# Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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# Network gives rural facilities strength in numbers

*Shared resources, benchmarking enable improved performance*

Thirteen rural hospitals in the state of New Hampshire decided several years ago to pool the funding of each hospital's Small Rural Hospital Improvement Grant Program (SHIP) funds to create a network for a QI initiative called the New Hampshire Critical Access Hospital, Quality Improvement Network (QIN). The goal of the collaborative was to overcome challenges common to small, rural hospitals, such as limited resources and data that make it difficult to implement successful initiatives on their own. The sharing of best practices and benchmarking was also seen as a potential benefit.

So far their "bet" appears to be paying off. "You see lots of examples of improvement," asserts **Andrew McClure**, who has served as project coordinator of the QIN for about six months. He points specifically to examples such as the average composite score for the Surgical Care Improvement Project (SCIP) measures from 2004 to 2010 and the average composite score for congestive heart failure (CHF) treatment.

"We struggled with influenza and pneumonia vaccinations," recalls **Sue Marshall**, QI director at Monadnock Community Hospital. "Some hospitals ended up putting their assessment of subsequent administration [of the vaccine] on patients' records to see if it had been done, and we had really not thought of doing that. By our involvement with the network it allowed us to see there was

## KEY POINTS

- Sharing funds enables facilities to hire QI consultant.
- Pooled information improves collection of quantitative data.
- Collaborative leads to improved performance by member hospitals.


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a better way to do it — and we made significant improvement in our scores." For example, she notes, her facility had been down around 60% for influenza vaccinations; its most recent reading was at 94%. "And pneumococcal vaccines were at 97%, simply by introducing one simple intervention," says Marshall.

"The network was talking about implementing a just culture, and it really helped me think about how to develop our program," adds **Sue Ruka**, vice president of quality improvement at Memorial Hospital in North Conway. "I met with one or two of the other hospitals, visited their facilities, and got a handle on how to do it."

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## Unique challenges

When it comes to implementing QI initiatives, small rural hospitals face unique challenges that practically make a network like the QIN a necessity, note McClure, Marshall, and Ruka.

"They face two key disadvantages," says McClure. "First, with the volume of care they deliver, a lot of traditional quality metrics apply to conditions that are seen on rarer occurrences, like pneumonia treatment or CHF, so there's a smaller sample size. The other challenge is they have tighter resources, so it's hard to have what's needed to do some of this work."

QI, he continues, depends on comparable data and comparable information. "If you're off on your own and measure yourself, unless you have something to compare it to, you do not know if you're good or bad," he explains. "The benefit of this collaboration is that you can learn from each other and compare results. You need sources of benchmarking and solutions — and this allows them to do that."

The pooling of the SHIP funds is also critical, he continues. "If you think about it, something like $9,000 per hospital is not enough to hire a person, but you could conceivably do it by pooling the funds — so, for example, I'm like a dedicated consultant to all of the hospitals."

What's more, he adds, even if the 13 hospitals were each able to hire their own consultant, they might be using 13 different approaches. "This way, we can make connections and share information," says McClure. In fact, he says, one of the first things he did was ask the hospitals to review a list of about a dozen topics he provided and tell him which they were really strong on and where they felt they needed help. "If someone needs help in one area, I can connect with a facility that's strong in that area and magnify the impact of my position," he explains.

"We all have to do more with less," says Marshall. "At the director/manager level, we have to wear a lot of hats, and we do not necessarily have a specific team or person for these projects." Personally, she shares, she has been interim vice president of nursing for several months, and also oversees utilization review.

"We all have to multi-task," says Ruka. "I'm vice president of quality, but I also am in charge of elderly services — I manage our elderly care facility — and infection control. Also, you want to look at things in a quantitative way, but we may

have only five patients for a single core measure. Even patient satisfaction is affected; we use Press Ganey, but we have to wait six months to maybe have enough data to make it meaningful."

## Addressing the challenges

Marshall says the network has definitely helped address some of these challenges. "The thing they most recently helped with is the HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) patient perspective survey," she shares. "Not all hospitals use outside vendors — we do not — so it's very time-consuming but cost-effective, but in doing that we want to make sure we're getting the biggest bang for the buck. QIN has offered us the opportunity to join with them in the IHI's HCAPS Passport Initiative. Every other week they do a collaborative that you can telephone into and be a part of."

In the "off" week, she continues, "we telephone into the rural health network and brainstorm — what will we take away, what works for us, and what does not. It's a tremendous opportunity to think outside the box we often get ourselves in. Through networking and sharing other tools and approaches, it has given us tremendous support to be able do more and do it better."

So, for example, "Working through the QIN, we realized that some hospitals help the patients understand, for example, what their discharge instructions mean," Marshall says. She notes that when the question was asked in the survey, patients indicated they did not really understand what was given to them.

"It has given us the opportunity to help understand where we may need to improve — and also explains what we need to do for them," Marshall continues. "We're trying to give them clearer language."

"It has definitely addressed the issue of resources," Ruka adds. "Andy has been great; if something has been updated or if there are new regulatory implications, he'll let us know. He's come in and done audits of our quality processes, and I can look at them and see where we're really doing well and where we can improve. He also arranges conference calls for sharing best practices."

## Facilitating collaboration

McClure says there are several different vehicles for sharing information. "Through the Foundation for Healthy Communities (which established the QIN), the New Hampshire Hospital Association, and the New Hampshire Quality of Care website, we facilitate collection of CMS core data and HCAPS data and have that posted on this public website, so we have comparative datasets to use," he explains. "Also, through the association we have focused on hand hygiene and developed an assessment tool. In terms of surgical timeouts and checklists, we've collaborated with the World Health Organization. In all instances we share our data."

His regular assessments have also led to collaborative change, he notes. "As I was doing my credentialing assessment, I got the sense we were not consistent in primary source verification processes," he shares. "So we developed a credentialing consensus document — how you should verify credentials. Through a collaborative session we agreed it should be done during initial hiring and for re-credentialing."

"The benchmarking we currently use to compare one another for HCAPS is through the Hospital Quality Alliance," says Marshall. "We all submit data into this repository, and through the public reporting initiative we can look and see how well we've done as compared with state and national averages."

In terms of evidence-based medicine, data on heart attacks, pneumonia, heart failure, and surgical care is all data shared, she says, enabling facilities to compare themselves to one another. "The hospital association, along with the state QIO, does a state report and lets us see where we're at, so we do not have to be lumped into the national data," she explains.

"We've had a couple of conference calls around surveys on areas we might feel really strong in, and sharing that with others where we feel we can be helpful," adds Ruka. "One thing we're working on is a disclosure policy — transparency — and Andy said we were working on something that's a bit unique that was already on his mind, and asked if we wanted to talk to others about it."

McClure adds that the collaborative has given participating facilities more confidence in their ability to deal with QI challenges. "They really wanted to do a good job but they were insecure," he notes. "Now, as long as they follow the collaborative data, they'll know they're doing the same things as 12 other hospitals in New Hampshire."

This should help them with the whole QI process,

he continues. "If each hospital hired their own consultant, they would have gotten variable information and would not have been as confident they were doing the same things as other hospitals," he notes.

The good news for other rural facilities across the country, he says, is that the QIN model is replicable. "It absolutely is," he asserts. "It just takes someone to facilitate the collaboration, and as long as the hospitals are interested in working together and sharing information they can do it."

"It's absolutely good for rural states and can be done anywhere," adds Ruka. "You just have to have that resource to go to, that person who can say 'This hospital has dealt with this problem already; let me check with them.' You feel so isolated; this clearinghouse is very helpful."

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# A variation on rapid response theme

*Program focuses on non life-threatening issues*

Spectrum Health, based in Grand Rapids, MI, has introduced a successful patient safety program called "Condition Concern" that its proponents say offers a unique approach to patient and family involvement in expressing concerns they have about care. The program was described in a recent article in the *Journal of Nursing Care Quality*.[1]

What makes the program so different is that when concerns are expressed, they are not relayed directly to the rapid response team, as in other facilities, but rather to an administrative associate manager (AAM), or house supervisor, via an emergency phone number provided to patients and family. The AAM then determines whether emergency medical care is required by the rapid response team, or whether the situation is something that can be addressed by another type of intervention — which often resolves the problem "on the spot."

In fact, notes **Sylvia K. Baird**, RN, BSN, MM, nursing quality manager and lead author of the article, "As of the end of December we have had about 140 calls and of those calls, 76%-78% are resolved immediately."

## NPSG lends impetus

One of the dynamics that led to the creation of the program was The Joint Commission's National Patient Safety Goal 13, which encouraged patients to participate in their own safety. "Sylvia and I were having a conversation about the goal," recalls **Lynn Bobel Turbin**, MSN, RN, CCRN, NE-BC, director of adult critical care, and a co-author of the paper. "There was minimal literature available on the topic to guide us, but I did go to an IHI symposium, and one of the sessions talked about what one hospital (Virginia Mason in Seattle) did with rapid response teams and patient and family concerns."

However, adds Turbin, who also runs the rapid response team program, "We had also done some process improvement with our rapid response team, and we were reluctant to use that vehicle as the one to respond to patient and family concerns. We wanted them available, but not initially."

"We did not know what types of calls we'd be receiving," adds Baird. "We wanted to gather some information [before alerting the rapid response team]; we only wanted the rapid response team to respond to serious clinical events requiring immediate intervention."

In looking at programs like the one at Virginia Mason, she notes, most of the calls initiated by patients and family did not involve life-threaten-

### KEY POINTS

- House supervisor assigned responsibility as initial responder to patient, family concerns.
- All department heads are provided an information packet to help them implement the program.
- More than three-quarters of problems reported have been resolved immediately.

ing issues (the data from their own program has shown a similar pattern). "Our goal was to set up a mechanism where they'd be involved in their care, and given a voice," Baird explains.

So, a task force was formed to decide the best approach to take. "We decided on having the clinical house supervisor as the first responder to a Condition Concern alert; they are RNs," notes Baird.

"One of the members of the task force was the head of patient relations, and she and her members had received some calls [from patients and family members], so that gave us information on what these calls happened to be, and where they should go first," adds Turbin, who led the task force. "We knew that most places that had operationalized this approach used a rapid response team as that first responder, but we wanted to test the waters and not 'go for the gusto' immediately — and the data has confirmed we were right."

But before the program could be launched, it had to be "sold" to hospital leaders, including several quality committees, through a series of meetings and PowerPoint presentations. "We presented to the hospital board, quality, lay people, professors, administration, and physicians," says Baird. "We presented back into our clinical quality improvement committee, the executive quality committee, which reports up to the board, and clinical relations."

### Paving the way

The task force developed an information packet for each of the clinical areas, says Turbin. "Each included a 'to-do' checklist for managers, and scripts we developed for meetings; we wanted staff to tell patients about the program during orientation," she explains. "We had a brochure in the welcome packet and signage in the rooms that instructed patients to call the alert number if they had concerns they felt were not being addressed by their primary providers."

The program was implemented in July 2009. "When the AAM gets a complaint, they go to the unit and have a dialogue with the staff; they tell them they've just received an alert from 'so and so,' and ask if they know why they may have called," says Turbin. "Sometimes they do, but other times they don't."

Then she continues, the AAM decides who shall accompany them to talk with the patient. "A majority of the time they do it independently," says Turbin.

"Most of the time these issues can be resolved immediately," adds Baird. "In some case they might just want more discussions with the doctor, so the AAM facilitates that, or they may not be satisfied with their pain control, so they'll work with the nurse and the doctor."

Baird says she is pleased with the results to date. "I believe we have provided a mechanism for patients and family to have another voice, and we're extremely pleased that those things they're concerned about are things that can be problem resolved on the spot," she says.

Of course, not all such problems can be resolved, and there have been a few cases where the complaints were not satisfied, notes Turbin. "Someone may have wanted access to a medical record that did not have permission to get it, or they saw an episode of 'Grey's Anatomy' where a patient with a similar condition had surgery and the patient wanted it too, but in their particular presentation it was not indicated," she says.

Turbin is convinced this program can be replicated at other facilities. "So many institutions have [clinical] management folk around all the time," she notes. "If they do not have them during the day, they have some sort of house supervisor, and with that staff population it's certainly doable."

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# Medicare deaths report cites fatal infections

*CMS says "aggressive action" coming*

A recent federal report that included the highly publicized finding that some 15,000 Medicare patients die every month due to adverse events and hospital-acquired conditions (HAC) may ratchet up pressure on hospitals to prevent infec-

tions, which represented some 15% of the HACs. In addition, hospital care associated with adverse and temporary harm events cost Medicare an estimated $4.4 billion annually, the report by the Department of Health and Human Services' Office of Inspector General (IG) estimated.[1]

The IG report urged action by the Center for Medicare and Medicaid Services (CMS), noting that based on the findings the "CMS stated that it will 'aggressively pursue' broadening the scope and definition of patient safety efforts to be more inclusive of various types of adverse events and more closely monitor and address hospital quality of care."

That could mean more pressure on reducing HAIs in the form of withheld CMS reimbursements, but the IG report also acknowledged that not all infections are preventable.

"I don't know how it is going to [affect] policy, but I think that this is in line with what many of us already feel," says **Eli Perencevich**, MD, MS, an epidemiologist at the University of Iowa Healthcare in Iowa City. "Basically the report suggested that some of the medical errors are hospital acquired infections and a certain percent of those — some 60% — were preventable.

However, since the report was based on extrapolated data, only 19 infections (three of which were fatal) were actually subject to analysis, Perencevich notes. That makes any broad extrapolations about preventability somewhat suspect in any case, but the bottom-line is that HAIs and other adverse events must be reduced to the extent possible.

"The key thing is that errors are still occurring in hospitals," he says. "Too many are occurring and more efforts need to be made. They found 134,000 adverse events in a single month — that's obviously too many. A subset of those — only 15% of the errors — were attributable to infections."

In general, the report focused on adverse events defined as harm to a patient as a result of medical care, including HACs such as catheter-associated urinary tract infection, vascular catheter-associated infection, blood incompatibility, pressure ulcers and falls. The report included adverse events from relatively minor patient glycemic control problems to serious events that prolonged hospital stay, or caused permanent harm or death. The fatal infections cited included two bloodstream infections and a ventilator associated pneumonia.

The reports used a nationally representative random sample of 780 Medicare beneficiaries from all beneficiaries discharged during October 2008. An estimated 1.5% of hospitalized Medicare beneficiaries experienced events that contributed to their deaths. Among the 128 adverse events that we identified in the sample, 12 events (9% of 128 events) contributed to the deaths of beneficiaries. That projects to an estimated 1.5 % of hospitalized Medicare beneficiaries experiencing events that contributed to death or approximately 15,000 beneficiaries during the study period. In addition to the aforementioned fatal infections, seven patient deaths were related to medication, either the result of improper administration of medication (wrong drug or wrong dosage) or inadequate treatment of known side effects. The most common type of medication-related death (five deaths) involved excessive bleeding from blood-thinning medication. The two other medication-related deaths involved inadequate insulin management resulting in hypoglycemic coma and respiratory failure resulting from over-sedation. Two patient deaths involved aspiration, which led to pneumonia in one case and cardiac arrest in another.

Overall, the IG report used physician reviewers to conclude that 44% of all events were preventable and 51% were not preventable. (For the remaining 5% of events, physicians were unable to make determinations.)

"Events related to surgery or procedures were less likely to be preventable than other types of events, such as hospital-acquired infections," the report concluded. "Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment. Physician reviewers assessed events as not preventable when they occurred despite proper assessment and care or when the patients were highly susceptible to the events due to health status."

Because many adverse events we identified were preventable, hospitals must reduce their incidence, the IG concluded. "A number of agencies within HHS share responsibility for addressing this issue, most prominently the Agency for Healthcare Research and Quality (AHRQ) as a coordinating body for efforts to improve health care quality and CMS as an oversight entity and the Nation's largest health care payer."

## Recommendations for action

The IG report recommended the following:

• AHRQ and CMS should broaden patient safety efforts to include all types of adverse events. This broader definition would apply to a number of activities, including setting priorities for research, establishing guidelines for hospital reporting, developing prevention strategies, measuring health care quality, and determining payment policies.

• AHRQ and CMS should enhance efforts to identify adverse events. Identifying adverse events assists policymakers and researchers in directing resources to the areas of greatest need, setting clear goals for improvement, assessing the effectiveness of specific strategies, holding hospitals accountable, and gauging progress in reducing incidence.

• AHRQ should sponsor periodic, ongoing measurement of the incidence of adverse events.

• AHRQ should continue to encourage hospital participation with Patient Safety Organizations, entities intended to receive adverse event reports from hospitals, and forward the information to a national AHRQ database.

• CMS should use Present on Admission Indicators in billing data to calculate the frequency of adverse events occurring within hospitals.

• CMS should provide further incentives for hospitals to reduce the incidence of adverse events through its payment and oversight functions.

• CMS should strengthen the Medicare HAC policy, such as by expanding the policy to include more events that harm beneficiaries.

• CMS should look for opportunities to hold hospitals accountable for adoption of evidence-based practice guidelines.

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# Wound care program keeps patients safe

*Health plan collaborates with vascular surgeons*

A team-oriented approach to working with members with non-healing wounds has paid off for UPMC Health Plan and its network providers.

In April 2010, the last period for which data are available, almost 89% of non-healing wounds achieved optimal healing response within eight weeks, says **Roseann DeGrazia**, RN, BSN, MEd, senior director, medical management for the Pittsburgh-based health plan.

The UPMC Wound Care Program is a collaborative effort between UPMC Health Plan, University of Pittsburgh Physicians Division of Vascular Surgery, the UPMC Center for Quality Improvement and Innovation, UPMC/Jefferson Regional Home Health LP, and the UPMC Wound Healing/Limb Preservation clinic.

The project's goal is to increase the healing rate of wounds and increase quality of life for members with non-healing wounds, DeGrazia says.

"As a health plan, we work collaboratively with our network providers on ways to improve care for our members. One of the areas we're interested in is wound healing. We decided to work with our vascular surgeons and the home care agency to manage members with chronic, non-healing wounds," she adds.

Members who have non-healing wounds with a duration of four weeks or longer are eligible for the program. The program is designed to facilitate state-of-the art treatment for chronic wounds in the home care setting. Wound care specialists and UPMC Health Plan wound care case managers collaborate with the member's primary care physician on a treatment plan for the patient's wound. UPMC vascular surgeons review the wound information and treatment plan and offer suggestions to the treating physician.

"The goal of the program is to increase the healing rate by 50% in four weeks. If patients are on a healing trajectory after four weeks, the results will show. If not, the physician can change the treatment plan," DeGrazia says.

The health plan identifies many members for the program when they are hospitalized with non-healing wounds as a primary and secondary diagnosis. Other referrals come from physicians, home health agency nurses who are treating a different condition, and UPMC's case managers who may be working with members for a different reason and learn that they have a non-healing wound.

When a patient is referred to the program, **Lori Painter**, RN, BSN, CCM, wound care case manager for UPMC health plan, accesses the patient record and compiles a thorough medical history including medications and any co-morbidities.

The health plan has an integrated system, which allows the case manager to access utilization management information in the hospital, clinical data from claims, laboratory data and lab results, and

pharmacy data, including what drugs were prescribed and when the patient filled them. Painter can leverage the information to help engage patients, DeGrazia says.

More than 40% of patients in the program have diabetes. Others have peripheral vascular disease or other conditions that compromise their blood circulation.

Painter calls patients referred to the program, finds out if they are interested in enrolling in the program, and if so, arranges for a specially trained wound, ostomy, continence nurse (WOCN) to visit the patient in his or her home.

"I do a thorough history of their social system. I find out if they have significant others or friends in the community to help care for them and if they live in an area where they have difficulties getting to their physician office," she says.

The program is optional for patients. If they opt out when Painter calls, she gives them information and the program phone number. If the patient ends up back in the hospital for wound treatment, then Painter initiates another outreach call.

"If the primary care physician recommends the program to patients, they're more likely to participate. We work closely with the primary care providers to keep them informed about the program, publishing information in our provider newsletter and attending their meetings," DeGrazia adds.

The patients have the option of having a home care visit, talking to the nurse, and then opting out of the program, but most choose to stay in the program, DeGrazia adds.

"We take a high-touch approach to wound care. Our patients are very satisfied with the program," she says.

Specially trained enterostomal nurses employed by the home care agency assess the patient in the home, then visit every two weeks, or more often, depending on the wound.

The nurse takes measurements and photographs of the wound and performs a Doppler study on the first visit to determine if vascular problems may be interfering with the healing. If so, she contacts the patient's primary care provider for a referral to a vascular surgeon in order to facilitate early intervention.

The nurse uses a special wound care photo information form to record the type of wound, the height and depth, type of drainage, and the treatment protocol, DeGrazia says.

The wound care nurse sends photographs and measurements of the wounds every few weeks to Painter, the primary care physician, and the vascular surgeons group, which oversees the program, DeGrazia says.

The UPMC vascular surgeons review the wound photo information form to assess the progression of healing and offer recommendations for change to the wound care protocol as needed, she says.

The primary care physician is responsible for the management of the patient and takes into consideration the input from the wound care photo information form, the home care WOCN nurse, and the wound care reviewing vascular surgeon. Changes to the wound care treatment protocol are made only as ordered by the primary care physician, she says.

If the wound doesn't improve within a certain time, the reviewing vascular surgeon may recommend a change to the wound care treatment as per the protocol, DeGrazia says.

Painter is involved in transitioning patients from the hospital to home, enrolling the patients in the program, and letting them know when the home care visit is scheduled.

She collaborates with the WOCN nurse to make sure the patient understands everything he or she needs to know for self-care, such as how and when the dressing should be changed and what medication should be applied in between visits from the nurse, she says.

She makes sure the patients understand their condition and their discharge instructions and answers any questions they may have. In some cases, she may need to clarify the treatment plan with the physician, she says.

She communicates with the home care agency nurse by telephone and by e-mail and calls patients frequently, usually weekly or bi-weekly depending on the patient's preferences and condition.

When she calls patients, Painter conducts a medication review, making sure the patients got their prescriptions filled, going over the medications and when and why they should be taken, and helping patients understand why they may need to take multiple drugs, she adds.

If the patient has diabetes, she educates him or her on the disease process and enrolls him or her in the health plan's diabetes program.

"I educate them on the importance of checking their blood sugar and taking their medication as directed. I explain that elevated blood sugar can cause healing to slow down and make sure they are getting enough protein in their diet to help with healing. If they are having trouble control-

ling their blood sugar, I contact the primary care provider to discuss treatment, including the need for further evaluation by a diabetes specialist," she says.

"The wound care case manager is the key contact for the patient while the patient is in the program. When the wound heals, she transitions the patient to a disease management health coach for ongoing support in keeping his or her diabetes under control," DeGrazia says.

Managing the care of the patients is a team effort, Painter points out. "If I find patients are having difficulty getting in to see the doctor or have problems paying for their treatment, I can get the health plan's social worker involved. The pharmacist who is embedded in the care management department is available to conduct a medication review or assist with pain management," she says.

If the patient is having trouble with general medical care, Painter can call on the health plan's mobile case manager to go into the home and assess the situation.

"I have a network of people I can call on to enhance the quality of life for these patients. We work as a team to look for ways to avoid repeat admissions and complications including pain management issues," she says.

She conducts a depression screen on all the patients and refers appropriate patients who agree to the health plan's behavioral health program.

For instance, one patient who was facing an amputation told Painter he was afraid and didn't think he could handle losing his limb. She called in the home care behavioral health nurses who visited him in the home and helped him learn to cope with the changes to his daily life.

The wound care team takes a holistic approach to treatment, Painter says.

"At UPMC, our job is not just to take care of the wound. We try to involve the patient, the whole family or caregiver, and the community in helping people maintain their health," Painter says.

For instance, when Painter called one patient to remind him of his appointment with a vascular surgeon, the man told her he couldn't go because he was out of colostomy supplies. Painter called the home health agency, which put out a bulletin to the nurses serving the patient's area, and one of them brought extra colostomy supplies to the patient's home.

The wound care nurses and Painter meet at least quarterly and discuss the individual members enrolled in the wound care program wounds. The team addresses any barriers to healing. The team meets regularly with the vascular surgeons to go over the patient records and treatment plans.

"As a payer, we have a lot of information that can be useful to the integrated care team. We know the utilization data, including claims, and pharmacy data. In addition, our case managers and social workers know the psychosocial history of these patients and can collaborate on the plan of care during case conferences," DeGrazia adds.

Members of the wound care team get to know each other very well and are very familiar with the patients, their wounds, their treatment plans, and their progress, DeGrazia says.

The team reviews the wound care protocols annually to determine if there are new products or new treatments that may benefit the patients, she says.

Patients are discharged from the program when their wound is healed. The case manager gives discharged patients a number to call in case they have any problems.

Before starting the program, DeGrazia, Painter, network managers, a representative from the home care agency, and one of the vascular surgeons met with provider groups who have the highest volume of UPMC Health Plan members, educated them about the program, and asked them to refer their patients who have non-healing wounds to the program, DeGrazia says. ■

# Is your OR holding out against sharps safety?

*Surgeons, nurses push for safer devices*

Amid the successes in sharps safety in hospitals in the 21st century, there is one glaring gap: the operating room. Sharps injuries there remain as much of a problem as they were in 2000, when the Needlestick Safety and Prevention Act was signed into law. Needlesticks could put your facility at risk for costly lawsuits, particularly if safety devices are not being used.

Safety advocates, including some surgeons who have emerged as sharps safety champions, are hoping that the momentum is finally beginning to change.

"We do now have a critical mass to make some change," says **Ramon Berguer**, MD, FACS, chief

of surgery at Contra Costa Regional Medical Center in Martinez, CA. "We have the data. We have second-generation devices that are well-made and well-marketed. We have the endorsement of leading surgical associations."

The American College of Surgeons (ACS) endorsed blunt suture needles, double-gloving, using a neutral zone for passing instruments, and other safety devices in the OR, although adoption of those safety efforts has been slow.

Berguer, a member of the ACS Committee on Perioperative Care, has been a vocal proponent of sharps safety in the OR. With Janine Jagger and Elayne Kornblatt Phillips of the International Healthcare Worker Safety Center, he co-authored an analysis of sharps injuries at 87 hospitals around the country from 1993 to 2006. It showed that sharps injuries actually rose by 6.7% in the OR while they declined by 31.6% elsewhere in the hospital.[1]

That information might be a turning-point in the effort to improve sharps safety in the OR. "It was very sobering," says **Linda Groah**, RN, MSN, CNOR, NEA-BC, FAAN, executive director and CEO of the Association of periOperative Registered Nurses (AORN). It caused the association to question, "What can we do to enforce the practices that we know make a difference?" she says.

AORN recently issued "A Call to Arms to Prevent Sharps Injuries in our ORs" through its AORN Journal.[2] The association also plans to release a toolkit for reducing OR sharps injuries, which will be available on the web site (http://www.aorn.org/PracticeResources/ToolKits).

Two-thirds of sharps injuries in the OR are incurred by nurses and surgical technicians, according to data from the center's Exposure Prevention Information Network (EPINet). Berguer says, "Decisions made by one member of the team affect the risk of other members of the team. To me, that's the key leverage point I'm taking to my colleagues."

*(For more information on how to address needlesticks within your facility, see story, right.)*

REFERENCES

1. Jagger J, Berguer R, Phillips EK, et al. Increase in sharps injuries in surgical settings versus nonsurgical settings after passage of national needlestick legislation. *J Am Coll Surg* 2010;210:496–502.

2. Guglielmi C. A call to arms to prevent sharps injuries in our ORs. *AORN J* 2010;92:387-392. ■

# Do you have a policy targeting needlesticks?

*Needlestick toolkit being developed*

Sharps safety in the OR needs to be an institutional mandate, says **Ramon Berguer**, MD, FACS, chief of surgery at Contra Costa Regional Medical Center in Martinez, CA. It may be expressed in a policy that is developed by OR leadership, including the OR manager and chief of anesthesia, Berguer says.

"The OR is a service center that physicians contract with. They have a right to regulate their workplace safety," he says.

If sharps safety becomes a commonplace policy in hospitals, then surgeons will have no choice but to adapt, Berguer says.

A needlesticks toolkit being developed by the Association of periOperative Registered Nurses (AORN) will include a sample policy. Healthcare leaders need to "embrace this issue," says **Linda Groah**, RN, MSN, CNOR, NEA-BC, FAAN, executive director and CEO of AORN. That means setting expectations for safety and taking a close look at the OR injuries, Groah says. "If there continue to be sharps injuries [after adoption of a policy], I think ultimately there needs to be critical analysis of why those injuries occurred," she says.

If a surgeon continually fails to follow facility policy on safe practices, such as maintaining safe zone for passing instruments, leaders should follow through by curtailing privileges, Groah says.

Outside enforcement is unlikely because the Occupational Safety and Health Administration (OSHA) rarely inspects ORs, unless there is a complaint. But OSHA does expect health care facilities to be using some safety devices, including blunt suture needles in the OR, says senior industrial hygienist **Dionne Williams**, MPH. "We know there's a lot of evidence showing blunt sutures are capable of being used for certain kinds of closures," she says.

Managers can play a role by sharing sharps injury data and educational material with OR staff and physicians. Acting often as independent contractors, surgeons aren't necessarily aware of the hazards and how they can be reduced, says Berguer. "I don't think it's clear for many surgeons what the problem is and why they should change," he says.

An OR sharps safety policy at Contra Costa Regional Medical Center mandates the use of hands-free passing and of safety-engineered scalpels.

The hospital strongly encourages the use of blunt suture needles and double gloving, says Berguer.

### Blunt suture needles

He has switched to blunt suture needles, which are now more widely available in a variety of sizes. While Berguer once had needlesticks about twice a year, he says he hasn't had a needlestick in three years.

"There is an initial increase in pressure that is required to penetrate the tissue [with blunt suture needles]," he says. "As with all safety measures, there's a minor inconvenience. I personally like it because it reminds me that I'm using a safe device."

Berguer believes that the safer sharps eventually will be like other safety initiatives that took time to gain acceptance but eventually became the standard. "The data is so overwhelming it would be very hard to make any rational argument against it," he says. ■

# AHA has new award for leaders in HC quality

The first Dick Davidson Quality Milestone Award for Allied Association Leadership will be presented in July, 2011, by the American Hospital Association (AHA) of Washington, DC.

The new award will recognize state, regional and metropolitan hospital associations' leadership in improving health care quality.

It will be presented annually to a hospital association that demonstrates leadership and innovation in quality improvement and contributes to national health care improvement efforts. The first award will be given at the 2011 American Hospital Association/Health Forum Leadership Summit in July.

The award is named for AHA President Emeritus Dick Davidson who strongly promoted the role of hospital associations in leading quality improvement during his tenure as president from 1991 to 2006 and as president of the Maryland Hospital Association (MHA) from 1969 to 1991. During his time at MHA, the organization was recognized nationally for its work on the development of clinical quality indicators which allowed hospitals in Maryland for the first time to measure and compare quality of care.

### Goals of the award

The goals of the award initially are to:

- recognize outstanding efforts among state, regional and metropolitan hospital associations to improve hospital quality of care;
- encourage hospital associations to play key roles in raising the level of hospital and health system performance to achieve care that is safe, timely, effective, equitable, efficient and patient-centered;
- and to share ideas and efforts toward health national health care improvement that are being promoted by hospital associations.

A multidisciplinary award committee will review all applications and select the award recipient, with the AHA Board of Trustees providing final approval.

Jonathan B. Perlin, M.D., PhD, an American Hospital Association board member, will chair the committee, which will include hospital association executives, hospital and health system clinical and operational leaders and a representative from a national non-AHA organization involved in quality and performance improvement.

Information on the award and how to apply is available on the American Hospital Association's website at www.aha.org. ■

## COMING IN FUTURE MONTHS

- Pay for performance fails to boost hypertension care or outcomes
- Study questions clinical claims, cost efficiencies of eHealth technologies
- Proposed CMS rule would give patients greater access to QIOs

# Doc, can you read this?

*Data helps to improve physician legibility*

At most hospitals, the vast majority of physician orders are still written by hand. That means a lot of hurried squiggles that no one can decipher, and time-wasting phone calls to clarify the order, not to mention the threat to patient safety.

But St. Rita's Medical Center in Lima, OH, found that if you have the data to prove which doctors have the worst handwriting, you can cut the clarification phone calls by 40%.

A recent report found that only 14% of all U.S. hospitals are entering at least 10% of orders electronically — the level of computerized physician order entry required to reach the federal government's proposed standard for Stage 1 of meaningful use.

The legibility of these orders can be a problem that is more pervasive — and more of a threat to patient safety — than most hospitals realize, says **Herbert Schumm**, MD, St. Rita's vice president of medical affairs.

According to the Agency for Healthcare Research and Quality, poor penmanship is responsible for an estimated 6% of all hospital medication errors.

To address this issue, St. Rita's used its communication and analytics system to document and measure incidents of illegible handwriting. For defined periods of time, the phone system prompted callers to indicate when they were calling to clarify an illegible order. The system captured data on where the order was received and who wrote it.

The system then compiled this information into reports for the Patient Safety Steering Committee.

"We sat down with about four or five doctors and showed them the number of calls that were made to clarify their orders," Schumm says. "We also reminded them to use pre-printed order sets whenever possible, and we explained that if they work on legibility, they can cut down on the calls they're getting for clarification. Everyone wants fewer calls."

The analysis showed that, during the first three months of the study, an average of more than 80 calls per week were made to clarify orders. On two subsequent analyses, after discussions with some of the doctors, the average was only 53, a drop of more than 40%. ■