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Partnership for Patients: ‘It’s about time,’ say quality experts

CMS predicts that the program will help save 60,000 lives

Hot on the heels of the release of its proposed rule to govern the operation of Accountable Care Organizations, the Centers for Medicare & Medicaid Services has unveiled its Partnership for Patients, a program whose main goals include the reduction of preventable harm in hospitals in the U.S. by 40% by 2013, and a reduction of hospital readmissions by 20% by the same deadline date.

While the Accountable Care Organization rule drew mixed reviews, the “Partnership” has been met with nearly universal acclaim. Organizations issuing statements in support of the initiative included The Leapfrog Group, the American Hospital Association, The National Patient Safety Foundation, and the Premier Healthcare Alliance, to name just a few.

“This is tremendous; it’s really the first time the federal government has put substantial funding into capacity building around adverse events and preventing readmission,” says Robert M. Wachter, MD, professor and associate chairman of the Department of Medicine at the University of California, San Francisco, and a recognized patient safety expert. “It’s ambitious in that it recognizes the feds can’t do it by themselves, but they need to form partnerships with all stakeholders. And it dovetails nicely with all the transparency and payment initiatives that will roll out over the next five years.”

KEY POINTS

- CMS to invest \$1 billion in quality, safety initiatives and collaborations.
- Stakeholders, CMS should offer consistent messages about performance.
- Reducing preventable harm, re-admissions are two main goals.

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“I think it’s very exciting that CMS is exerting leadership on patient safety,” adds **Leah Binder**, CEO of The Leapfrog Group. “Unfortunately, we still have what I would call a crisis level of safety problems at U.S. hospitals, and it’s time for the federal government to begin addressing this with more of the tools in its toolbox. It’s also exciting that it is reaching out to the private sector and partnering, and moving forward in some kind of unity to address this crisis.”

According to CMS, participants in the “Partnership” will include hospital leaders, employers, health plans, physicians, nurses, and patient advocates — as well as state and federal government. The Department of Health and

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EDITORIAL QUESTIONS

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Human Services will invest up to \$1 billion in new funding provided by the Affordable Care Act. In a statement announcing the new initiative, the department indicated the investments would be apportioned as follows:

- “Preventing Harm: The new Innovation Center at the Centers for Medicare & Medicaid Services (CMS) will dedicate up to \$500 million to test different models of improving patient care and patient engagement and collaboration in order to reduce hospital-acquired conditions and improve care transitions nationwide. The Partnership will target all forms of harm to patients but will start by asking hospitals to focus on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country, including preventing adverse drug reactions, pressure ulcers, childbirth complications and surgical site infections.”

- “Improving Care Transitions: The new Community-based Care Transition Program at the CMS Innovation Center will provide \$500 million in funding to community-based organizations partnering with eligible hospitals for care transition services that include timely, culturally, and linguistically competent post-discharge education, medication review and management, and patient-centered self-management support within 24 hours of discharge. Starting April 12, 2011, eligible community-based organizations and acute care hospitals that partner with community based organizations can begin submitting applications for that funding. Those interested in applying should visit: www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313.”

CMS claims that more than 500 stakeholders have committed to support the new initiative; you can find the list at partnershippledge.HealthCare.gov. It predicts that the program will help save 60,000 lives and “has the potential to save up to \$35 billion, including up to \$10 billion for Medicare.”

Structuring partnerships

With the initiative just being announced, observers are not yet clear on how the partnerships will unfold — but that doesn’t mean they don’t have their own visions. “What we’d like to see is employers setting up value-based purchasing programs that are consistent with goals of value-based purchasing that CMS is involved in, so hospitals and others providers are given consistent messages

about the performance they should seek,” says Binder. “That does not mean we want the same exact incentive structures as CMS — I’m not even sure that’s a good idea — but, for example, if CMS is focused on central-line infections, employers should also be focused on it. They might decide that if you use a hospital that has a low rate they will waive your deductible, or in contracting negotiations they will weigh those rates heavily. That’s what’s going to drive real change.”

“While the program still has to be rolled out, my understanding is there will be funding available to support hospital networks, regional collaborations, some hospital associations, or even physician professional societies to do this work,” adds Wachter. “I think we will soon see RFPs for working to improve safety. Later, when individual hospitals or groups demonstrate they have made real progress, there will be funding available to disseminate their lessons to other hospitals.”

There are certainly echoes of IHI in the program, which is not surprising given that the former head of IHI, Don Berwick, is now the administrator of CMS. “They are mostly good echoes — lessons from IHI around campaigns that took hold, and got people enthusiastic around initiatives,” says Wachter. “You need to have ambitious but achievable goals, and whether you’re a 100-person operation in Cambridge or a million-person government in Washington, DC, you should not do these things alone; you have to try and make it a big boat with a lot of people rowing.”

“To his credit, in many respects this encapsulates the world view he has promoted his whole career,” adds Binder. “That actually gives great vision and power for those of us working with him because of his personal passion; it makes it very exciting for all of us.”

An investment of \$1 billion certainly adds to the excitement, but will it truly help to improve quality and safety? “There’s already a lot of momentum for quality and safety, built over the last 11 years following the first IOM report [*To Err Is Human*] and then *Quality Chasm*,” says Wachter. “There’s now a deeper understanding of the problems in quality and safety, better understanding, more research, more interest among caregivers and leaders, and more pressure that did not exist before in the form of transparency in public reporting — and now pressures of the payment system coming on line. The pressure was already there, organizations were already trying to figure out how to get the work done, but the partnership says, ‘We, the federal government, with a lot of

partnership, will do what we can to help.’”

Wachter recognizes that many are skeptical about government involvement, “But in this one the motives are good; they do want hospitals and healthcare systems to be motivated to improve,” he says. “So we have a situation where the soil is right, everyone wants to do better, but sometimes they do not know how to prevent readmissions or hospital-acquired infections.” If the government had announced a similar initiative five years ago, he adds, “I do not think it would have had the same effect.”

Binder is convinced that quality and safety will improve as a result of the partnership. “If your child has a fever at two a.m. and you take them to the ED and they get admitted, you will have far less chance your child will get harmed or even killed by infection, medical error, the wrong medication, or any of a myriad of problems in the system that keep us up at night,” she predicts. “There will be less worry when you enter a hospital that you will suffer even more from the visit than from the disease that brings you there.”

But are the initiative’s goals actually achievable? “Yes, I think they are, but they are ambitious,” says Wachter. “Part of the key will be in the definition of what preventable harm truly is. If you look at studies of design to prevent readmissions, you will see results everywhere from a 20%-40% decrease, so the question then is what is the preventable number? There may be some wiggle room, but I like the concept — rather than saying we should prevent all readmissions, or all falls, which is completely unrealistic. I felt 50% was too high, and 20% was too wimpy.”

“The goals are achievable, but ambitious,” adds Binder. “Let’s say this: If we just use this as a PR play and its business as usual it won’t work, because it’s too ambitious. But if we’re bold and transparent in a way that’s uncomfortable, it could work.” (*For more on transparency, see the related story on page 76.*)

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‘Transformed’ QI leaders take center stage

“Whether or not their facility takes the pledge to participate in the Partnership for Patients their role has been transformed in the last few years,” says **Robert M. Wachter**, MD, professor and associate chairman of the Department of Medicine at the University of California, San Francisco, and a recognized patient safety expert, about quality managers. “They’ve gone from someone who often was there just to meet regulatory requirements and did not get deep involvement or engagement in QI and patient safety from doctors or hospital leaders, because there was relatively little skin in game, to someone who is now central to the hospital not only meeting its ethical obligation to provide high quality but the business survival of the hospital.”

What this new initiative does, he continues, “is provide them potentially significant new resources in the form of potential funding for new quality and safety initiatives, and new opportunities for they themselves or people working with them to be trained in best practices and creative new strategies.”

“I think they’ll be extremely significant, and hopefully, pressure in the form of CMS and all of the partners will help elevate their leverage within the hospital,” adds **Leah Binder**, CEO of The Leapfrog Group. “What they do is extraordinary; when I meet with them I’m extremely impressed with their knowledge, sophistication, and the treasure trove of information they have on how to improve. Sometimes they do not have the voice they deserve, and hopefully this will elevate their stature.” ■

Expert seeks transparency from CMS

Leah Binder, CEO of The Leapfrog Group, is supportive of the new Partnership for Patients initiative unveiled by the Centers for Medicare & Medicaid Services, but she wants more. “I think the next step is for Medicare to publicly release the data it collects on core measures and patient safety indicators in hospitals so that the private sector can begin to analyze that data and publicly report it ourselves,” she says. “They now publicly report

analysis of data through Hospital Compare, but that just shows that hospitals are mostly average; I believe the public deserves to know what each hospital is reporting, so we are able to frame our own analysis. As we know from our Leapfrog analyses, there is very significant variation among hospitals — and that’s not reflected in Hospital Compare or other public reporting.”

Progress has been made, she continues. “We’ve had conversations with CMS, and they did report data on ‘never events,’ and we’re very pleased,” she notes. “They will get a lot of stakeholders concerned about too much public reporting, so we will have to continue to ask for it; it’s not something other stakeholders will be happy about. However, it goes back to transparency — it will be very, very important in maintaining this partnership of trust. We need full transparency of what we learn in the performance of hospitals so the public, employers, and other purchasers, as well as government agencies will be able to share that information and use it productively together.” ■

“Critical conversations” important in care process

Three key points identified in study

While interventions such as “time-outs” have gained support as important safety tools during procedures, not nearly as much attention has been paid to similar interventions where procedures are not involved. But similar tools are also extremely important in several such situations, argued a group of researchers from the University of California schools of medicine and nursing in San Francisco, who developed a set of interventions they call “critical conversations” for three key points of time during the care process: Admission, changes in clinical condition, and discharge.

“I was working closely with a nurse educator on a broader project, and he and I got into a discussion during a teaching session,” recalls **Niraj L. Sehgal**, MD, MPH, associate professor of Hospital Medicine and Associate Chair for Quality & Safety in the Department of Medicine at the University of California, San Francisco, and lead author of the article, which appeared in the April issue of the *Journal of Hospital Medicine*¹. “He said, ‘Why is it that you guys do not talk to every

bedside nurse of every patient every day?’ The reality is that the dialogue created by that would make it hard to get treatment plans moving. Think, for example, if I had patients on five or six different units and spent 10 minutes talking to every nurse. Even that nurse said they were not sure they’d want us to do that.”

However, the conversation continued, in a world where we know teamwork and communication are so important, perhaps we could think about times where face-to-face communication is really needed. “In the surgical setting, the idea of a timeout was mandated during the Universal Protocol; getting everyone on the same page seemed like a logical thing to do,” says Sehgal. “So we started to examine what such a tool and the policy and the structure around it would look like.”

At the time, the facility was paper-based (it now has an EMR). “We did the study on one of the medical units as part of the broader project,” Sehgal explains. “We started with educational efforts, leveraging our existing educational programs to bring the various disciplines together in a conference setting; it also included putting posters up in the unit.”

Key items enumerated

Why did they end up focusing on these three junctures? “There has been a lot of focus — quite appropriately — on trying to ensure team members are on the same page at times of procedures,” says Sehgal. “When we think of moving patients, the highest-risk times are during discharge, so that was clearly important. Admission also seems obvious, given these are new times and new entries. Then, changing clinical conditions — like unexpected deterioration — organically grew from provider comments. The idea was, it’s time to take steps; how do we prioritize, how do we make sure the patient gets what he or she needs? It’s a re-set, to make sure you’re doing the right things, because

KEY POINTS

- Discharge seen as highest-risk non-procedural part of care process.
- Staff were encouraged to come up with solutions.
- EMRs present a challenge for these types of tools.

the patient is potentially at higher risk.”

Part of the challenge with most communication interventions, such as handoffs, is to codify responses during such high-risk times, notes Sehgal. The researchers did just that, by creating a set of topics for each “critical conversation.”

So, for example, during admission process the discussion is to focus on the following:

- Admitting diagnosis;
- Immediate treatment plan;
- Medications ordered (particularly those new to a patient to anticipate an adverse event);
- Priority for completing any admitting orders;
- Guidelines for physician notification when a change in patient condition occurs.¹

For a change in clinical condition, the following is discussed:

- suspected diagnosis;
- immediate treatment plan;
- medications ordered (particularly those new to a patient to anticipate an adverse event);
- priority for completing any new orders;
- guidelines for physician notification when a change in patient condition occurs.¹

At discharge, the discussion includes:

- discharge diagnosis;
- follow-up plans;
- need for education/training prior to discharge;
- necessary paperwork completed;
- anticipated time of discharge.¹

It was the staff, says Sehgal, that “really came up with the solutions.” He posed a number of questions at the outset of the process “to get them to create the talking points — to let them raise the key issues.” So, for example, he asked them what they talk about when a patient is admitted, how often they found they had all the information they needed, and how easy it was to prioritize steps to be taken.

Challenges, lessons, and best practices

Interventions like these are not without their challenges, notes Sehgal. “One challenge is how to really enforce it — how to really measure a good communication intervention,” he shares. “You can, of course, measure if it happened or not.”

In order to better measure the intervention, he continues, teams were interviewed two days after being on call and asked if they had direct conversations. “We followed that up with educational conversations with nurses about how things were going, and if they found that doctors were contacting them more at those three junctures,” says Sehgal.

Another challenge, it seems, was unavoidable, given the march of technology. “If you walked up to a medical unit at two in the afternoon four years ago before the electronic medical record, people of all disciplines would have been running around the unit mainly because they all had to find a chart,” Sehgal observes. “This created informal communications because they were all in the same space. Now, if you walk up to a medical unit at two it often looks like a ghost town; doctors are three or four floors away in the charting lounge, and nurses are also at computers. It has had an unintended consequence of removing times for informal communication.”

How can you meet this new challenge? “With the arrival of so many computer tools, you must figure out how it will fit into the EMR, and in general how to create a cohesive message of how we communicate,” says Sehgal.

“You can argue it’s even more reason to get this embedded in the culture,” he continues. This, he says, flows from education and from embedding the intervention into the care process. “Buy-in comes from seeing it work,” he asserts.

One of the lessons he learned, Sehgal says, is that such an intervention should be part of a broader program of improving teamwork and communication. “There are so many different interventions on different units,” he declares. “One thing we like to do is marry them together in ways to make it more cohesive, so every provider does not think he’s being asked to do so many things in silo.”

One best practice cited by the authors is capturing stories of success. “Stories are equally important to data,” Sehgal asserts.

Demonstrating effectiveness is both a challenge and a best practice, he continues. “It’s not that different from many communication interventions — how frequently it occurs, and whether people are adhering to it, and, like in timeouts, whether it is affecting clinical outcomes,” says Sehgal. “This is very challenging to demonstrate.

“The main lesson we learned is that the front-line providers are not only the best folks to identify where the gaps in care are, but without question the best to come up with solutions,” Sehgal continues. “The more you can get them involved, the more you really allow them to be part of making change. This undertaking is not successful if it’s a top-down intervention.”

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Using behavior, not vital signs, to assess pain

Tool focuses on non-communicative patients

How is your pain today? On a scale of 1 to 10, how would you rate your pain? Are you comfortable today? Did the medication lessen your pain? All of these questions are typical methods for physicians and nurses to assess the effectiveness of pain control methods. They work well for most patients, but what do you do when the patient cannot communicate?

“We have a lot of pain assessment tools available for newborn patients but there is no tool that addresses pain in non-communicative adults,” says **Deborah Bortle**, MS, BSN, CHPN, director of quality compliance at Hospice of Lancaster County in Lancaster, PA. Although hospice nurses use observation of various patient responses to assess pain in patients who could not communicate, there has been no standardized method for the process, she says. The need for a proven, standardized tool was the reason her hospice chose to participate in a study of a new tool being developed by researchers at University of Maryland Medical Center.

Initial results for the Multidimensional Objective Pain Assessment Tool (MOPAT) do show that pain control is more effective when assessment of pain and evaluation of pain control methods are standardized,¹ says lead researcher **Deborah McGuire**, PhD, RN, FAAN, professor and director of the Developing Center of Excellence in Palliative Care Research and Oncology Graduate Program at the University of Maryland School of Nursing in Baltimore, MD. The tool is a result of four research projects con-

ducted in several locations over many years, she says. The forms enable nurses and other providers to score behavioral and physiological indicators or signs from the patient, she explains.

Focus groups helped researchers gather information about how nurses assessed pain in non-communicative patients in one of the first projects, explains McGuire. “After the focus groups, we took the Post Anesthesia Care Unit Behavioral Pain Rating Scale (PACU BPRS), a pain tool designed for inpatient post-surgical patients, and modified it to reflect input from hospice nurses,” she says. Behaviors such as restlessness, tense muscles, frowning or grimacing, and patient sounds along with physiological signs such as blood pressure, heart rate, respirations, and diaphoresis were evaluated as indicators of pain.

At this time, researchers are waiting on data from their final test of MOPAT in a larger sample of both hospital and hospice inpatient settings before releasing the tool, as some preliminary results may help some people enhance their own pain assessment methods. Although nurses often rely upon physiological symptoms to indicate pain level in non-communicative patients, reliability was more consistent for the behavioral signs, says **Karen S. Kaiser**, PhD, RN-BC, CHPN, AOCN, clinical practice coordinator at the University of Maryland Medical Center, adjunct associate professor University of Maryland School of Nursing, and co-author of the study. “We were not surprised at this finding,” she says. “We know chronic pain in hospice patients does not produce changes in vital signs,” she says. The fragile condition of hospice patients and the medications they take reduce the fluctuations in blood pressure, heart rate, and other vital signs, she adds.

“Nurses don’t use numbers to evaluate symptoms of pain, they use ‘none, mild, moderate, or severe’ to rank the intensity of behavioral signs,” says Bortle. “The nurses then write a narrative describing the symptoms,” she says. The narrative focuses on the behaviors exhibited by the patient, such as restlessness, tensed muscles, or sounds when moved, she adds. The tool is used to assess pain before and after intervention for pain, she says.

When testing the MOPAT for the study, Bortle’s nurses only used the tool in the inpatient hospice unit, but nurses who make home visits are now using it, she says. A one-hour CD developed by the hospice teaches nurses how and when to use the tool, she says. “At first, nurses did not want another form to handle, but once they became

accustomed to the form they liked how easy it was to use,” she says. At this time, use of the tool for home-based patients is voluntary, she adds.

A standardized form enables nurses and other providers to better communicate levels of pain and effectiveness of different interventions, points out Bortle. “When everyone is assessing the same behaviors as signs of pain, we improve our communication with each other and are able to improve patient care,” she explains.

Researchers expect the final data and the release of the tool to occur this summer.

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Staff-driven effort cuts door-to-doc time

Streamlined triage process sets the tone

Sumner Regional Medical Center in Gallatin, MTN, offers good evidence that quick turn-arounds are indeed possible when you have motivated staff. Within just four months, Sumner went from the 5th percentile to the 98th percentile, according to patient reviews of their experience in the ED. **Mary Jo Lewis**, FACHE, the chief executive officer (CEO) at Sumner Regional since September 2010, emphasizes that the dramatic transformation is the result of a staff-driven improvement effort that is ongoing to this day; however, it is nonetheless clear that her own visit to the ED late last year served as a healthy catalyst for change.

It was hardly an undercover operation. Lewis had been cleaning her house on a Saturday morning when she began to experience chest pains. She wasn’t dressed in her usual CEO garb at the time, so when she entered the ED, no one picked up on the fact that she was the boss. “Whenever someone walks in and says they’re having mild chest pains, [ED personnel] don’t ask you any more questions. They take you straight back and start hooking things up,” says Lewis. “So, for the first 20 minutes of my visit, I was a totally anonymous patient.”

While Lewis is quick to emphasize that the care she received was first rate, she noticed that people kept asking her the same questions over and over, and there were inexplicable delays. So, while her health turned out to be fine, the experience led to a top-to-bottom review of ED operations to see where processes could be tightened up.

Put every task under scrutiny

Lewis brought in an efficiency expert from the health system's corporate office to help, but the improvement process was really driven by the ED personnel themselves. "We got staff nurses, emergency physicians, and other key players in the ED to spend two days looking at the process we use," explains Donna Mason, RN, MS, CEN, SAEN, director of the emergency department. "You get graded on door-to-doc time, so we first documented every step that takes place from the time people enter the ED to when they see a doctor."

The process was eye-opening, says Mason, recalling that staff tallied as many as 44 steps that patients and ED personnel would go through before a physician even entered the picture. These included social questionnaires, such as domestic-violence screening and suicide screening, finding out what medications patients were taking, and documenting whether patients had received various preventive vaccinations, adds Mason. "These were all things that were very important to patients, but we looked at whether they were being done in the right place," she says.

Ultimately, ED personnel drastically reduced the number of tasks involved with the triage process so that patients now only go through four steps before seeing a physician:

- they are immediately taken to a triage station as soon as they enter the ED;
- a triage nurse collects "quick-admit" information, including the patient's name, birth date, social security number, and primary complaint;
- the patient receives an arm band with identification information; and
- the triage nurse takes the patient to a bed.

Now, most of the screenings and documentation tasks that used to take place during triage are being carried out by the primary nurse, who takes care of the patient at the bedside. "This does add work for the bedside nurses, but they're collecting information that they need to take better care of the patient," says Mason.

Such changes have slashed the average door-to-doc time from 67 minutes to just 18 minutes, and

this all occurred while volume actually increased, explains Lewis. "In October of 2010, we had 2,649 ED visits, and in March of 2011, we had 2,946 ED visits, reflecting a 10.5% increase in volume in a community where the population did not change," she says. "Some of this increase is attributable to flu season, but ED personnel were able to accomplish these efficiencies at a time when ED volume was very high."

Include hospital's IT staff in the loop

Whenever you revamp patient flow, you need to make sure your information technology (IT) is working with the system, stresses Mason. In this case, IT people were part of the team, so they were on hand to make adjustments as needed. "We had to completely revamp the documentation system on the front end from quick registration to how we did triage," she says. "Our IT people were making changes every day to make the process work with the care of the patient instead of making the care of the patient work with the process of the computer."

However, there were plenty of low-tech changes as well, says Lewis. For example, when reviewing the patient-flow process, it came to light that whenever the person manning the switchboard went to lunch, incoming calls were then diverted to the ED registration clerk, overwhelming her with unnecessary tasks when she really needed to be focused on incoming patients. "That wasn't smart, so we fixed that, and now when someone comes in, she can give them her full attention," adds Lewis. "It wasn't rocket science. It was just identifying little things like that, and now the registration clerks are a lot happier."

With patient satisfaction way up, there are still more improvements yet to be made. For example, the next process to go under the microscope will be staffing, says Mason. She doesn't anticipate any changes in terms of adding or subtracting personnel, but she expects there will be adjustments in shift schedules. "Typical ED [volume] peaks are at 9 a.m., 11 a.m., and 1 p.m., but here we have a pretty significant peak at 8 a.m.," says Mason. "We have a 9 a.m. to 9 p.m. shift for nurses, so we may look to move that shift to 8 a.m. to 8 p.m."

There may also be adjustments made to later shift schedules to accommodate changing volume patterns. "Emergency department traffic used to slow down by 11 p.m.," observes Mason. "That doesn't happen anymore. Now the ED census doesn't drop off until about 1 a.m., so we may

look at having our 1pm to 1am shifts moved to 2 p.m. to 2 a.m. We are really just adjusting our staffing to meet the needs of patients.” ■

New standards address patient communications

ED setting presents special challenges

In July 2011, Joint Commission (JC) surveyors will begin holding hospitals accountable for some of the elements of performance (EP) contained in new patient-centered communication standards that were first unveiled last summer. The new accreditation standards, which are currently in the pilot phase of implementation, are designed to ensure that hospitals take all necessary steps to make sure that patients get the information and support necessary to make appropriate decisions about their own care.

While the JC has had standards for patient-centered communications for years, **Christina Cordero**, PhD, MPH, associate project director, department of standards and survey methods, division of healthcare quality evaluation, the Joint Commission, explains that years of involvement with an initiative focused on hospital language and culture led the JC to conclude that new standards were needed. “One of the interesting things we found was that most of the organizations we worked with as part of that initiative had some type of language interpreting services,” she says. “But when we interviewed the front-line staff, we found that many of the staff weren’t using the services that were provided, for several reasons.”

For example, many staff members would complain that the telephone interpreting services their hospitals offered tended to be cumbersome or difficult to use; in other cases, passwords would be required to use these services, but staff didn’t have ready access to these passwords, says Cordero. “Many times, we also found that the telephones were locked in drawers or closets, and people didn’t have keys in order to access these tools to their full potential,” she adds.

Problems like these prompted the JC to develop new accreditation standards and to develop a guidance monograph to help hospitals most effectively meet these standards. That document, “Advancing Effective Communication, Cultural Competence, and Patient and Family-centered Care: A Roadmap

for Hospitals,” is available for download at www.jointcommission.org/Advancing_Effective_Communication.

Alleviate stress and fear

The first of these new accreditation standards to be fully implemented are EP 29, which states that hospitals are to prohibit discrimination “based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression,” and EP 28, which states that the hospital will “allow a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.”

Hospitals will be held accountable to these accreditation standards beginning in July 2011, says Cordero. “The intent behind [EP 28] is to just make sure patients can identify an individual who they want to be with them in the hospital, and that the hospital will allow this person to be there. The policy is not intended to dictate visitation policies or to call for open visitation,” she stresses. “It is really about alleviating fear and stress for patients when they are alone in the hospital. There was a lot of concern that the presence of individuals would put stress on the patient, when the reality is that the opposite is true. It really does help patients feel better about being in the hospital.”

For compliance with EP 28 and EP 29, JC surveyors may review a hospital’s written policies, mission statement, staff training procedures, and they may gauge staff awareness and understanding of these standards, says Cordero. “We also put a note with this element of performance that the hospital would allow the presence of this individual, unless it infringed on the rights or safety of other patients or it is contraindicated by treatment, so there is some flexibility to determine whether or not it is appropriate to allow the presence of some people,” adds Cordero.

Determine patient needs

Hospitals will have at least until January 2012 before JC surveyors will include two other new patient-centered communications standards in their hospital reviews. The first of these, EP 1, directs hospitals to identify a “patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.” The second provision, EP 2, directs hospitals to then communicate with patients “in a

manner that meets the patient's oral and written needs.”

To be in compliance with these provisions, hospitals need to try to determine what written materials patients understand, or if they have health literacy needs, and what kind of materials they need, explains Cordero. “In addition, communications needs can be personal devices that people have brought with them to the hospital such as eyeglasses or hearing aids,” she says. “Sometimes throughout the care continuum, people are separated from those devices, so it is a matter of bringing patients back their glasses or hearing aids to facilitate communication between patients and providers.”

Surveyors are likely to review what policies and procedures are in place to ensure patient communications are effective; they may also conduct patient interviews, review staff training procedures, look at what resources are in place to help with communications, and find out how these resources can be accessed, explains Cordero. ■

Program guides seniors through EOL process

Plan helps seniors make their own decisions

Seniors covered by BlueCross BlueShield of Tennessee's Medicare Advantage plan are guided through the end-of-life (EOL) processes and are being empowered with the education, resources, and assistance they need to make their own decisions about what kind of care they want to receive at the end of life.

The Chattanooga-based health plan end-of-life planning program received a bronze award in fall 2010 at the Best Practices in Health Care Consumer Protection and Empowerment awards ceremony from URAC, a Washington, DC-based organization that promotes healthcare quality through its accreditation, education, and measurement programs.

The program began in 2009 after the health plan started its Medicare Advantage program in 2006, says Alice Greer, RN, BSN, CPHQ, quality research analyst in quality management. “As we worked with the Medicare population, we realized that end-of-life concerns are a big issue. We found that even though some of the members knew they were facing a potentially terminal illness, they

hadn't thought about end-of-life plans, or if they had, they didn't have a legally appropriate form or had not shared their wishes with their family or their physician,” Greer says.

At the same time, the insurer determined that many staff members were uncomfortable initiating a conversation about EOL considerations and needed education to learn how to approach members about their choices. “We looked for ways to assess our Medicare population to identify people who needed the program and to aid the case managers in bringing up the subject with members and leading them through the process,” Greer says. *(For more information on the assessment process, see story, p. 83.)*

The case managers who work with the Medicare Advantage members have been trained on how to approach the subject and have information at their fingertips to educate the members. The health plan also collaborated with the non-profit Tennessee End-of-Life Partnership and sponsored a daylong educational program for case managers and the health plan's providers.

When seniors sign up for Medicare Advantage, the health plan sends them the health needs assessment. They can return it by mail and have it scanned into the computer program, or they can call and complete the assessment over the telephone.

Referrals come from the health needs assessment, from the utilization management department, from claims data that show members with multiple hospital admissions, and from the health plan's predictive modeling. The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage to conduct an initial health needs assessment.

“We tweaked our assessment and configured our computer system so it would automatically send out a referral when someone had a condition that indicated they might benefit from an end-of-life discussion,” Greer says.

Medicare Advantage members who are referred to the program are asked if they have EOL plans and if they would like to discuss the subject. Those who meet the criteria for needing immediate EOL support are offered a more intensive care plan, Greer says.

Criteria for the intensive care plan include debility, failure to thrive, cancer patients with a terminal diagnosis or uncontrolled symptoms, advanced heart disease patients, advanced pulmonary diseases, dementia, end-stage liver or renal disease, and neurological disorders.

The utilization management department has a trigger list of criteria. If someone calls to obtain approval for a procedure and the patient falls into one of the diagnosis categories, those nurses are trained to send a referral, she says.

Outreach calls are then made to all members who are eligible for the intensive care planning program. The services the health plan offers are explained, the services, how the EOL planning will occur, and how they can be empowered to make their own decisions. ■

EOL program makes thorough assessment

If senior members consent to participate in the BlueCross BlueShield of Tennessee's Medicare Advantage end-of-life (EOL) plan, a thorough assessment is made that includes their current health status; their present functional status; resources they have; their caregivers; their understanding of their current level of health, diagnosis, and prognosis; information on their socioeconomic status; and any educational or language barriers.

The Medicare Advantage staff includes two social workers who help people complete the forms over the telephone or, if the member prefers, will meet with them at the health plan's Silver Life Center in Chattanooga, TN. Consent to notify the member's primary care provider is then obtained to collaborate with the physician as well as the caregiver so everyone is on the same page.

One of the goals of the EOL program is to overcome the negative impression many older people have of hospice care by educating them. Some members aren't aware of the hospice benefits they have. Others don't take advantage of them because of their perception of what hospice means, says Alice Greer, RN, BSN, CPHQ, quality research analyst in quality management.

"Length of stay in hospice is incredibly short with our Medicare population," Greer says. "If somebody doesn't get into hospice until the last two days of their life, they've lost the opportunity to increase the quality of life, have gone through unnecessary procedures, and increase the stress on the family. Knowing about hospice and what it means saves people a lot of panic-mode trips to the emergency room for interventions and makes them feel more in control." ■

Advocating means being a good steward

Keep limits to coverage in mind

Being an advocate for your patients is more than just trying to get them every treatment available. It's being a good steward of their healthcare funds so they'll have benefits for treatments in the future, says B.K. Kizziar, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Nobody has an unlimited bucket of resources," Kizziar says. "Case managers in all practice areas should be aware that patients are going to have needs after this particular episode of care and conserve their resources whenever possible."

The first step in the process is to be informed about your patients' benefits and resources and develop a plan to make them work for the best possible transition of care, she adds. Look at your patients' lifetime benefits while developing a treatment plan, Kizziar says. "For instance, if a chronically ill patient needs home care, look at the annual limit on home care visits. It might be wonderful if he could get five visits a week but if the limit is only 20 for the whole year, suggest the minimum he can get by with so he'll have funding to last the rest of the year," she suggests.

Remember that even when a patient has no lifetime maximum, that doesn't mean he or she has a blank check for healthcare costs. Even unlimited lifetime benefits usually have some kind of annual maximum, Kizziar points out. "Case managers should be concerned about doing the right thing for the patient at one particular time. Patients don't necessarily need a comprehensive total work up if they come in for one particular ailment. Part of the role of case managers is to partner with the

COMING IN FUTURE MONTHS

■ Measurement of children's healthcare quality must be improved.

■ 'Blues' provide hospitals with quality improvement incentives.

■ Quality requirements for meaningful use are clarified.

physician to ensure that patients get what they need to transition as smoothly and appropriately as possible,” she says.

Case managers should ensure that their patients know all the options for care and become actively engaged in the healthcare process and decision making. They should also provide the information they need to make informed decisions, she says.

Beware of making personal judgments about what patients can or can't afford if their insurance doesn't cover a particular service, says **John Banja**, PhD, professor, Department of Rehabilitation Medicine, and a medical ethicist at the Center for Ethics at Emory University in Atlanta. “Often healthcare professionals make up their mind as to how much patients can afford, and they don't mention a modality if they think the client can't afford it. This is always a mistake. You never know what the client or patient has in the way or resources. Case managers should always inform the patient about whatever reasonable options there are and not make judgments about what he or she can afford,” Banja says.

For example, if a patient could benefit from home care but doesn't have coverage for it, talk to the family. They might be able to find a way to pay for it. Kizziar says, “In healthcare we tend to think we know what is best for our clients, and we have made them dependent on us. But with the changing healthcare environment, it's critical to help them become more engaged in their own care plans. This means giving them more information about what is covered and what is not, and giving them the option, and letting them make their own decisions,” Kizziar says. Doing otherwise takes the decision process away from the patients, she adds.

In some cases, when spending a little more now can save a lot more later, providers and payers might be able to work out a way for patients to get what they need, Banja says. For example, a patient might have a limit of 10 physical therapy benefits, but when he is reaching the limit, the case manager sees that he is doing so well that if he has five more visits, he could be entirely fit to return to work and avoid reinjuring himself. In this case, not only would the patient benefit, the third-party payer also might benefit by saving money down the road, he says.

“The case manager could make a plea for the insurer to cover extra visits. If that doesn't work, she could ask if the physical therapist would give a self-pay patient a discount and ask the patient if he's willing to pay a reduced rate out of pocket,” Banja suggests. ■

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