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May 2011: Vol. 36, No. 5
Pages 49-60

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Financial Disclosure:
Editor Lisa Hubbell, Executive Editor Russ Underwood and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

Communication key to reducing disruptive behaviors

How to facilitate a safe environment for patients, staff

How many times a day do you hear or read the word "safety"? If you are a typical quality wonk working in an acute care setting, it must number at least in the dozens. But when you think safety, are you prefacing it with another word? Patient? Workplace? Employee? All are important, and all are at risk if communication breaks down, problems with disruptive staff members are not addressed, and you do not regularly assess how well staff communicate and what safety issues need to be addressed.

The topic is important enough to be the subject of a 2008 alert from the Joint Commission that stressed the importance of behaviors that can undermine a culture of safety. It has also been a popular topic of research, including a new study in the *American Journal of Obstetrics and Gynecology*[1] by **Alan Rosenstein**, MD, MBA, medical director of clinical efficiency and care management at Valley Care Hospital in Pleasanton and medical director of Physician Wellness Services, a physician employee assistance program company based in Minneapolis.

In this study, which follows on from work Rosenstein did earlier on the role of disruptive behavior on the nursing shortage and a similar study released last month on disruptive employees in the emergency room setting, he looked at the impact of disruptive staff on patient outcomes in an obstetric setting and appropriate ways of addressing it.

"I think people are starting to get the relationship between respectful workplaces and safety," Rosenstein says. "We have a tradition of being a hierarchical profession, with very autonomous physicians, who are important revenue sources for hospitals. Physicians have been seen as godlike. But we are not. And there is a business case that when a physician is disruptive, it affects productivity and efficiency. And there is now a proven relationship between it and bad things happening to staff and patients."

He says maybe a quarter of organizations are giving the requirement to maintain a safe work environment serious consideration, another 40% are working at it but are not doing enough, and another quarter are doing nothing, maybe because their culture will not support such efforts.

What to do

The first step is to have a code of conduct and define what is inappropriate behavior and what is not. There are some differences from location to location, but 95% of what is deemed disruptive or offensive in one hospital will be considered in the same way at another, says Rosenstein.

You also have to ensure that whatever standards you apply are interpreted in the same way from case to case, Rosenstein says. "Whoever is in charge of interpreting the event must recognize that people do not intend to be disruptive, that they may be in a stressful situation where they become less tolerant of errors or slowness," he notes. "There is a gray line of perception and interpretation, and whoever is in charge has to know that there are always two sides to every story."

The person has to be skilled in facilitating and conflict management, with a knowledge of human behavior and great communication skills. Rosenstein recommends it be a physician, because then other physicians cannot come to a discussion of an event and say that the person on the other side of the desk can't possibly understand what it is like to be a busy doctor in a stressful situation. Director-level staff from safety, risk management, medical staff or human resources are good suggestions for where to find people to handle disruptive staff.

Getting physicians to change is not easy, Rosenstein continues. "We have been trained through harassment and hazing. There is low self-esteem and little if any training in team collaboration skills. It is changing a little now in medical schools, but the emphasis is still on communication with patients, not other team members."

The best approach is to have policies that relay information in a non-confrontational manner, explain the business and clinical reasons for improving behavior and communication, and teach the skills in a supportive manner that acknowledges the time constraints of a modern doctor, he says. "If you tell someone they have to go off to some communication seminar for a weekend, they may not respond well." With all the niceness, though, has to come a real message that disruptive behavior is not going to be tolerated and that the reputation of the physician is on the line. In a world of constantly available information, the last statement alone should get the attention you need.

Statistics show that 80% of nurses and 50% of doctors say they see disruptive behavior at work, but there is nowhere near the number of complaints that those numbers suggest. When you have that level of frustration, you are bound to see more mistakes and lower quality

Hospital Peer Review® (ISSN# 0149-2632) is published monthly and Patient Satisfaction Planner™ is published quarterly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication.

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Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

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care, he says.

The issue has been growing in importance and will continue to, says **Deborah Anderson**, principal at PivotPoint, a healthcare consulting firm based in St. Paul that specializes in behavioral change. Her organization has been surveying healthcare organizations for years, collating some 72,000 responses. "Almost everyone sees it," she says. "Only 10% or fewer will report that they never see disruptive behaviors."

Shifting the culture

What it takes to be successful in creating a program that will change behavior is more than a two- or four-hour training session, Anderson says. "You need a culture shift and from the top down know what is healthy behavior and what is bad behavior. Everyone has to know the difference." Mostly, everyone does — except those bad apples. "A third grader knows when someone is being mean."

What works is something akin to how people got smoking cessation to take hold, she says. "First, they made everyone stop smoking in offices and waiting rooms. Then there were smoke-free environments and some awful smoking room. Then it was moved off campus completely. We're on that kind of journey with bad behavior where we start with something small and it builds awareness. Then we move onto something bigger."

Anderson says there is a growing body of data that prove that if you treat your workmates badly, you probably aren't great with patients, either. Patients do better when they come from facilities that have this down, she says. "Rolling your eyes at someone is always bad. Good communication is always important. And if you roll your eyes at someone, you may lose out on important communication that someone will not pass on to you because you have belittled them. That can undermine safety."

Autocrats do not get feedback, to the point of wrong place/wrong patient surgery — which happens about 40 times a week in this country. "It is critical to be engaged in healthy behavior," she says. "It sets the tone. Will patients tell you what is wrong if you can't communicate effectively? Will they follow your directions or think you are not listening if you are not respectful?"

Tool kit to the rescue

One group that has made the link between workplace safety, patient safety, and effective communication is the Emergency Nurses Association (ENA). The group recently released a toolkit, complete with articles, sample surveys, and other resources that anyone can access, says **AnnMarie Papa**, DNP, FAEN, the current president of the organization and interim clinical director of the emergency department at the Hospital of the University of Pennsylvania in Philadelphia.

She says that patient safety has taken a lot of the spotlight lately, but it is increasingly acknowledged that unsafe workplaces for employees impact patient safety. The increased realization of its importance to patient safety, requirements from the Joint Commission that it be considered a sentinel event, and Occupational Safety and Health Administration mandates that you have to have a plan in place to prevent workplace violence have helped put it on an equal footing with patient safety measures.

Along with the Joint Commission standards, there are rules coming down the bend that will require organizations to have smooth working teams, Rosenstein says. "Accountable Care Organizations, when they come to fruition, will mean that the people you get into bed with for business have to be people and organizations that are respected, trustworthy, and team players. This will be required."

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REFERENCE

1. Rosenstein AH. Managing disruptive behaviors in the health care setting: focus on obstetrics services. *Am J Obstet Gynecol*. 2011 Mar;204(3):187-92. ■

How to measure success of communication

Keys to knowing if you're making a difference

If anyone knows how difficult it is to measure something as ephemeral as "good communication," it is **David Maxfield**. He was the lead researcher on the Silence Kills study in 2005 on the dangers to patients of not speaking up, conducted for the Association of periOperative Registered Nurses (AORN) and the American Association of Critical-Care Nurses (AACN).

Maxfield says the first mistake that organizations make is that they do not measure how well their staff communicate frequently enough. "A lot of organizations know that they should measure it, and use good tools like the [Agency for Healthcare Research and Quality] one," says Maxfield. *(See page 53 for a list of resources, including AHRQ tools.)* "But they use it once a year. If you have a webcam pointed at a freeway, you need to look at it fairly often to see if there has been an accident."

At a minimum, Maxfield says organizations with a good safety culture will measure their success and assess strengths and weaknesses three or four times a year.

Along with getting the frequency right, Maxfield says organizations need to determine how fine a grain their measurements should be. There can be very specific measures, such as end-of-day surveys that look at every single procedure done and assess whether there were good handoffs. Broader measures might be questions such as, "Was everyone respectful to you today?" The broader questions can help an organization determine patterns.

Those fine-grained measurements should be taken every so often, for a specific period, says Maxfield. The frequency during that duration should be high — perhaps even daily over two weeks. That kind of data gathering is especially beneficial when you are implementing a new process or procedure to make sure it is working. "You'd do it every day for a few weeks, then do it weekly, then monthly," he says.

The broader measurements are best taken less frequently, but over a longer period because they are asking objective questions such as how you are treated over time.

"Certainly the number of incident reports is one metric you should look at," says **Alan Rosenstein**, MD. MBA, medical director of clinical efficiency and care management at Valley Care Hospital in Pleasanton, CA, and the medical director of Physician Wellness Services, a doctor employee assistance program based in Minneapolis. Rosenstein recently published an article on workplace safety and has often served as an expert witness in cases involving disruptive employees. "And you should also look at where the incidents are originated — what department, what person."

Indirect measures

There are other indirect measures that can give you a sense of how well staff communicate, too, such as turnover, says Rosenstein. Studying the times when an error almost happens is another way to get a sense of whether your staff talk to each other. If there was a near miss, it is likely a time when someone spoke up and was listened to. Each near miss might be a successful measure of your communication culture.

Lower numbers of adverse events is another indirect measure, Rosenstein adds, "because 70% of an adverse event is about communication."

Are there good measurement tools out there? Yes, says Maxfield, but every organization will have slightly different needs. In creating one for use in your organization, he suggests looking at what is available from organizations such as the Institute for Healthcare Improvement (IHI – ihi.org) or the AHRQ. Professional associations also often have tools you can use as a guide. "See what is out there first and use it as a template. Then ask yourself what is missing that you might need to add to make it relevant to your organization."

The goal is to measure things such as whether there are safety tools available in your facility, whether they are used every time, and whether they are used well. You need to measure whether people are frank and honest, whether they are encouraged to speak up, and whether they are heeded when they do. "The goal is that everyone talks and everyone listens," Maxfield says.

Don't expect your scores to be consistent all the time. Personnel changes, for instance, can influence the figures you get from your surveys. Someone who might feel unable to speak up during his or her first month of employ-

ment might be much more willing to after three months. Or a new physician who is gruff initially may adopt your organization's more collegial pattern of work. But know that if you keep seeing the same kinds of issues during the same shifts, or certain names popping up over time, then you have a pattern of problems that has to be addressed.

"You have to especially track those patterns. Look at how often something happens, look for patterns of people taking shortcuts, and look for comments about disrespect and incompetence," says Maxfield. What is the impact of those problems? How resolvable are they?

Tracking numbers is vital. After the Silence Kills original study, when only 12% of those asked said they shared their concerns with doctors, many were discouraged. But five years later, those rates have tripled. Other studies have shown that even if a small number speak up, they can have an impact, and behaviors can change, leading to a safer work environment.

"The breakdowns we focus on are when you know or suspect something is wrong and you do not say anything. Or if you do then no one listens. There are not a lot of elephants in the room in most organizations and on most teams. That gives you incredible leverage. If you can speak up and deal with the elephant, you can change the whole relationship."

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FURTHER RESOURCES

- ENA's Workplace Safety Toolkit: http://www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm
- Joint Commission Alert on Workplace Safety: http://www.jointcommission.org/assets/1/18/SEA_40.PDF
- Process for a Healthy Work Environment, PivotPoint: http://www.pivotpt.biz/processsteps.html
- Silence Kills workplace survey tool: http://www.silenttreatmentstudy.com/media/Silent%20Treatment%20Survey%20Form%20B.pdf
- Agency for Healthcare Research and Quality workplace safety culture survey: http://www.ahrq.gov/qual/patientsafetyculture/
- Resources for dealing with disruptive behavior: http://www.physiciandisruptivebehavior.com/
- Silence Kills Study: http://silenttreatmentstudy.com/silent/The%20Silent%20Treatment.pdf ■

The new push for reliability

Why are airlines safer than healthcare?

Perhaps one of the most startling sentences in a recent *Health Affairs*[1] article by Joint Commission president **Mark Chassin**, MD, FACP, MPP, MPH, is one in which he and his co-author, commission executive vice president Jerod Loeb, state that "…we know of no health care organization that has been able to achieve a consistent state of high reliability." The authors go on to state that there are "pockets of excellence on specific measures or in particular services at individual health care facilities." They note that there are even some across-the-board measures of excellence, such as the fact that 98% of the time, heart attack patients get beta-blockers.

But Chassin is quick to point out that when you look at how many times per million beta-blockers are not provided, you are looking at thousands of patients not getting that life-extending medication. "The state of high reliability is the absence of major quality failures at a level of measurement that is well beyond what we do now," Chassin says. "It is not that we cannot achieve that as human beings — they do it on an aircraft carrier flight deck all the time. But it does not exist in healthcare, partly because we have never tried and partly because we have been satisfied with 80% good when measured in the way Six Sigma measures. Commercial aviation is at maybe 5 deaths per million takeoffs and landings. Maybe lower than that." Numbers like that make him scoff at

80% compliance with processes that we know save lives.

For years, physicians and other healthcare stakeholders have responded to efforts to compare what they do to what is done in other industries, with cries that comparisons are not fair because healthcare is different. "I hear that all the time," Chassin says. "But a few years ago, no one ever thought that we could get rid of central-line infections in the ICU or get people to wash their hands. But we did. There are instances where we have achieved this level of reliability."

He again mentions the beta-blockers and heart attack patients. Although he'd love 100% compliance — and to a degree really expects it — there was a time when the percentage of patients who left with a beta-blocker prescription and aspirin was something around 50%.

In the *Health Affairs* piece, Chassin and Loeb argue that with a group mindset that understands the importance of every single step taken in healthcare, the industry can achieve high reliability like aviation and jet landings. They say it requires just three things: a commitment to leadership, a culture of safety that encourages reporting of problems, and "robust process improvement."

Demand for safer processes

What does that mean to quality professionals in hospitals? "There are increasing demands on hospitals to produce much safer processes and prevent complications," he says. "This will increase dramatically, even further than now, and there will be penalties for complications. Trying to do improvement the same way will not get us to the level of safety the way we want, will not allow us to avoid penalties, and will not protect patients. We have to do something different."

There are no healthcare organizations that are as safe as nuclear power — despite the recent accident in Japan — or air travel, he says. "I've said we cannot just transfer blindly from other industries, but we can learn a lot from them." And while the commission will not tell organizations exactly what to do, Chassin is happy to mention that there are tools he likes to use for robust process improvement, including GE's change acceleration process, which when combined with Lean Six Sigma has helped the commission to successfully engineer change internally.

Using a formal process to manage change like the GE model helps to ensure that the best plan for fixing a process is created. "If everyone hates it and nobody uses it, it doesn't matter if you've done it because no benefit accrues. It is not just the technical quality of the solution that matters. You also have to manage the process and get everyone to accept it and use it and be enthusiastic about maintaining improvement," he says.

Chassin says that right now, what you do next depends on where you are. The *Health Affairs* piece includes a table that outlines the relative maturity of organizations according to characteristics of leadership commitment, adoption of tools, and establishment of a safety culture. For instance, a minimally mature organization's leadership will focus quality improvement (QI) efforts on regulatory requirements, will not recognize the strategic importance of QI efforts, and may not have physicians who are really engaged in QI. A more mature organization will aim for and sometimes achieve zero-error rates, will show strong physician leadership, and will reward successes. Someone in the middle might not yet have a robust process improvement plan, but will be looking to adopt appropriate tools, will have begun to train staff, and will use the tools they adopt for both clinical and administrative improvements.

To start, Chassin says you should do "an honest, if not brutally honest" assessment of where you are on that chart. Are you an organization whose leadership only cares about quality as it relates to surveys or CMS payments? If you have no introspection about what you have to do to get better, no commitment to reaching zero failure rates, and the quality department has no idea it is sitting on what Chassin refers to as "a burning platform," then chances are you are in that first, least mature place. Then you need to bring it to the attention of your leadership.

This will all take time and money. But Chassin says it will pay off financially, as well as in better safety and improved outcomes. "When we got eight organizations, including Johns Hopkins and Memorial Hermann, to look at hand hygiene, it was at 48% performance levels. A little over a year later, it was at 81% after using robust process improvement methods." When he was at Mt. Sinai hospital in 1999, Chassin wanted to show the chief finan-

cial officer that using some of these tools could bring hard dollars to the bottom line and still improve safety and quality. "We did that by paying for expertise to be brought to the facility, then taking over the training of staff for them," he says. "We focused on a broad range of improvements, including billing, and ended up bringing in enough savings to pay for the program for over four years."

For more information on this story contact: Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., president, Joint Commission, Oak Brook Terrace, IL. Email: mchassin@jointcommission.org

REFERENCE
1. Chassin MR, Loeb JM. The ongoing quality improvement journey: next stop high reliability. *Health Aff*. 2011 Apr;30(4):559-68. ■

Accreditation field report

One facility's answer: always be ready

Laura Sellers, director of operations at Skyland Trail, an 80-bed behavioral health hospital in Atlanta, has gone through 10 Joint Commission surveys. Over time, she has learned an invaluable lesson: Getting ready a few months before the survey was a sure way to drive herself and the rest of the staff crazy.

Taking a leaf out of the Boy Scout handbook, she decided that the best way to prepare was to always be prepared. "You would panic six months before and start cleaning everything up and getting everything ready," she says. "It is not worth all the hassle and drama to do it that way. I think you are better off being ready every day. Incorporate all the things you are supposed to do into your culture and then it doesn't matter when they come, you will always be ready."

The Joint Commission's tracer program means there is no more dusting off binders of policies every three years. You are working with real patients, not pieces of paper.

Her experience last fall did not provide many surprises. There was a big push on suicide risk assessment — even bigger than she expected. But Skyland Trail had its policy and assessment ready since it is a mental health facility. "We did have to argue our position. There were some intense discussions, and the focus was more than we anticipated."

The surveyor also spent a lot of time talking with clients — six of the 80, one from each of the recovery communities resident in the facility. "It was a high percentage, I thought," Sellers says. The surveyor also spent less time on physical plant issues than one might have thought. Sellers thinks that might be because they had recently remodeled, and thanks to some great donors, the place is really pleasant and attractive. "I don't know how much that figured into his lack of interest, but people are only human and probably respond to environment."

The final report was very complimentary, Sellers says. There were just two areas that she was directed to improve. One was a policy for disaster drill debriefing — the emergency management standard talks about four separate areas, and Sellers says the surveyor wanted their form to follow that policy. She called some peers and got samples of their forms and quickly adapted them to her needs.

The second area was in treatment planning. "In our residential program, patients self-administer their medications, and adherence is a problem," she notes. "He wanted us to include medication adherence issues in our treatment plans."

The staff developed an assessment form that tied into medication compliance, adding content and planning training for nurses. Both areas for improvement were completed well before the allotted 60 days were up.

After the surveyor leaves, Sellers always makes sure to let staff know what happened and have a celebration. "Some people only have the CEO and medical director involved in reviewing the report. But I think everyone is involved in getting ready, everyone was part of the survey, so they should come in and see what it says. It makes people feel good, and it helps keep them invested in the process, too."

Better safe than sorry

While Sellers firmly believes in being always ready, she also believes in preparation. A few months before the survey is due, she'll hire someone to come in and do a review or mock survey. "It helps to have someone with fresh

eyes look at your organization," she says.

After that, there's nothing to do but try to relax. "There are more than 3,000 standards. Even if you went through them all one at a time, you know that someone will be able to find something you missed. You have to understand that."

Fear of the unknown, worry over who your surveyor will be — it can stress out even the most ready organizations. "There is always some document that has to be done, always something that has to be improved, always something you need to catch up on." But Sellers says there can be good stress — the kind that makes you work hard to complete something in a collected manner — and bad stress that has people snapping at each other and running around with more panic than purpose.

"That is why I emphasize being ready and adhering to the standards. I am really thankful to the commission. I'm sure if it was not for surveys that people would not always do the things they should. And most of the standards are very practical and useful. There is a good reason behind them. That makes it easier to get people to comply."

Stay in touch

Another thing that Sellers does as her survey approaches is to stay in touch with her peer group through an electronic listserv or professional group. What is happening at their organizations may give you a hint at trends and what you should be paying special attention to. Talking to those who have been recently surveyed can keep you from being overwhelmed by giving you specific areas on which you can focus.

If you haven't been ready since the last survey, there is not a lot you can do after you get your seven days notice. "You cannot correct six months of incomplete records in a week," she says. "Having beautiful policies is not good enough. You have to be able to show you are using them. That is the purpose of tracers."

But Sellers does have a couple of last-minute tips. First, she says never answer a question that hasn't been asked. Second, she advises that you never change the shower curtains right before a survey. "I had one surveyor tell me that he cannot stand that new vinyl smell anymore because people always put new shower curtains up before they have a survey."

Then, once the survey is over, keep going as if that surveyor is going to reappear the following week. It will save you grief three years down the road.

For more information on this topic contact Laura Sellers, RHIA, Director of Operations, Skyland Trail. Atlanta, GA. Telephone: (678) 686-5910. ■

CMS releases proposed ACO rules

65 quality measures included

The proposed rules for accountable care organizations (ACOs) were released at the end of March, and Donald Berwick, MD, administrator for the Centers For Medicare & Medicaid Services, lost no time writing about their potential import in the *New England Journal of Medicine*[1]. The rules are designed to help groups create new organizations for caring for specific Medicare populations in the hopes that they can provide better care, as well as lower the cost of care — or at least the rate of growth in costs. Berwick hopes that ACOs will not only save money, but mark the death knell for fragmented care.

This may seem like nothing that matters to quality improvement staff at the local hospital, but you need to be involved in the process, says **Kathy Heilig**, RN, MSN, a consultant in North Carolina who has 17 years experience working for the NC Hospital Association. "Hospitals are connecting with physician practices because of this," she says. "That means that more and more physician offices will be relying on hospital quality people to get to where they need to be to meet the proposed quality goals."

There are some 65 quality measures in five measure domains for quality performance standards for ACOs, according to the proposed rules. *(See the complete rule at http://www.federalregister.gov/articles/2011/04/07/2011-7880/medicare-program-medicare-shared-savings-program-accountable-care-organizations#p-729.)*

The quality measures include several categories:

- patient and caregiver experience;
- care coordination for transitions;
- use of technology for care coordination;
- patient safety;

- preventive health;
- diabetic patients;
- heart patients;
- coronary artery disease patients;
- hypertensive patients;
- patients with COPD;
- the frail elderly.

In a future issue of *HPR*, look for extended coverage on exactly how hospitals can prepare for the ACO reality and the quality goals they require.

For more information on this story, contact Kathryn Heilig, RN, MSN, consultant. Telephone: (919) 851-7533. Email: kheilig1@nc.rr.com.

REFERENCE
Berwick DM. Launching accountable care organizations: the proposed rule for the Medicare shared savings program. *N Engl J Med*. 2011 Mar 31. ■

TJC joins partnership for patients

The Joint Commission has announced that it and its Center for Transforming Healthcare will participate in the Partnership for Patients, a public/private initiative designed to make hospitals safer by reducing harm and readmissions. The goal is to reduce hospital readmissions by 20% in the next two years, and hospital-acquired conditions by 40% in the same time period.

Joint Commission president **Mark Chassin**, MD, MPH, says that this provides "real opportunities" to find solutions that will improve healthcare and reduce spending.

Other organizations involved include large employers and unions, health plans, and state governments. They will work to create tools to achieve the stated goals. ■

Memorial Hermann wins care management award

The Houston-based health system currently famous for overseeing the rehabilitation of Congresswoman Gabrielle Giffords has another distinction to add to its honors: in April Memorial Hermann Health System's Care Management Services program was awarded the Franklin Award of Distinction for 2011.

The seven-hospital system uses a standardized approach in all of its facilities — one of the reasons cited by the Joint Commission and the American Case Management Association for bestowing the award on Memorial Hermann. Using common policies and procedures, electronic case management tools and a team approach, the staff has created a system they noted is "robust." The organization was evaluated on its ability to collaborate, its interdisciplinary processes and interdependence, and its innovations and excellent outcomes.

In the next issue of *HPR*, quality improvement professionals will talk about what they did to help the Care Management Services program become so effective. ■

NQF outcomes project has final three measures

The National Quality Forum has endorsed two diabetes composite measures and an inpatient acute myocardial infarction measure as the final three measures for its patient outcomes project.

The first, optimal diabetes care, is a Minnesota Community Measurement. Comprehensive diabetes care comes from the National Committee for Quality Assurance. And the heart attack mortality rate comes from the Agency for Healthcare Research and Quality.

Appeals of this decision are due in by the end of April. ■

Readmissions costly, impact quality of life

Collaborate to ensure smooth transitions

In today's healthcare environment, as patients are being discharged from the hospital sicker and quicker than ever before, some patients are in and out of the hospital as if they are going through a revolving door, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company based in Huntington, NY.

"Something happens between the time people

leave the hospital and when they are readmitted within a short period of time. As case managers, we need to identify what is happening and develop a concerted plan to avoid it," Mullahy says.

The problem is especially acute among Medicare recipients who often are frail with multiple comorbidities and polypharmacy issues. They might be socially isolated with little family support and have hearing and eyesight problems that impair their ability to understand and carry out their post-discharge plan, she adds.

According to a study in *The New England Journal of Medicine*, nearly 20% (19.6%) of all Medicare beneficiaries discharged from the hospital are readmitted within 30 days, and 35% are rehospitalized within 90 days.[1]

Data posted on the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website (www.hospitalcompare.hhs.gov) in July 2010 shows the 30-day readmission rates were 19.9% for heart attack patients, 24.7% for patients with heart failure, and 18.3% for patients hospitalized with pneumonia from July 1, 2006, to June 30, 2009. These rates were essentially the same as the 2005-2008 rates. The average stay of rehospitalized patients was .6 days longer than patients in the same diagnosis-related group who had not been hospitalized for at least six months, *The New England Journal of Medicine* study reports.

When she spoke at a seminar for case managers several years ago, Mullahy was startled to find that many hospital case managers were doing little to prevent readmissions because they believed that when patients were readmitted, that meant more revenue for the hospital. "We're supposed to be doing what is best for patients. As long as payers were reimbursing for it, nobody did anything differently to prevent readmissions," she says.

That's going to change since CMS has announced its intentions to penalize hospitals when patients with pneumonia, heart failure, or heart attack are readmitted within 30 days, beginning with discharges on Oct. 1, 2012. The agency has declared that it is likely to add other conditions to the list in the future. In addition, an explicit provision in the Patient Protection and Accountable Care Act mandates that in fiscal 2014, hospitals in the highest quartile for hospital-acquired conditions receive a 1% reduction in total Medicare reimbursement, and CMS has proposed using hospital readmissions as one of the processes of care measures used to determine hospital reimbursement in its value-based purchasing system.

Readmissions are expensive, says **Cory Sevin**, RN, MSN, NP, director with the Institute for Healthcare

CNE QUESTIONS

17. The Joint Commission made workplace safety problems sentinel events in
A. 2000
B. 1998
C. 1999
D. 2008

18. A good frequency of measuring how well your staff communicates is
A. Daily
B. Weekly
C. Quarterly
D. Annually

19. Hand-washing rates at hospitals involved in a QI project increased from less than half to
A. 81%
B. 91%
C. 61%
D. 71%

20. The best advice Laura Sellers has for impending surveys is
A. Never answer a question that isn't asked.
B. Always answer the implied questions.
C. Change the shower curtains before the surveyor comes.
D. Shampoo the carpet the week before the surveyor comes.

Answers: 17. D; 18. C; 19. A; 20. A

CNE INSTRUCTIONS

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

Improvement (IHI), an independent, not-for-profit organization in Cambridge, MA, that works with providers to achieve safe and effective healthcare. "In a report to Congress in 2007, MedPac estimated that readmissions within 30 days account for $12 billion in Medicare spending each year,"[2] Sevin says. "In addition, when patients go in and out of the hospital and are very sick, it impacts their quality of life. In the hospital, they are at risk for infections, falls, and medical errors."

The best way to prevent hospital readmissions is to make sure the patients are better managed and receive the care they need after they leave the hospital, says **Donna Zazworsky,** RN, MS, CCM, FAAN, vice president of Community Health and Continuum Care for Carondelet Health Network in Tucson, AZ. "Many patients are readmitted to the hospital because they don't have what they need to stay stable once discharged back into the community. If patients don't have the basic things they need to take care of themselves, it can derail a discharge," Zazworsky says.

About half of patients discharged from the hospital don't understand what to do when they get home, Sevin says. Hospital stays are very short, and inpatient education activities often do not ensure that patients and their caregivers understand the key information needed for the patient to stay stable, she adds. "When the discharge instructions are complicated and the patient is ill and frail, it's even harder to make sure they understand. Many times family members, primary care physicians, and post-acute providers don't have the information they need to help the patient remain stable," Sevin says.

Patients and family members need to understand how to take their medication, any dietary restrictions, signs and symptoms that indicate they should seek medical care, and who to call. Sevin advises using the "teach-back" method, which involves having patients or caregivers repeat their discharge instructions to ensure that they understand them. Post-actute providers need complete and accurate information about what happened during the hospital stay, medication regimen, details of the patient's post-discharge treatment plan as ordered by the physician in the hospital, and any psycho-social issues or other issues that could impact the patient's post-acute stay.

Case managers should make sure patients understand their treatment plan and their medications, that they have support at home, that they have a follow-up visit with a physician, and that caregivers and providers at the next level of care have the information they need to ensure a smooth transition, Zazworsky says. Sevin says, "A huge part of reducing readmissions is designing the care process across the continuum of care. Hospital case managers need to work with home health agencies, nursing homes, primary care physicians and specialists, and their counterparts at health plans to ensure that care is coordinated and that everyone is giving the patient consistent information."

Patients are at highest risk for readmissions during the first week after discharge, Zazworsky points out. For that reason, it's critical to make sure that patients have a follow-up visit with a primary care physician or a specialist within a week of being discharged from the hospital. "Case managers can do a wonderful job of educating patients, but if they don't get that follow-up visit, they are likely to have problems after discharge

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

- How did the VA bring MRSA rates down?
- More survey insights from the newly surveyed
- What the new national quality strategy report to Congress means to you
- What you need to do now to prepare for the move to ACOs

that could result in a rehospitalization or emergency room visit," Zazworsky says. "The linkage to the community beyond the hospital walls is critical."

It's not enough for case managers to come up with a discharge plan. They have a responsibility to make sure that the care plan they set up is working, that the supplies the patient needs at home were delivered, that the home health nurse showed up, and that the patient made a follow-up visit to the doctor, Mullahy says.

Case managers need to identify the causes of readmissions before they can begin to make changes in the discharge and follow-up processes to keep patients from coming back, Mullahy says.

"Providers and payers need to look backward before they start to look forward and to analyze each readmission to find out the root causes. Then they can start to address the issues that contribute to readmissions," Mullahy says.

For example, if patients are being readmitted to the acute care hospital after a stay in a skilled nursing facility, it might be that the transition to post-acute care wasn't smooth and gaps in care occurred, or it might be that the nursing home is providing less than optimal care, she says. If patients aren't seeing their physicians in a timely manner, it might be that they didn't understand the need to make the appointment within a week of hospital discharge rather than accepting the next available physician appointment, which might have been a month away, Mullahy adds.

"Find out what caused each readmission, identify trends, and go back and start chipping away at barriers and reasons for readmissions," she says. For example, many patients are readmitted because they don't get their prescriptions filled. Find out if it's because they can't afford the medication, they don't have transportation to the pharmacy, or another reason, Mullahy says.

REFERENCES

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009;360:1418-1428.
2. Medicare Payment Advisory Commission. Report to the Congress, Reporting Greater Efficiency in Medicare, June 2007. Washington, DC: 2007. Accessed at http://www.medpac.gov/chapters/Jun07_Ch05.pdf. ■