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Quality approach, hard-wiring, repetition lead to excellence

Director says one key is focusing on frontline staff

With so many conditions and processes to worry about, not to mention all the organizations that require performance data, it's a wonder that a quality manager can keep a handle on all of them. But at Payson (AZ) Regional Medical Center (PRMC), the quality team seems not only to be addressing all of them, but also to be excelling in several areas at once.

For example: PRMC has achieved close to 100% compliance with the Centers for Medicare & Medicaid Services (CMS) core measures; it recently received a 94% score on its Joint Commission survey; and it was recognized as one of the "Top 100" hospitals by Thomson Reuters for the second time in four years.

There's an underlying philosophy behind all this success, explains **Becky Nissila**, RN, MBA, director of quality management and regulatory compliance. "My motto is, 'Quality happens at the bedside,'" she says. "I'm an administrative person who sits up on the food chain, but that's totally not what quality is about. My main gig is getting knowledge and tools to the people who deliver the care."

Seeking perfection

Nissila says that for the CMS core measures, "Overall, we're at 99.2% or 99.3%; our lowest in the last year was 98.6%. My big goal is a 100% a quarter." If that goal is achieved, she says, "I told everybody

KEY POINTS

- Give staff tools and knowledge, and then hold them accountable.
- Never stop trying to improve your performance — no matter how good it is.
- ACOs will look different in various locations, populations.

there will be a big cookout at my house." However, she's quick to add, "The major motivator is doing the right things for the patients."

At this point, Nissila notes, processes and protocols to assure best care practices are "hard-wired," but it wasn't always this way. "Repetition builds definition," she explains. "People have to hear it and see it. The things we put into place made it impossible for people not to address."

When a new initiative is put in place, she says, there is first general education for the staff. "We say, 'OK, here are our new measures, here's what we have to meet,'" she says. "We explain that this is the outcome we have to get to, and here's what we do in our daily processes."

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EDITORIAL QUESTIONS

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The people who do the work create what the process looks like — staff nurses, techs, and so on, Nissila says. "We create the initial plan, educate the staff, and then try it. If the initial plan doesn't work, we tweak it."

Once the information is disseminated, she adds, "It has to be walked, talked, and made part of everyday work in the hospital; that's how you get it hard-wired. Everyone gets quizzed on it; it's addressed every day. Not a day goes by that we don't have a core-measure patient in the hospital, so we have to be there to talk the talk, make sure people understand the processes we have in place, and that they follow through."

Once the staff have the information and tools they need, says Nissila, "You have to hold them accountable. We say, 'You have the knowledge now; this is the expectation, and it's non-negotiable — it's part of your job.'"

When someone is not doing what's expected, she says, "It becomes a counseling session. You can ask, 'Is there a reason you did not do this? Is there something we're not aware of?'" The "whole," Nissila explains, is much smarter than the "one."

But now that the staff are so close to 100% compliance, is continued improvement really possible? "At this point, our failures are so few and far between that we can look at each failure and ask how it happened, and what we need to do differently," Nissila explains. "Did the process fail or did a person fail? Then we know if we need to re-do the process or if it's an education issue."

Most recently, for example, "We figured out we needed to tweak documentation, so we did heavy-duty education of ER physicians," she says.

How does Nissila know when there has been a failure? "I have a person in my department whose whole job pretty much is to be the core measure 'guru' for the whole organization," she explains. "She does open chart audits because you have to catch the failures when they happen."

Nissila acknowledges that she's fortunate to be able to dedicate an FTE to do an audit on every core measure patient in the facility, but adds that "an individual like this does not need to be in the quality department." In fact, she adds, "In my opinion, the optimal people are charge nurses, or case managers, because they are in the charts every day."

Have your ducks in a row

When it comes to being constantly prepared for an unannounced Joint Commission survey, says Nissila, "Presentation is everything; how you pres-

ent when they walk in the door when they enter is huge. You have to have things in place and your ducks in a row."

In some ways, this preparation is similar to the core measures approach, she continues. "Your staff in particular need to speak National Patient Safety Goals," Nissila says. "It's the same deal; you have to walk it and talk it. I try to weave it into my conversations and fit it in any time I can when I'm on the floor or doing a chart. You have to keep it in the forefront so it becomes part of your culture."

Other forms of preparation, she adds, involve documentation. "The Joint Commission has a list of documents they want," she notes. "They're already prepared, and during the whole year we update them. We had two huge box files of these documents, and we put a plan in place. This way, when they walk in the door, so and so knows to bring the board minutes, while someone else brings other documents."

Every year, Nissila continues, the department puts together a giant binder of all performance improvement data. "When they walk in the door I have three years of PI [performance improvement] data for them," she notes. "They don't look at all of it, but they see you have it together. That is so, so, so key."

Preparation also involves how your staff look when The Joint Commission walks in the door, Nissila notes. "We even did drills about their arrival," she shares. "The first people they see are volunteers; you have to rehearse the way you're going to perform as if it were music. Then, when it happens, you'll be more prepared to bring it off smoothly."

So, for example, the volunteers are trained on how to alert everybody. "The Joint Commission does not need to know we let everyone know they're here," Nissila says. "We did a couple of drills on that."

In addition, says Nissila, education plays an important role. "This helps make sure documentation is the way it should be," she notes. "At every medical staff meeting, I talk to the doctors and discuss what we need to do and tell them how much we appreciate them."

The bottom line, she says, is that "it was not by chance that we did well; it was by design."

Showing you care

The "Top 100" award, according to PRMC, recognizes a recipient "as having achieved excellence in clinical outcomes, patient safety, satisfaction, financial performance, and operational efficiency." The key to recognition for patient satisfaction, says Nisilla, is the adoption of a program from The Studer Group called "Community Cares."

"Rounding totally makes a difference," she asserts. "That means hourly rounding on patients by your staff and having your leaders round as well — the director, and sometimes, administration." Patients, she explains, are asked how things are going, whether the staff are meeting all their needs, and how they can make them totally satisfied.

"We use a lot of scripting," Nissila shares. "When you ask those questions, people are totally shocked and impressed; they think, 'Wow, they really care!' People need to perceive that their caregivers genuinely care about them. Studies have shown that you can be the best surgeon around, but if you are curt, people will not be satisfied."

As for the outcomes, says Nissila, using evidence-based medicine is a must. "You've got to look at things and try to improve; do not be afraid to look at the hard things," she advises. "Sometimes you have to rock the boat to make it better."

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'Targeted' EHR use can reduce unnecessary tests

Focus on specific age groups with specific condition

A recent study conducted by Kaiser Permanente's Institute for Health Research has shown that unnecessary medical tests can be reduced when targeted alerts are used in electronic health record (EHR) systems. The study was published in *The American Journal of Managed Care*.[1]

The researchers conducted a randomized trial of 223,877 visits by patients ages 65 and older, and 564,264 visits by patients younger than age 65. In this particular study, they focused on the "D-dimer" blood test, which is used to diagnose deep-vein thrombosis and pulmonary embolism.

(Previous studies had indicated a low rate of accuracy for this test.) When outpatient physicians ordered the test for elderly patients, Kaiser's EHR system sent an alert telling physicians that the test was inaccurate for elderly patients, and suggested conducting a radiology test. The percentage of physicians ordering the D-dimer tests fell by almost 70%.

Ted Palen, PhD, MD, MSPH, clinician researcher at the Institute for Health Research of Colorado Permanente Medical in Denver and lead author of the study, says the findings also would apply to the hospital setting. "While these patients came to the outpatient setting, the use of EHR is proliferating in hospitals, and there the use of alerts or advisories should also be used judiciously," he asserts. "Targeting," he explains, helps providers use the alert for specific age groups of patients for a specific condition, "so you deliver decision support advice at the point of care."

An additional take-home message, says Palen, is that "we not only targeted the alert to a specific test and a specific population, but we also included advisory information as to what you should do besides ordering this test."

How good is your system?

How do quality managers and providers determine which patient populations and which tests/conditions to target? "This is an important question in the sense that as these quality managers start investigating the capabilities of their EHRs and IT, they also have to start investigating whether or not the system has the capabilities of making the alert specific, or whether these are generalized alerts," Palen cautions. "If they are not specific for certain patients or conditions or parameters, you end up with a problem that's been written about a lot — alert fatigue. Things will fire off whether they pertain to your particular case or not — like all the pop-ups you see when you're surfing the net.

"If the pop-ups are generalized, a lot of times you get frustrated and ignore them," Palen continues. "The same thing can happen in EHRs. If there is not intelligent use of your alerts, providers may start to ignore the important ones."

So, your first step, says Palen, is to consult with your IT people to see if your system can do what you want it to. "If it can't, you need a different system, or you need to think about when you want to turn on certain alerts," he says.

KEY POINTS

- Alerts and advisories should be used judiciously.
- Include advisory information as to what you should do besides ordering a particular test.
- Make sure your IT system is capable of targeting specific populations and tests.

If your system can provide targeted alerts, how do you choose your targets? "You have to go back to the adages of preventive medicine," Palen advises. "If it's a potentially lethal or very serious condition, obviously you want to target those. If there's something seen as a common issue arising in your system [where testing is] being chronically misused or misappropriated or a lot of people are doing something that is not optimal to quality delivery of care, you might be able to use alerts to help reduce over-utilization of inappropriate care."

Choose the right people

Besides the quality manager, who should be involved in the targeting process? "A lot of times it is thought to be a physician, but the physician is not always in the best point in the work flow of patient care through the system," says Palen. "What the quality manager has to look at is the work flow, and where through the multiple contact points is the most appropriate place for an alert to fire. It could be at check-in, it could be a nursing contact, or even ancillary staff contact like the lab, or it could be the physician."

Such an approach, Palen asserts, "can improve our delivery of care. It can improve our adherence to known, proved, evidence-based medicine techniques, and in the long run, hopefully improve patient outcomes and quality of care."

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Best implementation techniques not enough

'Positive cultural context' required

You've successfully identified an important area for quality improvement. You've researched all the literature and identified best practices. You've even joined a nationwide collaborative so you can learn from the successes of top performers. Your odds of success are pretty good, right?

Not necessarily, according to a new study sponsored by the VA Ann Arbor (MI) Healthcare System.[1] The researchers looked at QI efforts to prevent central line-associated bloodstream infections (CLABSI) in a number of U.S. hospitals in an attempt to understand why some initiatives were more successful than others. "This study reveals that among a number of hospitals that focused on implementing practices to prevent CLABSI, the experience and outcomes varied considerably despite using similar implementation strategies," the researchers said.

What made the difference, then? "Our results showed that among a number of hospitals that focused on preventing CLABSI, despite using similar implementation strategies, the experiences and outcomes of these efforts varied considerably given the organizational context," wrote the researchers.

What is organizational context?

Organizational context, as the paper described, basically speaks to the culture of the organization, the relationships among individuals, and resources to accomplish goals. **Sarah L. Krein**, PhD, RN, research investigator, VA Ann Arbor HSR&D COE, research associate professor, division of general medicine, and lead author of the study, breaks down the four key elements identified and what they mean in terms of a hospital's context:

Structure: "Here, you really think about the resources in your organization — the leadership in your organization, and how good you think those various aspects are," says Krein. "Do you feel you have all the resources you need, is leadership supportive of what you're trying to do, do you have the manpower needed for activities?"

Politics: This covers all the relationships within the organization, Krein explains. "This may involve administrative and clinical relationships, as well as relationships among frontline providers — anyone involved in the improvement project," says Krein. "What are the relationships among those individuals — how good are their communications, and how well do they work with one another?"

Culture: "Everyone has to have the same mission and priorities, a shared understanding that this is what the organization is all about," says Krein. A shared mission statement she cited from the study, for example, was "we serve underserved people, and we do it well."

Emotions: "This is related to culture — the commitment and passion of the people about what they're doing," says Krein.

Without these elements, is it possible for QI projects to achieve optimal results? "I suppose you could get lucky and your project would work, but the odds are you would not be as successful as one would hope," Krein asserts.

KEY POINTS

- Collaboratives can be a challenge for high performers.
- Researchers find much value in "local champions."
- If your hospital's culture is lacking, focus on your own department.

Collaboratives: A two-edged sword

Involvement in collaboratives has been growing in popularity, and a number of them have touted excellent results. While Krein's study does not dispute that, she warns that they can sometimes have unintended consequences. In fact, the study stated, in hospitals that have positive emotional and cultural context "such initiatives…could work against organizations by diverting resources and impeding necessary changes in other areas."

"Part of the problem is that everybody gets on this bandwagon — which is not necessarily bad — but after a while you put a lot of energy and time into those activities and you're so focused on it that when other things come along you can't really invest in them; you just don't have the energy," Krein explains. "In addition, sometimes what you see in collaboratives is that the hospitals that are most successful have others turn to them and ask for assistance. That's a good thing, but it takes a

lot of effort to respond."

The researchers made a special effort to point out the value of "local champions"; are they preferable to participation in a collaborative? "For some things, you're better off with local champions, but sometimes you want to be part of a larger network," Krein observes. "You've got to weigh it out — do you want to jump on everything that comes along? One high-performing organization we interviewed was selective about wanting to participate in collaboratives."

On the other hand, the researchers noted that participation in collaboratives could be very positive for facilities with less positive emotional and cultural contexts. "They help weaker organizations because they bring in new ideas, they may provide resources you did not have initially, and support from the outside," says Krein. "If you're a quality manager and you're not getting internal support, it may be of benefit to you to have that external support system."

Where do you fall?

Krein notes that many quality managers have a pretty good idea of where their organization stands. The study included quotes from leaders at several facilities that provide insight into both the good and the bad.

For example, here are some comments from the study from a facility with a "positive" environment:

- "I have a separate budget for clinical, education, research, and administrative work."
- "Everybody is involved in the care of the patients… The patients and the people that touch the patient are part of the care of the patient."
- "My philosophy has always been, what if it's your mother, your father, your brother; we always want the best care for those we love and try to bring that point home to everyone."

And here are some from a facility that did not fare so well:

- A major barrier to implementing evidence-based practices is "getting people coordinated; who's going to do it, who's going to spearhead it, who's going to monitor it?"
- "It's better received if it's from the top down."
- "We're probably not implementing all these practices the way we should. I think we say we are, but it's a fantasy."

What are your options if you feel your organization falls into the latter category? "That's a tough one," Krein says. "But sometimes it's not necessarily the entire hospital that has to change all at once, but just the culture in your own area. Some other people may see that and see you're doing well and ask what you're doing. You should focus on those things you can really impact."

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Patient ed affects patient satisfaction

Use survey results to improve services

What role does patient education play in patient satisfaction scores for health care organizations? How important is patient education to the patient's opinion of the entire health care experience?

"There is a lot more interest around the topic of the correlation of patient education to patient satisfaction," says **Christy Dempsey**, vice president of clinical and operational consulting at Press Ganey, a South Bend, IN-based quality improvement company. "We have found that when education begins at the first contact with a patient, the patient reports a higher level of satisfaction," she says. Conversations with patients should always include a discussion of expected time frame for discharge, she suggests. When a nurse or patient educator talks in terms of discharge, such as, "Are there any questions you have about your medication before you go home tomorrow?" the patient has time to think about questions when he or she is not on the way out the door, she explains. "This increases the patient's perception that nurses and educators are trying to make sure instructions and teaching [are] thoroughly understood," she adds.

A focus on patient education does mean that

the mean score for two of the measurements in Press Ganey's national patient satisfaction survey have increased over the last seven quarters. The level of satisfaction with instructions given for care at home have increased from a mean score of 86.0 in January 2009 to 86.8 in July 2010; and the level of satisfaction with explanations of tests and treatments have risen from a mean score of 85.0 in January 2009 to 85.8 in July 2010.

Hospitals will continue to place an emphasis on improved patient education as reimbursement is tied to outcomes, including patient satisfaction reports on HCAPS [Hospital Consumer Assessment of Healthcare Providers and Systems], says Dempsey.

Patient satisfaction surveys can also provide important feedback on how to improve your service to patients, says **Kimberly A. Hume**, MSN, RN, FAHCEP, manager of the Family Resource Center at St. Louis Children's Hospital in St. Louis. "I think that most resource centers conduct some sort of satisfaction survey," she says. "We include a survey form in every packet of information we provide to patients," she explains. Although it is nice to be able to report levels of patient satisfaction to show that you and your staff are doing a good job, don't let your review of satisfaction surveys stop at numerical ratings for your service, she suggests.

"We want to do more than satisfy the patient's or family's immediate need; we want to establish a relationship so that they come back to us in the future or recommend us to others who need information," says Hume. Questions on her survey form ask if the resource center was easy to use, if the information provided was easy to read and understand, and if the family member or patient would recommend the center to other people, she says. "We also ask how the information was received, because we want to know if our customers want to receive written information, e-mailed information, or print information mailed to their homes," she says.

As a result of the survey information, Hume's resource center now tailors delivery options to the recipient's preferences, she says. "We've gone from mailing all information to the homes, to a combination of e-mail, fax, and mail," she explains. "If a patient is still in the hospital, we give families an option of visiting the resource center to pick up information or asking us to deliver it to the patient's room," she says. The most important thing Hume's staff learned from satisfaction surveys is that patients and their families want to be asked how they prefer information to be delivered to them. She adds, "Just asking them how we can make the process easier increases their satisfaction with our service."

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Think of RM as a profit center, not an expense

Here's a radical idea: Instead of trying to show management why your department is worthy of respect, go on the offensive and declare that risk management is a profit center every bit as much as that shiny new cardiac center or the plastic surgery clinic.

That approach makes sense when you look at the current activities of a risk management department, says **Edwin Foulke Jr.**, JD, former assistant secretary of the federal Occupational Safety and Health Administration (OSHA) and now co-chair of the Workplace Safety & Catastrophe Management Practice Group with the law firm of Fisher & Phillips in Atlanta. Over the years, most businesses have focused on efficiency and quality, with strategies such as Six Sigma and Continuous Quality Improvement, and as a result they have become more profitable, Foulke says. Health care providers have been following the same path as other businesses, and they are finding that they have exhausted the obvious ways for improving revenue.

"Companies have been able to achieve a lot of cost savings and become more profitable and more competitive, but as you squeeze anything you get to a point where it becomes harder to achieve any more cost savings," Foulke says. "So, the question becomes what areas are left where they can achieve cost savings; there are really only two areas left — workers' comp and health care. And risk management is what deals with those two areas."

Risk management traditionally has been seen

as an expense on the liability side of the ledger and not as a potential profit center, he says. That is partly because business schools and MBA programs rarely include instruction on occupational safety and health, much less how risk management and safety can improve profit, he says.

Show how you make money

The savings from risk management must be quantified and presented as not just money you didn't lose, but rather money that contributed to the bottom-line success of the organization. In other words, Foulke says, show that risk management actively makes money for the organization, rather than just helping avoid losses.

Risk management's efforts to improve workplace safety by reducing back injuries among nurses, for example, can have significant and direct effects on the organization's bottom line, Foulke says. And it's not just the reduced workers' comp costs because of fewer injuries, he says.

"When you reduce injuries, you dramatically increase efficiency and productivity, because you have that person on the job working instead of home recuperating," he says. "If that person gets injured and doesn't show up for work the next day, his or her productivity is zero, and the organization will spend money to cover for that loss of productivity. If you're eliminating that, you are achieving greater cost savings than just the massive savings in the workers' comp area. That's money right to the bottom line."

Risk management also contributes to the organization's public image, which is an important factor for hospitals and other providers in competitive environments, Foulke says. Worker injuries or deaths, as well as medical errors, can tarnish the hospital's reputation, which can drive away profitable patients, he says.

"The truth is that you cannot have great productivity, efficiency, and quality until you have great safety," Foulke says. "It's a one-way street. If you don't have good safety, people are getting injured, and that is going to impact your organization in all the ways that upper management . . . most focuses on. They will see it impact revenue, profitability, growth, all the important determinants of success, even if they don't read between the lines and see the impact of safety."

The risk manager should make it a priority to show that relationship, rather than hoping upper management will make the connection, Foulke says.

"Unfortunately, we see companies cut risk management and safety and health instead of realizing that they are the people who can help the company become more profitable, even when every other path is blocked," he says. ■

'No-wait' ED a five-year success

Wait time to see practitioner cut in half

A true test of the success of a process improvement initiative is whether the results can be sustained, and the ED at Hudson Valley Hospital Center in Cortlandt Manor, NY, has just celebrated the fifth anniversary of its "no wait" process. Most patients skip the waiting room entirely and go right to registration, and then to triage.

"We've cut the wait time to be seen by a practitioner by 50%," says **Ron Nutovits**, MD, FAAEM, chair of the ED. "Most patients are now triaged within five minutes and seen by a practitioner within 20. Within the first month, our rate of patients who left without being seen went from .7% to .33%, and our Press Ganey scores went to the mid-90s." Nuvovits says the 35,000-visit ED was also recognized by Press Ganey for its high staff satisfaction scores.

Maryanne Maffei, RN, MS, director of nursing, explains the process. "When the patient comes in, they sign in at the registration desk. We do a quick registration — name and date of birth — so we can give them a medical record number, and then they have a seat. Their name then appears on our computerized system, and the triage nurse takes them from the waiting room to the triage room." When triage is finished, the patient is taken immediately into the care area, where labs and X-rays can be ordered and treatment begun, Maffei says.

Nuvovits says, "It became a one-way system. Instead of coming in, registering, and going back to the waiting room, now they come in and the greeter gets them into our tracking system, alerts the triage nurse; they go to triage and come directly from triage to the main ED." The department has two triage areas, so patients can be treated simultaneously, he adds.

Maffei says, "We really focused on triage in training. If more than two people are in the waiting room, the staff will go there, bring them to a room, and triage them."

It was emphasized to staff that this change

would benefit patient safety. "We needed to change the thought process of some of the nurses in the department, so they could see how much safer it was going to be to bring patients immediately into the department for treatment," says Maffei.

Eventually, this approach became "part of the norm," she says. In fact, Maffei shares, there's another hospital nearby that is trying to implement a similar approach. "They were discussing it with one of our nurses, and she told them, 'Don't worry, it's hard at the beginning, but you get used to it,'" she says. (The transition was also made easier through the use of simulations, which helped ensure that staffing levels matched demand fluctuation.

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Prepare for rising liability costs

Hospitals and physicians should prepare for increasing liability costs, according to the 2010 Hospital Professional Liability and Physician Liability Benchmark Analysis created by Aon Risk Solutions, the global risk management business of Aon Corporation, in conjunction with the American Society for Healthcare Risk Management (ASHRM) in Chicago.

In its eleventh year, the study confirms an emerging change in the liability environment: The frequency of claims against hospitals has entered a growth phase, says **Erik Johnson**, FCAS, MAAA, Health Care Practice leader for Aon Risk Solutions' Actuarial and Analytics Practice and author of the analysis. Combined with continued claim severity growth, this uptick is expected to drive liability costs up at a rate higher than general inflation, he says.

"Last year was the first year in which we thought we saw an increase in claims, and this year we certainly have confirmed that the number of claims has entered a growth phase. It's not huge, at 1%, but it is growing," Johnson says. "The severity of claims has been very consistent in rising over a 10-year period and continues to grow at about 4%. That means we think the cost of claims is increasing at a 5% annual rate, which is quite a bit higher than inflation."

The Hospital Professional Liability and Physician Liability Benchmark Analysis has examined trends in frequency, severity, and overall loss rates related to hospital and physician professional liability for the past 11 years, Johnson says. The 2010 analysis includes 119 hospital systems and more than 1,800 facilities, representing 23% of the total U.S. hospital industry segment.

Erosion of tort reform one cause

A number of things could be driving the increased number of claims, Johnson says. There was a significant drop in claims in 2003 through 2006, which can be attributed to tort reform, a stronger focus on patient safety, and more investment in safety technology, he says. In the current environment, the number of claims is being affected by an erosion in those earlier tort reform efforts and a lack of new tort reform, he says.

"The continued economic stress on households is another factor," Johnson says. "The increase in claims is modest, but it is significant for an industry that is used to seeing a decrease or a flat level of claims. We're going to have to get used [to] a growth pattern in claims."

U.S.-based hospitals are expected to face more than 44,000 claims arising from incidents occurring in 2009, according to the report, with anticipated costs exceeding $8.6 billion. Claims resulting from incidents in two key hospital risk areas, the obstetrics unit and the emergency department, make up more than a quarter of that expected expense, Johnson says.

Loss rates, which measure the total cost of medical malpractice claims per hospital bed, are expected to grow 5% annually. In 2011, hospitals are expected to experience a rate of $3,280, reflecting a $150 increase from 2010's expected rate of $3,130 and a $300 rise from 2009's rate of $2,980.

From 2000 to 2006, tort reforms, patient safety initiatives, and sympathetic public attitudes were influential in the reduction of medical malpractice costs. Today, there is less momentum associated with establishing new tort reforms, and existing tort reforms face serious legal challenges in several states, Johnson says.

"The uncertainties of health care reform and difficult economic times represent significant sources of risk for many hospital systems," Johnson says. "While many hospitals have grown

accustomed to declining professional liability costs, the underlying claim frequency and severity cost drivers have entered a period of growth. Whether commercially insured or self-insured, hospitals and physicians should prepare for increases to their professional liability costs in the coming years."

Compare to your own stats

Risk managers should use this information to guide their financial strategy, says Dominic Colaizzo, managing director of Aon Risk Solutions' Health Care Practice.

"This challenging environment increases the pressure on health care providers to seek the most appropriate and cost-effective risk financing programs — and to monitor and manage the overall cost of risk per exposure," Colaizzo says.

Colaizzo and Johnson point out these additional findings of the analysis:

- Claim severity (indemnity and claim-related expenses) continues to increase at a consistent rate of 4% annually.
- Hospital professional liability claim frequency is growing at a rate of 1% annually.
- For accidents occurring in 2010, hospitals should expect to incur $204 per birth for liability costs associated with obstetrics claims and $6.30 per visit for emergency department claims.
- Hospitals are employing more physicians and as a result, the health care industry may experience a shift in claims costs from physician professional liability to hospital professional liability. From 2005 to 2009, the average number of employed physicians per hospital bed increased 12% annually.

Johnson advises risk managers to study their own claims in light of the patterns revealed by the Aon study.

"Risk managers should be aware of their own statistics and the underlying cost drivers. The premiums reflect losses, but they also reflect drivers in the marketplace like capacity, surplus, and competition; and that's one reason premiums have been flat or decreasing," he says. "But risk managers should be paying attention to frequency and severity of their losses as well, because ultimately that will drive their total cost of risk."

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Department redesign leads to cuts in LOS

Since North Oaks Health System redesigned its case management program and assigned its RN case managers by physicians, the average length of stay has decreased by a half a day, one-day stays have decreased to within state and national averages, and the readmissions rate has decreased by 43%.

"Denied days historically have been well below 2%. In 2010, they've decreased to about 0.5% of the total patient days. Our patient satisfaction scores consistently have us in the top 20% of hospitals in the nation. The physicians say this is the greatest thing the hospital has ever done for them," adds **Sherri Hayes**, RN, CCM, assistant vice president of case management at the 269-bed community hospital located in Hammond, LA.

Case managers and social workers were unit-based at the time the hospital started its redesign project in April 2004.

Under the reorganization, the case management umbrella includes acute care case management, emergency department case management, social work, utilization review, bed control, and a clinical documentation improvement program staffed by RN documentation specialists and an inpatient coder. The Recovery Audit Contractor (RAC) program coordinator also is assigned to the case management department.

The care managers are assigned by physician, and each care manager works with between one and five physicians, depending on the doctor's average daily census. They coordinate care for 100% of the patient population, regardless of payer, and assess patients for medical necessity every day.

Social workers are assigned by unit and work as a team with the care manager.

"This arrangement works well because both the care managers and the social workers know their patients well. The social workers can intervene on psychosocial issues and to set up post-acute services. Although one discipline is patient-based and the other is unit-based, there is a lot of gray area and the two disciplines work very well together, accomplishing team goals," Hayes says.

For a brief time, the hospital paired the social workers with the RN care managers, but moving them from unit to unit to implement a discharge plan proved difficult, Hayes says.

"The social worker was faced with working on one case at a time instead of batching work and

phone calls. They had to backtrack often, as they would receive a consult shortly after they had left a unit and have to return. Sometimes a difficult discharge plan could have them stuck on one unit all day, forcing them to get a co-worker to check on their other cases," she says.

When the new model first was launched, the RN care managers continued to perform utilization review.

"Logistically, that kept them in the charts more than with patients and physicians. We decided to utilize LPNs in that role with clerical support to help them," she says.

The utilization review staff conduct clinical reviews on patients covered by Medicaid, Medicare Managed Care, and commercial insurance.

Under the new model, case managers and social workers work primarily in the hospital on units, but have a suite of offices adjacent to the hospital. The care managers take cell phones with them on their rounds. The social workers have a computer and a phone with voice mail at their designated nursing units.

"We found that the cell phones improve communication between the care manager, physicians, and other staff because they are moving from unit to unit. This way, no one has to page them and wait for a call back. They can reach them immediately or leave a voice mail," she says.

Each morning, the RN care managers receive a print-out of all their patients, the admitting physician, the admitting diagnosis, the MS-DRG, the estimated length of stay, and any pertinent financial information, along with a notation if the patient has been readmitted within 30 days.

"This information helps the case managers identify which patients they need to see first," she says.

The case managers set their daily routine according to when the physicians they work with make rounds.

The majority round with the physician they're assigned to who has the largest case load. Then they round on their other patients they didn't see on the initial rounds.

"They keep track of the tests ordered for the day, call the physician back with the results, talk to family members, and arrange for consultations. Their focus is to move the patient through the continuum as smoothly as possible. This may mean getting the family together with the physician or talking with an ancillary department," she says.

When patients are readmitted within 30 days, the case managers conduct an in-depth assessment to determine what went wrong, using a tool to determine any contributing factors to the readmission.

The CM conducts an initial review and turns the case over to Hayes or the department coordinator. The administrative team and the medical staff receive reports on the readmission trends.

"If they feel the patient was prematurely discharged, that case goes back to the medical staff for review. If it's an incomplete discharge plan, we identify what we should have done on the previous stay. If noncompliance was an issue, we compile that information as well," she says.

When patients have been discharged after the readmission, the care manager makes a follow-up phone call to ensure they have met their discharge goals, that their prescriptions have been filled, and any needed equipment has arrived. The care manager makes sure patients have a follow-up appointment and answers to any questions or concerns.

All utilization data and delays in services are reported to the administrative team on a monthly basis. The administrative team and the medical staff receive dashboard reports on the average length of stay, readmissions, denied days, and case mix index.

In addition to the normal case management metrics, the administrative team also receives productivity data that include the volume of patients seen, reviews conducted, types of interventions, and other related information.

"We communicate constantly with our nursing department and the ancillary departments to ensure that the patients' needs are met in a timely manner," Hayes says.

"In addition, we communicate with our administrators to make sure they know the return on investment they are getting from this program, not only financially — but, equally as important — in terms of quality of patient care and physician relations," she adds.

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COMING IN FUTURE MONTHS

- Joint Commission setting National Patient Safety goals for HAIs
- Using workforce practices to drive quality improvement
- AHRQ unveils new pediatric quality measurement program

Websites providing easy-to-read info

Quick reference guide for PEMs

As a consumer health librarian at The Ohio State University Medical Center in Columbus, **Abigail Jones**, MLIS, MS, has become skilled at selecting websites that provide appropriate information for patients and families who may not read well or have low health literacy.

Following are a few of her favorites:

— MedlinePlus (http://www.nlm.nih.gov/medlineplus/all_easytoread.html)

This website has information on how to write easy-to-read materials in four steps. Information covers planning and research, organizing and writing the information, language and writing style, and visual presentation and representation. The health education documents written in this easy-to-read format are listed in alphabetical order.

— KidsHealth (http://kidshealth.org/

KidsHealth has three sections, with materials for parents, kids, and teens. "For low-literacy adults, I often use the kids' site, not the parent site," says Jones.

Categories in the kids' section include information on illnesses,injuries, and health problems and a medical dictionary. The parent section includes selections on general health, infections, emotions and behaviors, growth and development, nutrition and fitness, medical problems, first aid and safety, and medications.

— NIH SeniorHealth (http://nihseniorhealth.gov/)

Jones says this website is an excellent example of good design and layout. Topics can be accessed alphabetically. The site provides a printer-friendly version in its entirety on selected sections such as symptoms and diagnosis.

Buttons at the top of the page allow site users to enlarge the text, change text color, or hear the text read aloud.

— Health information websites

The Ohio State University Medical Center and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute has produced handouts that include guidelines for evaluating health information on websites along with a list of trustworthy and up-to-date sites for consumers.

These include the following:

— General health websites (http://medicalcenter.osu.edu/patiented/materials/pdfdocs/general/lhi-websites.pdf.) ■