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TJC launches 'solution exchange' to addresses core measures

High performers will be able to share keys to success

Believing that facilities that have significantly improved their performance in core measures will be able to help others improve by sharing their experiences and knowledge, The Joint Commission has launched what it calls 'The Joint Commission's Core Measure Solution Exchange' to facilitate this process through the establishment of a website where hospitals can both post and search for information.

"We've had these measures for quite some time, and we're pleased that overall there has been significant improvement in performance across the board in the last six years, but we also know there are some hospitals that lag behind," says **Scott Williams**, PsyD, associate director of The Joint Commission's Division of Healthcare Quality Evaluation.

Williams says this approach is something new for The Joint Commission. "We decided to experiment a little with whether we could link those hospitals that have already improved to those that need to," he says, adding that at this point use of the site is totally voluntary. "We haven't specifically targeted lower-performing hospitals," Williams says. "There may be some point in the future when we could tell a hospital we've noticed they're struggling with a measure, and this is a way they can improve."

KEY POINTS

- Online service will be available to all accredited facilities.
- The Joint Commission has chosen some hospitals to post information on its website, to ensure solutions will be available to other users.
- Searches can be conducted according to size, location, and specific measure; users also can make notification requests.

Some "mentors" chosen

As it stands right now, any accredited hospital that has access to the Solution Exchange can describe a PI project that has worked, Williams says, "but we also wanted to make sure that when we put new measures out we had solutions for people to look for." So, he explains, in October 2010, a pilot test was conducted around surgical care measures. Williams says The Joint Commission "primed the pump" to generate site content; it invited postings from organizations whose core measure data showed that they had improved.

"These were not necessarily stellar performers from the get-go," Williams says. "We looked for facilities that had started lower, and then had statistically significantly improved performance to where they met or exceeded the national target and sustained improvement over a minimum of six months." These facilities, he continues, received an invitation to post their experience on the site; during that pilot test, 73 solutions were posted that ran the gamut of surgical care measures.

"In May, we added the rest of the measures and sent out invitations to a cohort of 200 solutions that cover a wide range — but not yet all — of the core measures," says Williams. "But even if you've not been invited to post, any accredited organization that visits the site can describe what they've done if they think it's useful to share." *(For an example of one of the facilities invited to post, see related story, page 87.)*

Solutions that are posted are set up according to a template provided by The Joint Commission, "but the hospital defines the problem in its own words," says Williams. Then, he adds, the hospital discusses how it analyzed the problem; what causes it discovered; what solutions it implemented in order to improve; any other types of measures it used to evaluate progress; challenges and barriers and how they overcame them; and how they sustained their progress. "You can also attach articles, links, order sets, PowerPoints, and so on," Williams notes.

The information is posted directly; The Joint Commission does not review the content. "This is a departure for us," says Williams. "We're basically providing a community of users with a forum, but not vetting content. We are giving users the ability to rate the value of solutions, to post comments, and so on."

Several search options

Users have several options for searching for solutions of interest to them. "For example, those who post solutions can identify primary and secondary measures that apply, and those who wish to view it may see a number of different things they can use," says Williams. "They also have the ability to add keywords."

In addition, he continues, if users wish, they can drill down farther for more targeted information. "You can, for example, identify the measure," Williams says. "You can include a whole bunch of demographic hospital care statistics. So, for example, if you want to, you can search surgical care infection prevention measures submitted by hospitals with fewer than 50 beds in a rural setting; if you put that in, the site will give you all hospitals that meet those

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EDITORIAL QUESTIONS

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criteria."

You can also further specify information based on all keywords, and can then filter that by measures, he notes. "For example, you can search surgical care measure solutions that involve 'assignment of responsibility,'" Williams explains. "You can also search for the highest rated solutions, or the newest solutions." Finally, he says, users can subscribe to "notification," and will then be notified via e-mail any time something they're interest in is posted.

But will it work?

Having examples to follow is all well and good, but has Williams found evidence that this strategy will result in improvement on the part of those hospitals that are not currently high performers? "Not as such, although if you look at the diffusion research literature, what we know is that before an organization or an individual can adopt a new innovation, one of the things they want to know is whether their peers have done anything with this approach," he says. "We're kind of building on this — if a hospital wants to know something's worth improving but they're gun-shy, can we show them something that will work for them? This will expand their network of peers — not just to the hospital across the street but to the accredited hospital community."

On the other hand, Williams' optimism is tinged with a note of caution. "High-performing healthcare systems do have a lot to teach, but the learning process and transformation are not simple," he says. "If knowledge were enough, we'd all be there already."

While it may be too early to judge the program's effectiveness, Williams says a survey was conducted following the pilot program, "and the feedback we got was very positive," he reports. "The biggest criticism was that they wanted more measures included."

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One of the "chosen" tells us how they did it

One of the facilities invited to post its experiences on The Joint Commission's Core Measure Solution Exchange is Hartselle (AL) Medical Center, which was recognized for "Adult Smoking Cessation Advice Counseling." **Judie Speer**, RN, MSN, chief quality officer, explains what the measure requires and the kind of information visitors to the site will be able to find.

"You have to have documentation within your medical records that you have offered smoking cessation advice counseling," she says. "We have concurrent reviewers who go out on the unit, review performance, and see if we're actually documenting and giving out information." If not, she leaves the doctors and nurses notes to do it.

How did this program come about? "My quality team decided what we needed to do," says Speer. It works like this: Whenever a patient comes to the facility and is being admitted, the staff immediately hand out information about smoking cessation — whether or not the patient or family member smokes.

"Then, when they are put on a nursing unit, the nurse does an assessment — lung sounds, heart sounds and so on, and finds out if they smoke," says Speer. "Again they are offered educational material, and it's documented in the chart."

The materials actually reside in the facility's AS 400 computer system. "The system is also in the ED, so education material about medications or cessation can be given there as well," Speer adds.

The facility also uses standardized order sets for smoking cessation, which cover treatments such as nicotine patches. "If they need therapy, our respiratory therapist reinforces education on cessation of smoking and documents it," Speer says.

It's easy to document your performance, Speer says. "CMS audits our records, so when we extract them we put them in our computer. They send us a note back saying they need us to send five random records to audit and they give you a grade, or a validation score," she explains. "You have to make 75% or above to be considered as passing validation, and we're usually at 95%; we've basically nailed it."

Speer also has advice to share about what happens if you don't "nail" it. "If we keep having a problem with one of the core measures, we do an action plan on how to correct it," she says.

That seems unlikely to happen with this smoking cessation initiative. "This year, we also went to a non-smoking campus as a model to the community," Speer says. "This was a real issue, because a lot of patients' family members smoked. Now, even the staff has to go off property to smoke." Speer adds that smoking cessation programs and medications were also made available to the staff. ■

Study examines trends for Medicare patients at EOL

Findings indicate more time is spent in the ICU

A new study from the Dartmouth Atlas Project seems to indicate the "report card" for Medicare patients at the end of their lives is a mixed bag of pluses and minuses. On the positive side, the study, "Trends and Variations in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness," showed that Medicare beneficiaries with severe chronic illness spent fewer days in the hospital at the end of life in 2007 than they did in 2003, and that they were less likely to die in a hospital and more likely to receive hospice care. On the other hand, they were more likely to be treated by 10 or more doctors in the last six months of life in 2007 (36.1%) than they were in 2003 (30.8%), and the average number of intensive care days increased to 3.8 from 3.5.

"The fact that these patients are spending less time in the hospital is connected with the fact that they are spending more time in hospice," notes lead author **David Goodman**, MD, MS, the co-principal investigator of Dartmouth Atlas of Health Care, professor of pediatrics and of health policy, and director, Center for Health Policy Research, at the Dartmouth Institute for Health Policy and Clinical Practice. "But the fact remains that these are the two domains where patients receive higher-intensity care, and there were more ICU days. And it's not just the ones left in the hospital who are sicker patients; there are more numbers of ICU days across the entire population of those who died, so there is a real increase of ICU care in this population. Patients certainly spend less time on general hospital wards, but they spend more time on the ICU."

Goodman says the medical profession is uncertain as to why this is, and adds, "This is not true for every hospital. It's fascinating that there are some hospitals where their change is in parallel with this study, while others have defied this general trend."

In other words, he continues, it is not the "destiny" of any specific facility to have these patients spend more time in the ICU. "I think one of the important factors that tend to shape the local experience is how local healthcare systems invest — and what they invest in," says Goodman. "Places that make relatively greater investment into ICU units can be providing valuable care for certain patients, but they can have unintended consequences as well."

Patients prefer less intensive care

One of those "unintended consequences," says Goodman, is lower patient satisfaction at a difficult time in their lives. "For this report, one of the major findings is that patients near the end of life on average strongly prefer to spend as much time as they can in a home-like environment," he says. "Many spend time in the ICU when it is not their preference — but that preference is not often elicited or legitimized by healthcare systems that have tremendous resources available for curative care and then assume the patient wants that applied to them, even in situations where the likelihood of their returning to the life they once knew is nil."

In earlier research, notes Goodman, "We studied the relationship of intensity of care and the HCAPS rating, and patients' perception of hospital experience and quality of care, and it really showed a negative correlation — patients were most unhappy in places where care was of the highest intensity. Also, many research studies look at what happens in patients at the end of life in terms of decision quality — whether their preferences are followed by caregivers, even when those preferences are clearly articulated." What did he glean from that research? "We have a long way to go," he says.

Intensity of care has a lot of physical consequences as well, says Goodman. "Sometimes a patient will be in the ICU and we will not only save their life, but create the opportunity for that patient to acquire an HAI, or the clinician may give the patient more cyto-toxic chemotherapy, which can lead to pneumonia. These are fragile patients, and sometimes intensity can tip them over the edge."

Trends must be reversed

Goodman says that for things to improve in hospitals, health systems and providers must "unlearn" certain assumptions. "In places that have grown their population of physicians and sub-specialists, that is the capacity that gets used," he explains.

"I am a trained physician," he continues. "The classic way we think of ourselves is that our job is to gather as much information as we can about

the patient and their condition; we have knowledge of treatments, we learn about the patient's condition, and we make a recommendation."

But that common role of making recommendations does not work today, says Goodman, and it won't in the future — particularly for very sick patients. "It assumes we understand all of the care options, and often we don't," he asserts. "Oncologists, for example, are very much focused on curative care, but they won't be experts on palliative care. They may not understand what the patients' values are; studies have shown that doctors often use their own value sets. That approach is well intentioned, but it misses the mark."

What's more, Goodman continues, there is no correlation between intensity of care and measures of technical quality. "When you spend many more days in a hospital ICU, you see many different doctors, but the quality of care tends to be lower," he observes. "We think that's because care becomes disordered. There are more handoffs, and more chances for missed communication."

In addition, he says, electronic medical records do not solve that problem. "EMRs rarely extend to full care, especially in chronic care facilities," Goodman asserts.

Reduce spending, improve quality

Another implication of the study's findings is that "providers can look for insights into potential savings they can achieve through improved care of chronic illness that allows patients to remain safely out of the hospital," asserted Risa Lavizzo-Mourey, MD, MBA, president and CEO of the Robert Wood Johnson Foundation, a longtime funder of the Dartmouth Atlas Project, in a statement released to accompany the study's publication.

Goodman agrees. "We shouldn't be surprised we're spending more money on healthcare than any other developed country in the world, but there might be opportunities to do a better job with less money, particularly when some patients get expensive care they do not want," he says. "There are opportunities for accomplishing greater efficiencies thoughtfully. I'm not talking surgery with dull tools, but crafting our models of care and reimbursements so we can deliver higher quality for less cost."

End-of-life care, he continues, is one place where we know if patients get palliative care services early in the care of chronic illness, they have a much better experience. "They generally have a lower intensity of care, which saves money, and at least in cancer care, there are studies that show they actually live longer," says Goodman.

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KEY POINTS

- Patients are more likely to be treated by 10 doctors or more.
- Researcher says that great intensity of care does not necessarily mean higher quality of care.
- Physicians must listen more carefully to wishes of patients at the end of life, researcher says.

Meaningful use quality requirements clarified

New regulations always bring with them their share of questions and confusion, but perhaps none in recent memory have raised as many questions as those governing "meaningful use." In an effort to clear up some of that confusion, the Centers for Medicare & Medicaid Services (CMS) has posted a FAQ that addresses "attestation statements" providers are required to concur with if they are to show meaningful use of electronic health records, and thus qualify to receive an incentive payment.

So, for example, facilities have to attest that the information they submitted for 15 clinical quality measures was generated by "certified" EHR technology and that the information is "accurate and complete for numerators, denomi-

nators, exclusions, and measures."

Here is an excerpt from the FAQ that outlines the attestations to which an eligible professional, eligible hospital, or critical access hospital must agree in order to successfully demonstrate meaningful use:

- The information submitted for clinical quality measures (CQMs) was generated as output from an identified certified EHR technology.
- The information submitted is accurate to the knowledge and belief of the EP (Eligible Professional) or the person submitting on behalf of the EP, eligible hospital, or CAH (Critical Access Hospital).
- The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EP, eligible hospital, or CAH.
- The information submitted includes information on all patients to whom the measure applies.

The FAQ goes on to explain that with the exception of CQMs, "meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. EPs, eligible hospitals, and CAHs can use a separate, uncertified system to calculate numerators and denominators and to generate reports on all measures of the core and menu set meaningful use objectives except CQMs."

In addition, according to the FAQ, "In order to provide complete and accurate information for certain of these measures, they may also have to include information from paper-based patient records or from records maintained in uncertified EHR technology."

The entire FAQ can be found at: http://questions.cms.hhs.gov/app/answers/detail/a_id/10589. ■

Callbacks can improve patient satisfaction

Experts: Patients appreciate follow-up

With Medicare's new value-based purchasing (VBP) program set to begin impacting payments to most acute-care hospitals in October 2012, providers have been put on notice that the fee-for-service payment methodology is being gradually replaced by payment formulas that reward quality. Further, under the final rules unveiled for VBP by the Department of Health and Human Services in April, a full 30% of the funding that will be set aside to reward quality will be based on how patients rate the care and experience that they receive while in the hospital.

While managers have long been concerned about patient satisfaction, the VBP initiative is certainly upping the stakes considerably. However, one way to gain the upper hand on this issue is to implement a practice of routinely checking back with patients who have been discharged from the ED to make sure their recovery is on track. Experts maintain that not only does this type of follow-up enable you to intervene quickly if there is a clinical problem, but patients also, naturally, appreciate having someone check up on how they are doing.

"From a patient satisfaction perspective, it is a differentiator. Patients love it," says **Jay Kaplan**, MD, FACEP, the director of service and operational excellence for Emeryville, CA-based CEP America, Emergency Physician Partners, and medical director of the Studer Group, a health care consulting firm based in Gulf Breeze, FL.

Consider link between quality, satisfaction

There is, in fact, a correlation between patient satisfaction and quality, observes Kaplan. "Some people think that core clinical quality, such as making the right diagnosis and giving the right medicines, is the real stuff, and that customer service or service excellence is the fluff stuff," he says. "But quality and service are intricately interdependent, and by making that phone call to someone for follow-up, you are confirming the diagnosis, and from a quality-outcome perspective, we know that people who rate the satisfaction of their experience higher are more likely to adhere to instructions and medication regimens that you give to them."

Typically, more than half of all patients discharged from the ED lack a full understanding of their discharge instructions, and a high percentage of these patients are not even aware that they may be doing things incorrectly, adds Kaplan. "From a quality perspective, [follow-up calls] give you the opportunity to ensure that people understand their instructions and how to take their medicines," he says.

Moreover, from an education and risk-management perspective, the calls enable providers to confirm their diagnoses. "I worry about my patients sometimes, so this gives me an opportu-

nity to see that it was what I thought it was or, alternatively, if we made a diagnosis and it turned out to be something else, it gives us the opportunity to intervene and recommend some alternative course of action. That can save lives."

For example, Kaplan recalls the case of a 52-year-old man who came into the ED with chest pain. "He had a negative stress test, but when I called him up the next day, he said that he knew it was not his heart, but it felt like he had an elephant sitting on his chest," says Kaplan. "I told him to come back in, and he had angioplasty done."

Start with a modest request

Kaplan recommends that follow-up calls be made to patients between 24 and 48 hours post-discharge from the ED, but he notes that you will still receive positive results even if these calls are made within a week of discharge. Further, while any clinician can make follow-up calls, the impact is more powerful when they are made by the treating physician, adds Kaplan.

Providers may push back on the idea of making follow-up calls, complaining that they don't have the time, but Kaplan says you can usually get the program started by making the modest request that every physician and nurse practitioner call two patients for every shift that they work, and that they document these calls. "If they get their individual patient-satisfaction score, they typically see such an improvement that it gives them the motivation to make many more calls," says Kaplan.

He also encourages any clinicians who make these follow-up calls to share their experiences with colleagues. "I often think it is best if the members of the departments themselves make the calls because then it is a little closer to home when somebody you work with tells you that he called your patient back and this is what he found," says Kaplan. "If you have someone who is on modified work leave because they cannot do heavy lifting or stand on their feet for long hours, [making the follow-up calls] is a great activity for such a person."

Use non-clinicians to retrieve feedback

While there are some advantages to having clinicians make the callbacks, **Mark Reiter**, MD, MBA, a practicing emergency medicine physician and CEO of Emergency Excellence, a Bethlehem, PA-based consulting firm, says there are other ways to approach the task as well. For example, he prefers to recruit personnel with excellent interpersonal skills, bilingual capabilities, and knowledge of HIPAA (Health Insurance Portability and Accountability Act) regulations to make callbacks to the 150,000 to 200,000 patients per year that his company is engaged to follow up with.

"I would say that 2% to 3% of patients report their condition has gotten worse, and 2% to 3% report that they don't understand their discharge instructions, and there is a lot of overlap between those two groups, so it usually ends up that less than 5% overall have one of those two issues," explains Reiter. "So we don't feel it is particularly cost effective to use a clinical person to make those calls when 95% of the time, clinical knowledge is not necessarily needed."

Instead, whenever a clinical issue or a significant patient satisfaction problem is identified by a patient callback representative, he or she will notify the appropriate individuals at the hospital right away by fax or email so that the matter can be dealt with promptly, says Reiter.

"There is a lot of value in using patient callbacks to track patient satisfaction, particularly to get feedback on the emergency department experience overall, as well as on individual physicians and nurses," adds Reiter. "When we identify patients who are dissatisfied after they leave the ED, [and then intervene through service recovery], then that is a good way to reduce malpractice claims, and certainly to improve patient satisfaction scores."

Callbacks are not recommended for every patient who is discharged from the ED, says Reiter. For example, you are much less likely to derive value from calling patients who have been discharged to a psychiatric facility, another ED or hospital, or a skilled nursing facility, and it can be very difficult to reach people who have been discharged to prison, he says.

"We also find that our [phone call] completion rate is much higher on Saturdays and in the evenings," says Reiter, noting that it also helps to let patients know that they may be receiving a follow-up call upon discharge, and to note that in their discharge instructions.

As recently as five years ago, patient callbacks were relatively rare in the ED, but the practice is growing in popularity, stresses Reiter. "ED and hospital leaders are much more cognizant of the need to collect data and to get feedback from

their patients than they have in the past," he says. "Hospitals really want to differentiate themselves from their competitors, and patient callbacks are a way to provide service above and beyond what patients expect." ■

OB program aims to cut claims, improve safety

The nation's largest Catholic and nonprofit healthcare system is launching a demonstration project to determine best methods to reduce or eliminate birth complications and at the same time seeking to avoid obstetrics claims through a renewed emphasis on transparency and full disclosure.

Ascension Health, based in St. Louis, MO, has begun the Excellence in Obstetrics program within the obstetrical care units at five Ascension Health facilities. The project is made possible through a $2.9 million grant that Ascension Health received from the Agency for Healthcare Research and Quality (AHRQ) under its Patient Safety and Medical Liability initiative.

The AHRQ initiative seeks to foster better doctor-patient communication, and ensure patients are fairly and quickly compensated in a fair and timely manner for medical injuries, thus reducing the incidence of lawsuits and liability premiums. The initiative also seeks to reduce the incidence of frivolous lawsuits and liability premiums.

The Excellence in Obstetrics project is designed to determine whether and how birth complications can be reduced or eliminated altogether, says **Christine K. McCoy**, JD, vice president of risk management at Ascension Health. It also will evaluate medical liability models that put patient safety first and foster better communication between doctors and their patients. The project initially will focus on improving patient safety and outcomes related to obstetrical deliveries, with the long-term goal of spreading concepts and key lessons to other high-risk areas, including emergency departments and operating rooms, McCoy says. The goal is to evaluate 40,000 obstetrics patients representing uniquely diverse geographies and ethnicities.

The model being studied is based on a pilot program of team training, situation analysis, and simulation exercises that have been developed as part of a bundle with measurable outcomes, says **Ann Hendrich**, RN, PhD (c), FAAN, vice president of clinical excellence operations for Ascension Health. One example is a new method for responding as a clinical team to changes in electronic fetal monitoring, and evaluation of how cases of shoulder dystocia are handled.

"We believe the Excellence in Obstetrics demonstration project will help save the lives of mothers and their babies by improving safety in the birthing process," Hendrich says.

The project also will evaluate a medical liability response model based on full disclosure, transparency, and early resolution, McCoy says. The model also calls for an immediate root cause analysis when unpredictable events happen. "We want to see, when we do a uniform approach to communicating with patients, if that has an impact on their response," McCoy says. "Do they still file a claim or suit? Or when the incident is without error, can we explain to the family what happened and potentially reduce any frivolous suits?"

The five Ascension Health Ministries that will participate in the study are: Sacred Heart Hospital on the Emerald Coast (Miramar Beach, FL), St. Vincent's Birmingham (Birmingham, AL.), St. John Hospital and Medical Center (Detroit), Columbia St. Mary's (Milwaukee), and Saint Agnes Hospital (Baltimore). The sites were chosen in part because they treat patients from a wide variety of social and economic backgrounds. The patient education materials are available in 11 languages, including Arabic, Farsi, Vietnamese, Burmese, and Hmong. "The business case for patient safety has not been adequately established in health care," Hendrich says. "We anticipate that the Excellence in Obstetrics project will offer successful models of practice, and we intend to translate the anticipated success of this program to other hospitals and clinical practice areas across Ascension Health and, ultimately, to other healthcare facilities across the U.S."

The program began in January 2011. While it is too early for any results to be available, the initial response from physicians, nurses, and patients has been extremely positive, McCoy says. More than 1,000 health care professionals have been trained in electronic fetal monitoring, simulation, managing shoulder dystocia, disclosure, and cause analysis. The sites also have begun consenting patients, and more than 80% of those approached have agreed to participate in the study.

At each participating facility, the lead obstetrician acts as the principal investigator, supported by the lead nurse, risk manager, and a project manager. The sites provide education and training

to all clinicians working with the OB unit, going beyond the standard competency training, McCoy says. For example, electronic fetal monitoring is a seven-module course for physicians and nurses, offered online. The shoulder dystocia training is provided in the same way, and the participants also are trained in crisis response and teamwork using simulations. Ascension Health provided all of the sites with a high-tech mannequin and new video equipment for the training.

All of the clinicians go through a three-hour course on communication and disclosure, and some leaders take additional training, McCoy says.

Ascension Health expects to see significant patient safety improvements from the Excellence in Obstetrics program, but there are no specific thresholds for success.

"If we implement a comprehensive approach to reporting, investigating, and communicating events, we will see a reduction in frequency and severity. The question is how much and how soon," McCoy says. "Obstetrical claims have a longer lag time than most claims typically do, and they're fairly rare events, even though they can be quite large claims. We're looking at our past data to benchmark our past experience, and we hypothesize that we will see significant results in the coming years."

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Tips for cutting infection risks in the ED

ED makes prevention a top priority

You may have been taking care of a patient for hours without realizing he or she has an infection that requires isolation. The fast-paced ED environment is an added challenge in preventing ED-acquired infections, according to **Susan Gray**, RN, BSN, CEN, an ED nurse at Greater Baltimore (MD) Medical Center. "Staff are in and out of rooms often," she adds.

Gray says that preventing ED-acquired infections has become "a top priority" in her ED. "It is an agenda item on the ED council about every month," she says. "We have hand-washing champions, as well as inservices on the proper ways to assist in the placement of central lines and on the proper use of isolation."

ED nurses now ensure the doctor is maintaining sterile procedure, says Gray, and that he or she does, in fact, stop a procedure if sterility is not maintained.

"Other changes have been how we assist and monitor physicians in placing central lines, placing our own peripheral IV [intravenous] lines, and the proper use of isolation," says Gray. To reduce ED-acquired infections, experts recommend making these practice changes:

Use chlorhexidine instead of 70% isopropyl alcohol or povidone-iodine.

"The proper use of [chlorhexidine] has been crucial to our blood culture contamination rates," says Gray. "We use it to place all of our IV lines."

By making this change, says **Kathy Karg Gutierrez**, RN, BSN, CEN, care coordinator for the ED at Fletcher Allen Health Care in Burlington, VT, "we have seen a remarkable reduction of contaminated blood cultures."

The ED cut its contamination rate in half, from 3% down to 1.6%. "We are the largest collector of blood cultures, with one of the lowest rates in the hospital, which we are pretty proud of," says Gutierrez.

Use a central line protocol to reduce the risk of sepsis.

This includes a 30-degree head of the bed elevation for ventilated patients, says Gutierrez. "We are very focused on early antibiotics for sepsis and pneumonia patients," she adds.

If a patient requires a ventilator, use a mobile intensive care unit (MICU) order set.

Oral care is done if the patient requires it, says Gray, but the patient does not typically stay long enough in the ED to require this. "These patients usually make it out of the ED and into the MICU quickly, so this order set is then continued in the MICU," says Gray.

Use specific order sets for central line insertion.

"This allows the person assisting with the procedure to ensure patient safety and decrease infection," says Gray.

ED nurses use a checklist for items such as what the doctor inserting the line was wearing and what they used to clean the area. "It also

allows the staff member to stop a procedure if they deem the doctor is not following proper procedure and putting a patient at risk," says Gray.

Make education mandatory on prevention of central line-associated bloodstream infections.

"This includes proper ways to draw blood and give medications and fluid through a central line," says Gray.

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Boost care coordination between ED, primary care

No quick fixes, but process improvements can help

If improved care coordination is integral to bending the health care cost curve, then the interchange between emergency physicians and primary care practitioners (PCPs) is in need of significant improvement, according to a new study on this issue conducted by the Washington, DC-based Center for Studying Health System Change (HSC) for the nonprofit National Institute for Health Care Reform (NIHCR).

The report, "Coordination Between Emergency and Primary Care Physicians," is based on telephone interviews with 41 pairs of emergency physicians and PCPs who were matched so that researchers could obtain the perspectives of both specialties working in the same hospital settings. *(See "Editor's Note" below for link to report.)* The study concludes that poor communication and poor coordination undermine effective patient care, and that there are no quick fixes to these problems. However, the authors stress that there are things ED managers can do to address existing barriers while at the same time reducing inefficiency, waste, and errors.

Unique challenges surface in the ED

Emily Carrier, MD, MSCI, a co-author of the study and a senior researcher at HSC, decided to look into the issue because, as an emergency physician herself, she has experienced firsthand the challenges of trying to coordinate with PCPs, but she has seen little research on the subject. "I saw that there had been a lot of thinking about how care can be better coordinated, but it hasn't really focused on this particular interface, so I wanted to fill in this gap," she explains.

Patient encounters in the ED are distinctly different from other care encounters in a number of ways that add complexity to the care coordination piece, says Carrier. "If you think about the classic PCP-specialist interaction, the PCP might identify the need for a specialist consultation, he might help the patient to schedule it, and prepare some information to be sent to the specialist's office in advance of the visit," says Carrier. "Then, after the evaluation, the specialist might send the information back to the PCP and the next time he looks at the file, he will read it over."

Typically, everybody knows what is going to happen next in such a situation, but that is not always the case in the ED, says Carrier. "Many encounters in the ED are unplanned. Further, the patient may go there on his own, or he may be sent there by someone who is not the PCP," she says. "ED visits may occur at any time of the day or night, and they can involve a broad spectrum of illness ranging from something very minor to something that is critical."

All of these factors make communications and care coordination more challenging for both emergency physicians and PCPs, says Carrier, and both sets of providers expressed frustration to researchers about the time and inconvenience required to perform care coordination tasks. "Many felt this task doesn't bring them very much in terms of reward, and people also felt that the extra effort doesn't decrease their risk in any meaningful way," she says.

There is no question that care coordination and communications are significantly streamlined in hospital-based health systems that have electronic health records (EHR) that are widely used by community PCPs, but Carrier emphasizes that the EHR is not a silver bullet.

"In most cases, EHR systems are not designed to facilitate a rapid overview and synthesis of information," she says. "They are very good at storing information and they are very good at retrieving information if you know what you are looking for, but if it is 2 o'clock in the morning and you've got to find out what a person's cardiac history is, the EHR can definitely be challenging."

In particular, Carrier explains that for those patients who could most benefit from care coordination — older patients and the chronically ill — you could be wading through screen after screen on a voluminous EHR, and it can be very difficult for either an emergency physician or a cross-coverage provider to figure out what is going on.

Time facilitates interactions

There are steps EDs can take to cut through such quagmires, but the most effective solution for one ED will not necessarily work well in another, says Carrier. "Let's say you work in an urban safety-net institution, and most of your patients are getting care through an ambulatory care clinic that is also part of your system," she says, noting that communicating back and forth isn't a big issue in this setting. "In that instance, the best [way to improve] care coordination might be through a proactive approach of setting up meetings between department leaders and coordinating ways to facilitate follow-up visits."

This type of solution would not, however, work well for an ED in a suburban setting that is surrounded by many small, independent PCP practices, observes Carrier. "There is no way you are going to get everybody at the same table, so the first challenge in this instance would be figuring out how you are going to talk to people," she says.

Any process or patient-flow improvements that free up time for emergency physicians and PCPs to interact will benefit virtually any ED setting, Carrier says. "We see many practices that reward physicians for having a short LOS (length of stay), but sometimes making a discharge stick takes time; it takes making that extra phone call, making sure the patient has a safe place to go, or making sure that key information that needs to get passed along is passed along," she says. "These steps can be very frustrating for emergency physicians, and many of them complain, accurately, that their efforts are not rewarded."

However, there are so many different care circumstances that occur in the ED that you can't address the issue of care coordination with simple incentives, observes Carrier. Further, she notes that incentives can lead to unintended consequences. "If you decided to reward emergency physicians every time they communicate directly with a patient's PCP, that would probably lead to a lot of unnecessary calls related to lower back pain, ankle sprains, and things like that," she says.

Use protocols to drive care coordination

Recognizing that some diagnoses require more care coordination than others, the Cleveland Clinic's Quality Alliance, a consortium between the organization's employed and private-practice physicians, is developing condition-specific guidelines for the sharing of medical information between the clinic's various affiliated offices, institutes, and hospitals, explains **Tarek Elsawy**, MD, an internist and medical director of the Quality Alliance.

"For certain diagnoses, such as congestive heart failure (CHF), for example, there is a really high rate of readmissions and people shuffling back into the ED," says Elsawy. "So one of the things we are trying to do is develop certain protocols that will make it part of the evaluation process that we use in terms of how well the ED physicians are getting back to the PCPs, and making sure the patient has follow-up with his PCP following a visit to the ED."

Many of the physicians affiliated with the Cleveland Clinic are already using the organization's EHR, so they have access to any patient labs, X-rays, or other studies in real time, notes Elsawy. "In a lot of cases, that is half the battle because many times patients aren't exactly sure what tests they have undergone, let alone what the results of those tests were," he says.

The Quality Alliance has also begun to track

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- Can patients provide reliable adverse event reports?
- CMS providing funds to help hospitals improve quality, safety
- TJC article offers framework to drastically reduce preventable harm

those patients who use the ED frequently to see if there is a portion of their care that is missing, whether that involves gaining access to a PCP or perhaps another resource, explains Elsawy. "Let's say that we find a patient who has been back and forth to the ED three times with the same diagnosis," he says. "What we are trying to do is coordinate with the patient's PCP to get him set up so that he uses the CHF clinic as a means of regular follow-up rather than just going back to the ED all the time."

Initially, the Quality Alliance is focusing its attention on those conditions that have the highest impact in terms of patient readmissions, so conditions like CHF, chronic obstructive pulmonary disease, and pneumonia are being targeted first, says Elsawy. "Most of the EDs are already using protocols for CHF, but what are missing are the handoffs," he says. "If a patient goes from the ED to the hospital, that is one transition, but one of the other things we are working on is making sure that patients who have been discharged from the hospital get back to their appropriate PCP or CHF clinic in a timely fashion to prevent them from repeating the cycle all over again. That is the process we are trying to follow through."

Elsawy acknowledges that just like other providers, ED physicians don't generally favor adding steps or tasks to their workflow, but they nonetheless understand the rationale behind what the Quality Alliance is trying to do, and they are involved with the process. "What we are doing is an absolute transition point to developing an accountable care organization [ACO]," he says. "If we all speak the same language and have the same expectations in terms of the guidelines themselves and how to implement them, then I think that will take us a long way toward what will be an ACO."

Editor's note: To access Coordination Between Emergency and Primary Care Physicians by Emily Carrier, MD, MSCI, Tracy Yee, PhD, and Rachel Holtzwart, visit this link: http://www.nihcr.org/ED-Coordination.html.

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