development of electronic, real-time interfaces between the health information exchange and a very disparate and diverse array of platforms being used at the clinical practice level," Gordon says.

This work has encouraging potential for the Colorado community and for other regions that may use it as a model.

"We have a multifaceted approach to care delivery, and now we have an opportunity to maximize that work and add health information exchange as a tool to take the work and amazing results to improve quality of care across all patient populations," Schilz says. ■

CNE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

■ More on credentialing your staff

■ Making data abstraction of core measures more efficient

■ TJC update on handoff communication problems

■ Making your way through OPPE and FPPE

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