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ICD-10 timetable: Readiness assessments should be complete

Are you ready for the big change?

Most people have trouble planning the next week's dinners or their next vacation, let alone something that is two and a half years away. But experts say that healthcare organizations need to be done with their readiness assessments for the upcoming change from ICD-9 coding to ICD-10 and moving on to the next phase of implementation.

"You should have a team in place and know the big picture for your organization," says Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources with the American Health Information Management Association (AHIMA). A coder with years of hands-on experience in hospitals and other settings, as well as a teacher of prospective coders, DeVault says hospitals need to go look at every department and its personnel, consider whether those staff members enter, trigger, or use ICD codes, how that happens, if they will be affected and what they need to know to succeed with the new code sets, PCS for procedures and CM, or clinical modification codes. "All of those people need to be educated on what ICD-10 is and how it will impact each of them."

For example, coders will need hands-on training for the differences, but for information technology staff, it is more important to look at every single program that will be affected by the change and whether various software vendors are working on new products or upgrades that will make your systems compatible with the new coding.

AHIMA's own checklist includes 13 things that should be completed already in the first phase (*to see the full checklist, go to <http://ahima.org/downloads/pdfs/resources/checklist.pdf>*). Second-phase readiness should be starting around now, DeVault says. That involves preparation for implementation, such as ensuring computer systems will have appropriate updates or evaluating new systems. This phase should be complete by the beginning of 2013. The last nine months of the process is preparation for going live on Oct. 1, 2013.

Currently, the Centers for Medicare & Medicaid Services (CMS) says that date is firm, even if some are arguing that it should be delayed. "This will happen," DeVault says. "If you work on the presumption of some sort of delay, you will not be ready."

Among the simple steps you can take now to prepare are:

- improving coder skills in anatomy and physiology. DeVault says she was surprised at how much more she needs to know to be an efficient coder using the new sets. “ICD-9 allows us to be just okay in those areas, but with 10, you need a much more in-depth knowledge.” She uses the

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Editorial Questions

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example of a Bill Roth II procedure. In the old PCS code set, you could look up the nick-name. But now, you need to know it is a resection of the stomach with a bypass to the small intestine. “I had to bone up on my cardiothoracic anatomy.”

The codes are logical, but knowing how a bypass graft looks and how it happens will help make the transition smoother. CMS acknowledges that productivity is likely to suffer for the first six to nine months. But if you prepare, DeVault says that decline in productivity may be shorter, particularly if you make sure you are caught up by the time the go-live date hits. In the end, she thinks the new codes will have a positive impact on reimbursement through enhanced accuracy and more specificity. This will ensure that every procedure is not down-coded because someone does not know enough about anatomy to make the right choice.

- If you are using or planning to use a computer-assisted coding project, now is the time for investigating new programs and beta-testing them, says DeVault. She talks about the benefits for some of the coding procedures that are done over and over again. Think about patients who come to the anticoagulation clinics every month, for instance. DeVault notes that coders working on those cases use the same codes over and over again. “That is just data entry, and computer-assisted coding can eliminate that drudgery.”

- Introduce coders to the guidelines. The CM set is very similar to the existing set and makes a lot of sense. DeVault likens it to learning Italian if you already speak Spanish. But PCS is like a different language altogether, she says. “It will eventually make sense when you apply it, but at first, it just seems strange.” Tell coders about the seven characters of the PCS codes and what each means.

- At every monthly department meeting, set aside time to talk about the new coding system. Talk about the concepts, about what the changes will mean. As they get more comfortable, you can take a particular case and go through it using the old and new sets to see the difference. “You have to think about life in the world of ICD-10. Denial is not an option anymore,” DeVault says.

- Pass on your concerns. When you find something that does not make sense, let the people at CMS know. DeVault says that there are things that have been changed because early users have raised concerns. While the nuts and bolts will not change, the codes are changing because it will be better for healthcare. The people in charge are willing to listen to complaints and address them if

required.

George Argus, senior director, health data management for the American Hospital Association (AHA), says that most hospitals are happier about the changes than other stakeholders. For example, the Medical Group Management Association (MGMA) has complained about the cost for solo and small practices in particular.

“I’m sympathetic to those who do not like the idea of the changes, but ICD-9 has outlived its usefulness, especially on the procedure (PCS) side,” he says of the 30+ year old codes. “There are areas that can no longer enumerate procedures and services anymore, so codes are manipulated or things just are not classified correctly.”

The work can be frustrating, but greater precision is needed, says Argus. “We want a system where people can report exactly what is taking place according to disease, illness, and procedure and can then develop comparative data which will let researchers and others refine protocols, reimbursement rates, and individual and facility performance.”

Hospitals not where they need to be

Argus thinks that hospitals are not, as a whole, where they need to be. And it is not just smaller or rural facilities that are lagging. There are some bigger hospitals that have yet to complete their assessments and move on to subsequent phases. Often, they have many different computer systems that have to be evaluated, which can slow them down. Meanwhile, there are small facilities that are already all over the change.

One thing that the AHA is working on is getting the national coordinator of health information technology and CMS to push back some of the Stage II requirements for meaningful use so that those requirements do not collide with ICD-10 implementation. “We’d like the former pushed back past the Oct. 1, 2013, date,” says Argus.

For now, hospitals need to define which computer systems are mission critical for Oct. 1, 2013, and ensure they are ready. “Develop a billing instrument for ICD-10 by then or you risk not getting paid,” he says.

Then identify all the systems that have to be changed and begin prioritizing, Argus recommends. If they are your own house-built systems, get to work on them now. If they are from vendors, start asking questions about upgrades and new programs. You’ll want to test them well

before October 2013.

While AHIMA talks a lot about coders getting ready, Argus mentions the importance of talking to physicians and making sure they are aware of the changes. “Find materials appropriate for physicians and develop a training program process.” Physicians need to understand how this will impact them, he continues. “Physicians need to know that their task is to provide really good documentation. They need to be very specific on the procedure side.” For example, PCS changes include specifying laterality of body — what you do on the right side will code differently from the same procedure on the left. “This is not complex,” he notes, “but it is something that will have to become habit.” Argus thinks that with practice, everyone will learn to love the new code sets. “The greater specificity should mean better reimbursement,” he says. “The more complex the case, the better pay you’ll get. And it should not have a great impact time with patients because there are tools out there that should help you to zero in on the most appropriate coding.”

Like Argus, DeVault believes in the new system and its potential. “After two years with my hands in it, I think it is great,” she says. “I get bothered when people say they will retire before the implementation, because we will lose so much leadership and experience. That experience will translate. They will get used to it, and while I do not expect a whole bunch of cheerleaders, they should understand that we can get through the change.”

ICD-10 CONVERSION RESOURCES

Here are some helpful resources for ICD-10 conversion information, including courses, seminars, webinars, and updated documentation:

- Centers for Medicare & Medicaid Services: www.cms.gov/ICD10
- American Hospital Association: <http://www.ahacentraloffice.com/ahacentraloffice/index.shtml>
- Centers for Disease Control and Prevention: <http://www.cdc.gov/nchs/icd/icd10cm.htm>
- Medical Group Management Association: <http://www.mgma.com/policy/default.aspx?id=28420>
- American Health Management Information Association: <http://www.ahima.org/icd10/default.aspx>

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TJC can accredit psych hospitals, says CMS

The Joint Commission can start accrediting psychiatric hospitals, the Centers for Medicare & Medicaid Services announced in late February 2011. The approval, which lasts for the next four years, will allow psychiatric facilities to seek deemed status on a voluntary basis. It is not required for those hospitals seeking Medicare approval, and they may be surveyed by another accredited body or state surveyors. ■

Proposed CMS rule may impact hospitals

The Centers for Medicare & Medicaid services published a new proposed rule related to patient notification of right to access survey agencies and Medicare beneficiary notification of the right to access quality improvement organizations. Published on Feb. 2, 2011, the proposed rule for providers and suppliers requires that they let patients know they can file complaints with the quality improvement organization in their state.

The proposed rule says that they have to give Medicare beneficiaries written information on how to contact the quality improvement organization. In addition, they are proposing that some Medicare providers and suppliers may have to inform every patient about the appropriate state quality agency and provide contact information.

Comments are requested by April 4, 2011. The entire rule can be seen at <http://edocket.access.gpo.gov/2011/pdf/2011-2275.pdf>. ■

Bridging the gap between ED and PCP

Reform puts problem area on front burner

There are literally dozens of studies that enumerate some of the problems that plague patients as a result of imperfect transitions of care. According to the National Institute for Health Care Reform (NIHCR), there will be an additional 32 million insured people by 2019, many of whom will seek care in hospital emergency departments (EDs). That makes improving care coordination between primary care physicians (PCPs) and the emergency department more important than ever. In a study of how well and how willing physicians are to communicate with each other, the NIHCR and Center for Studying Health System Change (HSC) found that there are few easy answers to the problems.¹

Using phone interviews of 21 pairs of ED and primary care physicians, researchers discovered that real-time communication is best in some circumstances, but could be very time-consuming; that faxes could be of limited use and physicians questioned how carefully they were reviewed; and that shared electronic records could address some problems.

One problem that physicians and their champions often raise is that doctors do not get reimbursed for communicating with another doctor about a patient. While one might expect the good of the patient to trump issues of reimbursement, physicians are people and they will do more readily that which is rewarded. **Ann S. O'Malley, MD, MPH**, a senior researcher at HSC, has looked at physician perceptions about how well they and others communicate with each other.

In her most recent study², O'Malley found that physicians think they communicate more often and better than they really do. Tracking some 4,700 physicians, O'Malley and her colleagues asked about perceptions of communications about referrals and consultations. While 69.3% of primary care physicians reported sending notification of patient history at least most of the time, only a bit over a third of the specialists said they always or most of the time received such notification. And while more than 80% of specialists said they always or most of the time send results to primary care physicians, just 62.2% of those PCPs said that was so. The quality of the communica-

tions was also lacking, according to the study, which appeared in the Jan. 10, 2011, issue of the *Archives of Internal Medicine*.

Regardless of the perceptions, O'Malley also mentions the lack of aligned incentives for getting physicians to do better at ensuring patients who are seen in a hospital or by a specialist have their cases relayed efficiently and effectively to their primary care doctors, and likewise that those specialists have all the information they need about a patient when they need it.

"I was not expecting quite the gross differences we found, although we know coordination of care and communication between physicians is lacking in this country," she says.

There are a variety of reasons for the disconnect between perception and reality, along with the lack of incentives to provide great communication. Some of them might include process problems, such as physicians thinking something was faxed and it not getting done, or not getting done in a timely manner. Some are physician problems, such as the legibility of notes that are faxed to other physicians. As for the problems with ED physicians in particular, O'Malley says her sample was not large enough to drill down to particular specialists. However, she notes that the sheer busy-ness of EDs and the increased complexity and severity of illness in the patients they see reduces the time they can spend on things like sending notes and phoning other physicians.

But EDs see some of the most vulnerable patients: the old, the very sick, those with multiple conditions, children, and those who have trouble navigating health systems, such as immigrants and the poor, O'Malley says. That makes ensuring good communication and coordination of care even more important.

How do we solve the problem? O'Malley says she hopes reform will change the incentives so that there is some sort of reimbursement available for communication activities. There should also be ways to make such communications automatic and easy.

That is just what Medical City Dallas Hospital is working on, says **Bev Cunningham, MS, RN**, vice president clinical performance improvement at the HCA facility. While electronic medical records make knowing what has happened to patients easy for physicians who are part of the system, those who are not have more of a problem, she says.

Currently, the hospital is working on a process improvement project that will have primary care

physicians phoning whenever they know a patient of theirs is coming to the ED, and the ED calling when that patient arrives. For unassigned patients, Cunningham says hospitalists handle communications. They are also considering a paper note that will be passed on between physicians at shift change.

Another option is to create a paper or online journal that helps create smooth transitions, whether to another unit or back to the medical home. In a study published in the *Journal of the Royal Society of Medicine*³ in February 2011, **Gurdev Singh** and his colleagues tested a journal developed by physicians and nurses using the Situation, Background, Assessment, and Recommendation (SBAR) format.

What they developed was used as a checklist for transitions, as an audit tool, and as a teaching tool. Initially only on paper, it quickly morphed to a Web-based tool, which may also address "Meaningful Use," says Singh.

Singh says that the lack of care coordination costs hundreds of billions of dollars per year and causes "a huge amount of harm" to patients and their families. Having timely and reliable communication between settings is the prevailing root cause, he says. The Joint Commission has recognized the importance, requiring "structured methods of transitioning patients." He thinks his study may be one way to address this need.

Rather than using a top-down approach, however, he thinks using a tool that was developed by the very people who will use it will result in better buy-in.

While noting that vulnerable populations are at particular risk from bad transitions, Singh thinks that "all groups are deficient" in this area. He hopes tools like his will help alleviate that problem.

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Five years without VAP? Two years without BSI?

Projects help MI hospitals attain the enviable

On March 14, there was a big celebration at Mercy Memorial Hospital in Monroe, MI, attended by officials from the Michigan Hospital Association. What was the occasion? Five full years without a single case of ventilator-associated pneumonia (VAP) in the hospital. It put the facility in the top 1% of the country, says **Ellie Wahl-Lenkovich, RN, MA**, chief nursing officer and senior vice president of patient care services at the 238-bed community hospital. The success is the result of a series of projects promoted by the Michigan Hospital Association's Keystone Center Intensive Care Unit (ICU) collaborative.

Wahl-Lenkovich was a critical care nurse when the project began in 2003. She remembers being the one who was making sure that every item on the protocols was done, doing the very work that was celebrated in mid-March.

It is not just VAP that was part of the program. Michigan hospitals also worked together to tackle catheter-related bloodstream infections and — the bane of every infection control professional in a hospital — urinary tract infections (UTIs).

The original peer review study, which covered catheter-related bloodstream infections, was published in the *New England Journal of Medicine* in 2006.¹ Peter Pronovost and his peers looked at data from 103 ICUs, mostly in Michigan. Initially, the rate of infection was 2.7 per 1,000 catheter days. Three months after the intervention, that was down to zero. The project included five steps, all recommended by the Centers for Disease Control and Prevention (CDC): hand-washing, using

full-barrier precautions during the insertion of central venous catheters, cleaning the skin with chlorhexidine, avoiding the femoral site whenever possible, and removing unnecessary catheters as soon as possible. Last year, researchers went back to the participating facilities to look at whether the impact was sustained² and found that, over 18 months, the reduction was about two-thirds.

Since the original implementation, Mercy Memorial has had stretches as long as 18 months without a single central-line infection. The success has been so promising that Wahl-Lenkovich says they expanded it to wherever there was a central-line insertion. "What happens in the ICU should not be different care than the same thing happening on another unit," she says. It has been expanded, too, to epidurals given in obstetrics. "We use the same sterile technique."

The ventilator and UTI portions of the project were also based on CDC recommendations and likewise reduced infections, which lowered length of stay, and, as an added bonus, saved money. That becomes increasingly important as payers commonly refuse to reimburse for any hospital-acquired infection, says Wahl-Lenkovich.

A study in the January issue of the *British Medical Journal*³ looked at all three of the interventions and their impact on mortality and length of stay (LOS). Lead author **Allison Lipitz-Snyderman, PhD**, now a postdoctoral fellow at the Johns Hopkins Bloomberg School of Public Health, says that while it may be intuitive that reduced infection rates will also lead to lower mortality rates and shorter hospital stays, good science mandates proving it. And her retrospective look shows it has, at least in terms of mortality rates. However, she found that the post-study period did not show as lasting an impact for the group as a whole as those that some of the participating hospitals are still enjoying and found no statistically significant change in LOS.

Lipitz-Snyderman says educating staff and creating a culture of safety seems to have been an important first step for the ICUs in question. Encouraging staff to speak up and talk about potential safety problems — and giving them the authority to stop a procedure like a central line placement if they did not see someone following the new protocols — was key, she says. "You have to encourage everyone to focus on quality."

The other element of their success was to get physicians to accept and adapt to the changes. That alone can require culture change and con-

vincing providers that particular interventions are important. Having some huffy physicians who object to being told to wash their hands will not lead to success, she says.

There is always push-back when change is implemented, says **Gretchen Schrage**, MBA, MT(ASCP) SH, CPHQ, manager of performance improvement and a patient safety officer at Northern Michigan Regional Hospital in Petoskey, a 214-bed regional referral center. But it is worth it to push back against those naysayers. “I’m proud to say we have not had a bloodstream infection in almost four years, ventilator-associated pneumonia in two years, and just one UTI since last November.”

She says that getting the bloodstream infection rate down was easy. Convincing people that a zero rate was possible was harder. “Just being below the mean was considered good enough,” Schrage says. “Now that we have been this successful, it is not anymore.”

The bloodstream infection bundle has been rolled out hospitalwide and is used whenever there is any kind of procedure done on a patient. “A sign goes up closing the room until the procedure is completed,” says Schrage. “People cannot poke their heads in anymore.”

The hospital rolled out a checklist for the infection reduction protocol, and also created fishbone diagrams that focused on everything that could cause an infection (*see tables, page 44 and 45*). “If there is an infection, we use it to help us do a mini-root cause analysis on why it happened.” There is a similar diagram for ventilator-associated pneumonia. Not that either diagram is getting much of a workout these days.

The latter condition has several parts. Among them:

- Raise the head of the bed to greater than 30 degrees.
- Implement an oral hygiene protocol with a chlorhexidine rinse.
- Deep vein thrombosis prophylaxis.
- Stress ulcer prophylaxis.
- Tight glucose control.
- Daily sedation awakening trials.
- Subglottal suctioning.

UTIs have been a headache for a number of years, Schrage says. It was problem enough that the hospital actually created its own bundle and protocol before Keystone attacked it. The results have been gratifying, even if the zero infection rate remains elusive. In 2007, there were 5.6 urinary infections per 1,000 device days. By 2010, it

was down to 0.8, which was a single infection in Schrage’s recollection.

The protocol includes daily washing with soap and water — and an admonishment to be gentle, as Schrage thinks one problem might have been people scrubbing too hard. There is a device to secure the catheter, a requirement to keep all bags below the bladder, and an elimination of the dependent loop. There was an issue with some new ICU beds in the beginning that had to be addressed, and the organization opted to use a single kind of bag with a urometer. That bag was more expensive than others, but if measurement was required, it meant one less catheter change and one less chance for an infection to catch hold. They use a large-mouth system to empty the bags and attempt to get the catheter out every single day.

A surgical unit is now using the same protocol. “I can spread the excitement — not just from one initiative to another by sharing successes, but from one unit to another. I can act as a bridge,” Schrage says.

There is no “there,” she adds. They continue to look for ways to improve performance. For example, this year, they are expanding the ICU protocols to include working on reducing sedation delirium, she says. Another big push is to work on reducing sepsis. And these programs have people champing at the bit, she says. “When you have great success, things get done, excitement.”

Wahl-Lenkovich concurs that a single great success can have an impact on how whole-heartedly hospital personnel embrace other quality improvement projects. “You see a goal — improvement and helping so many patients — that makes you want to do it again.

Both hospitals are excited to continue further with Keystone initiatives. If their peers are not, the Keystone Center has some data that might change minds. According to the CDC, there were 1.7 million hospital-acquired infections and 99,000 associated deaths in 2002. They cost as much as \$34 billion in preventable expenses which will no longer be reimbursed by payers. Meanwhile, in Michigan between 2004 and 2009, the Keystone ICU project saved an estimated 1,830 lives, nearly 140,000 excess hospital days, and more than \$271 million.

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Table 1. Catheter-associated bloodstream Infection diagram

<p>Case Review – Catheter Associated Bloodstream Infection</p> <p>Review Date: _____</p> <p>Present: _____</p>	<p>Patient: MRN: DOB: Adm: _____ Discharge: _____</p>
<p>Brief Summary:</p>	
<p>Infection Criteria Met:</p>	
<p>Probable Causes:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 22%;"> <p>Proper/Improper Technique</p> <ul style="list-style-type: none"> <input type="checkbox"/> No hand hygiene <input type="checkbox"/> No gown or mask worn during insertion <input type="checkbox"/> Line inserted without sterile technique <input type="checkbox"/> Dressing not changed on time <input type="checkbox"/> Dressing not occlusive <input type="checkbox"/> Line accessed without clean technique including alcohol swabbing of access site <input type="checkbox"/> Poor blood culture drawing technique </div> <div style="width: 22%;"> <p>Line/Colonization Contamination</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate skin prep before line insertion <input type="checkbox"/> Multiple sticks when starting a new line <input type="checkbox"/> Guidewire touches non-sterile field <input type="checkbox"/> Inadequate drape before line insertion <input type="checkbox"/> Line manipulation </div> <div style="width: 22%;"> <p>Contaminated Supplies</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood left in line <input type="checkbox"/> Line from ED/field not changed <input type="checkbox"/> Blood at insertion site not removed <input type="checkbox"/> Vascular end caps not changed <input type="checkbox"/> Vascular end cap in line with blood left in the end cap </div> <div style="width: 22%;"> <p>Length of Time</p> <ul style="list-style-type: none"> <input type="checkbox"/> IV tubing hanging without covered end <input type="checkbox"/> Lack of changing line and IVF's on time <input type="checkbox"/> Expired skin prep <input type="checkbox"/> Outdated IVF & outdated tubing <input type="checkbox"/> Using outdated IVF & tubing with new line <input type="checkbox"/> Line in place but central access no longer needed <input type="checkbox"/> Over the guidewire changes <input type="checkbox"/> Length of time line is in place <input type="checkbox"/> TPN infused via existing line/lumen </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 22%;"> <p>Number of Catheters and/or Lumens</p> <ul style="list-style-type: none"> <input type="checkbox"/> Multifunctional catheters <input type="checkbox"/> More than one CVC <input type="checkbox"/> More lumens on line than needed </div> <div style="width: 22%;"> <p>Antibiotic Usage</p> <ul style="list-style-type: none"> <input type="checkbox"/> Treatment of false positive/contaminated blood cultures <input type="checkbox"/> Blood cultures are contaminated and cultures were drawn through line <input type="checkbox"/> Antibiotic use outside hospital guidelines <input type="checkbox"/> Prior antibiotic use </div> <div style="width: 22%;"> <p>Education</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inexperienced clinicians <input type="checkbox"/> Resident unfamiliar with policy <input type="checkbox"/> Nurses don't know to change dressings (not dated) <input type="checkbox"/> No written policy <input type="checkbox"/> Supplemental staff unaware of policy and lack of training <input type="checkbox"/> Policy unavailable to physicians and staff <input type="checkbox"/> Physician unaware of technique evaluation process </div> <div style="width: 22%;"> <p>Site Selection</p> <ul style="list-style-type: none"> <input type="checkbox"/> Internal jugular sites used <input type="checkbox"/> Femoral sites used <input type="checkbox"/> Site adjacent to tracheostomy or wound site and evidence of drainage onto dressing </div> <div style="width: 22%;"> <p>Staffing Acuity/Time</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nurses are too busy to change dressing <input type="checkbox"/> MD inserts line alone – too busy to get nurse <input type="checkbox"/> Supplemental nursing staff <input type="checkbox"/> Inexperienced nursing staff </div> </div>	
<p>Conclusions / Actions to be Taken:</p>	
<p>Source: Northern Michigan Regional Hospital</p>	

Table 2

Central Venous Catheter Insertion Care Team Checklist

NOT A PERMANENT PART OF THE PATIENT RECORD

Purpose:	To work as a team to decrease patient harm from catheter-related blood stream infections.
When:	During all central venous or central arterial line insertions or re-wires.
By Whom:	Registered Nurse or Technician.
<ul style="list-style-type: none"> • If there is an observed violation of infection prevention practices, STOP LINE PLACEMENT IMMEDIATELY and correct the violation. • If there are any concerns, the Registered Nurse or Technician should contact the Department Manager or Chief Medical Officer directly. 	

1. Today's date: _____ **Name of Physician/PA/RN Inserting:** _____
2. Room number/location of insertion: _____
3. Line type: Triple Lumen CVC Double Lumen CVC PICC
 Umbilical Catheter Temporary Hemodialysis Catheter Swan-Ganz
 Other _____
4. Line location: Subclavian Internal Jugular Femoral Other _____
5. Procedure: New line Rewire (culture catheter tip once removed)
6. Is the procedure: Elective Emergent
7. Time out performed?: Yes No (if no, why? _____)
8. Consent obtained with signature, date, and time?: Yes No (if no, STOP and correct)
9. **Before the Procedure**, did the Physician (or IV Therapist):

	<u>Yes</u>	<u>No</u>	<u>Corrected</u>
Wash hands or use alcohol hand sanitizer immediately prior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was hand hygiene directly observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prep procedure site with Chloraprep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Prep procedure site with Betadine if infant < 2 months of age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drape patient in sterile fashion to below the knees (CVC other than PICC).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* If PICC line placement, was the drape from the kit used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- During the Procedure**, did the Physician (or IV Therapist) and Assistant:

Use sterile gloves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use hat, mask, and sterile gown?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain a sterile field?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did all personnel assisting with procedure follow above precautions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- After the Procedure:**

Was a sterile dressing applied to the site?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If you answered "no" to any question, specify details below:

Name of person completing checklist: _____

Please return completed form to unit manager or designee. Then forward to Infection Prevention.



Central Venous Catheter Insertion Care Team Checklist
NMRH 959.093 (05/2010)

<p style="font-size: small;">ADDRESSOGRAPH</p> <p style="font-size: 2em; font-weight: bold; margin: 20px 0;">DRAFT</p> <p style="font-size: x-small; margin-top: 20px;">Source: Northern Michigan Regional Hospital</p>

free online at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3031651/>).

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Collaborative uses data to bring uniformity

Variation can lead to improved outcomes

Increasing data show that variations in care have a negative impact on outcomes and costs — some estimates are that almost a third of healthcare dollars are spent in a wasteful manner or go to overuse of the system. That is one reason why a group of Findlay, OH-based employers came together with a local health system and area physicians to look for ways in which care varied and try to bring more consistency to what they do. Their hope was to use evidence-based medicine and proven protocols to reduce costs. The bonus was that while they succeeded in saving dollars, they also improved the health of patients suffering from chronic illnesses such as high blood pressure and diabetes.

The Employer Data Project was founded in 2005 and included more than 300 doctors, as well as employers such as Marathon Oil, which is headquartered in Findlay, a Whirlpool plant, Cooper Tire and Rubber, Bridgestone, and Nissin, says **Patricia Beham**, director of managed care for Blanchard Valley Health System. The health system includes two hospitals and a level three trauma center. Although the town has just 50,000 people, Beham says the employer base is bigger than one would think, representing about 30,000 employees.

“We had a long history of informally working together,” says Beham. That made creating a formal group easier. “We wanted to do something to

help employers manage their healthcare costs, and do it in both a constructive way and a local way.”

The group hired the Delta Group, a consulting firm, to look at claims and determine severity-adjusted episode-of-care measurements, such as inpatient and outpatient costs and pharmacy benefits. A six-month course in proper coding and chart audits was initiated. Physicians also learned about evidence-based practices for the various conditions, such as hypertension, diabetes, and knee-replacement surgery.

For hypertension alone, there was a reduction of more than a quarter in combined physician and hospital costs between 2004 and 2007, representing savings of more than half a million dollars by the employers. From an outcome perspective, the number of patients with controlled high blood pressure increased by more than 25% over a two-year period.

In looking at emergency department (ED) visits, the consultants discovered physicians were “practicing defensive medicine” according to a report by the Commonwealth Group on the program. (*The entire report with data on inpatient and outpatient measures is available at <http://www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2011/February-March-2011/Case-Study.aspx>.)* According to the report, they were more likely to order expensive tests that were probably not necessary — MRIs rather than simple X-rays, for example. Again, education was employed to effect change. The look at ED figures also uncovered the fact that some primary care physicians referred patients to the ED after hours rather than using nurse lines or some other triaging service, the report says. Often, these same patients were referred right back to their primary care physicians the next day, even if a prescribed treatment could not be assessed in that short of a time period. Those physicians were coached to tell patients to call their doctors, not visit, the day after an ED visit. The rate of visits to the ED for otitis media alone fell by a full percentage point to 10.8 in a single year, according to the report.

To help reinforce the changes, physicians are regularly provided with feedback that includes their data, as well as group data and national medians for key elements, Beham says. This helps them know where they stand and how they should adjust.

For diabetes, more problems were uncovered. Too few patients getting appropriate tests in the outpatient setting, for instance, and in the hospital, physicians did not always use the most up-to-date ways to control blood sugar, she says. Tight control can lower length of stay and promote faster recovery.

CNE QUESTIONS

13. The start go-live date for ICD-10 coding is
- A. October 1, 2012
 - B. October 31, 2011
 - C. January 1, 2014
 - D. October 1, 2013
14. Specialists say they get good communication from PCPs
- A. More than twice as often as the PCPs say they send it
 - B. Less than half as often as PCPs say they send it
 - C. 25% of the time
 - D. In the same percentage as PCPs say they send it.
15. According to the CDC, ways to help prevent blood stream infections include:
- A. Only using the femoral artery for central lines
 - B. Treating all insertions as sterile operations
 - C. Asking physicians if they washed their hands
 - D. Scrubbing the area vigorously.
16. Savings from the Findlay, OH, employer group GERD control efforts were:
- A. \$500,000
 - B. 1%
 - C. \$30,000
 - D. 25%

Answer Key: 13. D; 14. B; 15. B; 16. C.

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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

For surgical patients, it can reduce infection rates. Nursing now work with dietary services to be sure that medications and meals are given at the appropriate time. The interventions led to more hospitalized patients with diabetes having basal insulin orders — from 47% in January 2006 to 69% in April 2010, according to the report.

In another element of the program, elective surgical patients have to have an A1C level of below eight to be cleared. “Surgeons have been educated about that, and they can opt to do a fructosamine tests for a faster turnaround,” says Beham.

Anesthesiologists are pulled into the program, too, working with surgeons for preoperative and intra-operative care for patients with diabetes or hyperglycemia. Beham says infection rates are down as a result of many efforts, but she believes it is at least partly because of the diabetes program for inpatients.

The protocol even has an impact on future patients, she adds, noting that some physicians report seeing patients who are suddenly “very motivated to get their blood sugar under control in order to have

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

- Easing the workload of data abstraction
- More on credentialing and privileging
- What's new in quality surrounding childbirth

elective surgery.”

The employer group didn't stop with those three areas. It has also focused on gastro-esophageal reflux disease (GERD) and related ED visits for the condition. In two years, the number of such visits declined by more than a third, to 22 in 2007, a savings Beham says is worth some \$30,000. Heart failure and high cholesterol, as well as kidney disease are next in line for attention.

While the successes are enviable, and reducing variations in care, processes, and even coding can impact healthcare organizations in a positive way, the Findlay group thinks there may be some obstacles to others replicating what they have done. Geographic areas where hospitals are in direct competition with one another may see a lack in willingness to share data or collaborate; employers, likewise, may not be interested in committing resources to study the problems and effect necessary changes or to change benefits significantly. Insurers might not want to share data, either.

The financial costs alone may be daunting for any organization: Beham said the hospital has laid out in the “hundreds of thousands” of dollars over the years. Some of that is offset by subsidies from the companies involved, but the money is still considerable.

It helped that the health system CEO was interested in doing whatever was good for the community as a whole. “If it is good for the area, it is good for the hospital,” Beham says. “Keeping jobs here, by keeping companies competitive because we have lower healthcare costs is good for everyone.”

Physicians also have to be on board. A key group of physician leaders who have been involved from the start made the Findlay program work, she says. “This takes a process of having to reach out and get support from other doctors. Largely, we have been lucky that there has not been a whole lot of negative pushback. That might be because we are a smaller community where everyone knows each other.”

The beauty of the project is in how its goals have morphed. Beham says it started out as a way to save money. They have quickly discovered, however, that by reducing variation, they also improve the quality of care and improve outcomes for patients. Everyone wins.

For more information, contact Patricia Beham, Director of Managed Care, Blanch Valley Health System, Findley OH. Telephone: (419) 297-8894. ■

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