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AHC Media

Readmission rates respond to collaborative process

Working together multiplies benefits

There's not a healthcare organization around that isn't focused on reducing unplanned readmission rates. They cost money and are the focus of a variety of regulatory and payer organizations that are either no longer paying for care related to such readmissions or will soon stop. But as much as everyone wants to find some magic bullet that will work in multiple settings, the truth is that no one thing is going to solve the problem. Indeed, what works at one hospital for a particular type of patient may not work at another hospital 50 miles away for the exact same patient. That makes the idea of creating a state hospital association collaboration to work on the issue something of a head scratcher: If it all depends on where you are and the kind of patient and the time of day and phase of the moon, then really, shouldn't we all just figure it out on our own?

Absolutely not, says **Alison Hong**, MD, director of quality and patient safety of the Connecticut Hospital Association. She is working with hospitals in Connecticut on a multi-year collaborative to address statewide readmissions for congestive heart failure (CHF). People are forgetting one key aspect to the question — whether what any hospital does in isolation from the rest of the health care continuum does will make much difference at all. That's part of what makes this collaborative different: It involves not just association member hospitals, but also organizations outside the acute care setting who are involved in caring for these patients — nursing homes, home care, community physician practices large and small. All of the parties are working together, looking through data, doing chart reviews, and going through every possible process to find common factors that lead to unplanned readmissions among CHF patients. The group is using the Institute of Healthcare Improvement's (IHI) Transforming Care at the Bedside document as its QI template.

The collaborative started last year, meeting both in person and electronically to focus on five strategies:

- **delivering evidence-based care;**
- **using enhanced admissions assessments of post-discharge needs** — start planning for discharge as soon as the patient is on the unit, talking

with family, discussing social issues, medication issues, and logistical issues that might arise;

- **engaging family and patients** — identifying the right caregiver, asking patients why they think they returned to the hospital, using advanced teach-back methods;
- **medication safety**;
- **post-acute care follow-up** — requiring patients to have an appointment with a community physician or clinic made before they leave the hospital and see they get to that appointment within seven days of discharge, with no outstanding issues to address, including transportation to the appointment.

The latter issue has been critical, says Hong, and involved developing relationships with physicians and their office managers to ensure that seven-day window was met. Some offices opened heart failure clinics to deal with the need. Others changed staffing to ensure that if a hospitalist called at 4 p.m. on a Friday to make an appointment for the patient the next week, someone was there to answer the phone — or they changed the rounding so that the calls did not happen that late in the day, that late in the week.

Organizations that were used to looking within their four walls for ways to improve quality had to change their mindset and look outside for ways to improve efficiency and quality, too, she says.

There was increased telemonitoring and a move to do medication checks at home; organizations worked together to find the least amount of paperwork possible to meet various regulatory requirements and still provide all the information needed to ensure continuity of care. "Sometimes it was small issues, like remembering to put the weight of the patient when they were discharged from the hospital," Hong says. "Or it might be a change to call the physician first, rather than sending the patient from the nursing home right back to the emergency department. It was a matter of looking outside the organization and learning to work together."

Every single one of the ideas used was brought up at one of the consortium's monthly webinars or quarterly meetings. And what works for one may not work for another, but they are all willing to share. At the most recent meeting in early November, 138 people were present, Hong says, all taking notes, asking questions and sharing solutions. "The boon of working together is hearing the stories of what worked and what did not. You can pick and choose, you can get together and hash out new ideas."

Sometimes they bring in people from out of state or researchers to discuss the latest research and innovations. They keep an eye on IHI white-

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papers. "Everyone is working on readmissions, but it can be hard to know where to start," Hong says.

The heart failure component finishes up in February. Data will be released in the summer, but already organizations have seen improvements from their baseline readmission rates. The program has been so successful that they are expanding it to all-cause readmissions and continuing with the group. Some will leave, others will join, says Hong.

This is the fifth collaborative that the membership of the hospital association has worked on, says Hong. There is a lot of interest in it, and in using the team dynamic to create traction. Even those with fairly low CHF readmission rates are working on this and seeing an effect. "We all know that this is important to community health and the patient. We all know that this is going to be our parents in a few years, or us."

A STAAR turn

A year before the Connecticut collaborative started, four states — Massachusetts, Washington, Ohio and Michigan — began a collaborative initiative to reduce readmission. Called the State Action on Avoidable Rehospitalizations (STAAR) initiative, an interim report was released in the July 2011 issue of *Health Affairs*[1].

No data have been released yet, but the report notes that there are more than 500 partners across the continuum of care working on the project, including 148 hospitals. Of those hospitals, all of them now have teams that include people outside the hospital itself working to routinely review cases where a patient has an unplanned readmission.

Funded with a $5 million Commonwealth Fund grant to the IHI, researcher **Amy Boutwell**, MD, MPP, says what made this different was the emphasis on looking outside one particular care setting. "All QI projects are focused on what I need to do in this particular setting. What is interesting here is looking beyond that. Evidence shows that the handoffs, discharge processes, and transitions of care are a big issue in readmissions."

Participation in the project was predicated on committing to bring a cross-continuum team to the table. They had to include elder services, skilled nursing, visiting nurses, home care, and community physicians — whatever the organizations were that were most commonly involved in either "sending" or "receiving" patients. Patients and family representatives also had to be part of the cross-continuum teams. In addition, participants had to agree to collect data for all-cause 30-day readmissions and perform chart reviews and interviews of five recently readmitted patients to get their perspective on how to improve transitions.

"It's not just one provider who takes care of the patient, but a whole community," explains Boutwell. "The senders and receivers of those patients need to learn to talk to each other and figure out whether what they are doing works for us all, or for any of us."

The project runs for another two years, and anecdotal information shows that there is a lot of learning going on among participants. They purposely focused on all-cause readmissions because, says Boutwell, "we do not think that readmissions will be solved with a disease-specific focus." The average Medicare patient has more than one medical issue, so how do you know which one to focus on for readmissions? "We think if we do some basic things better, it will help all patients we serve. And we think that there is less risk of over-medicalizing it. The way we read the literature is that it is not about treating a disease or clinical condition better, but about helping patients navigate the system better."

The patient interviews were particularly helpful for participants, too, Boutwell says. "It was not about chart reviews or being statistically significant, but to get them to focus on the patient stories, the logistics and economic issues they face." Thus far, the issues that are arising probably sound familiar to the folks in Connecticut: getting post-discharge appointments in a timely manner; better communication with physicians, between providers, and with patients; and better patient education. "This is not exciting stuff. But it is all supported in the literature. We all think we are doing it, but if you study the process, you find out we aren't all doing it. They may think they do something 90 times out of 100, but it's really 50 or 60."

Along with the nearly complete participation with cross-continuum teams — something that no one was doing before STAAR — a recent survey of participants showed that 90% of them are working on using teach-back techniques

with patients and 76% are working on using enhanced assessments to find out more about why patients think they came back to the hospital. "That says to me that we are providing meaningful recommendations," Boutwell says.

Boutwell notes that some participating hospitals have already reached their stated goals of reducing readmissions by 30%; Tufts reported a 50% decline in heart failure readmissions. Bay State Health System expanded its program from heart failure to the general medicine ward.

The improvements are often based on different endeavors. For example, Evergreen Hospital in Kirkland, WA hired patient educators, while Bay State made following up with discharged patients part of the job description for newly hired unit secretaries. "That was clever — not adding to the work burden of someone already there, but raising the bar for new hires," Boutwell says.

There is not likely to be a single protocol that works, Boutwell says. "But I think what will make a difference is bringing public and private entities together to make progress on systemic changes."

In the end, Hong says it all comes down to better communication — within the hospital community, but also within a particular healthcare community. There was a move in the 1990s and early part of the new millennium toward faxes, pagers, and electronic data, but sometimes, calling someone and talking in real time works better, says Hong. "It helps make the patient safer. We have to remember that those other things are tools, not replacements for real-time communication, and a call from the nursing home to the doctor might be the thing that keeps that patient from becoming a frequent flyer."

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REFERENCE

1. Boutwell A, Johnson MB, Rutherford P et al. An early look at a four state initiative to reduce avoidable hospital readmissions. *HealthAff*. 2011 Jul;30(7);1272-80 ■

10 ideas to reduce CHF readmissions

Among the ideas put forward and tried by members of the Connecticut Hospital Association's collaborative on reducing readmissions for heart failure patients are:

1. heart failure coaches;
2. expanded palliative care;
3. unit-based hospitalist medicine;
4. incorporating teach-back methods to education;
5. starting teach-back simulation training (the audience seems to learn more than the simulators);
6. ensuring post-discharge appointment in three to five days;
7. using advanced practice nurses to see patients faster post-discharge;
8. using an opt-out rather than an opt-in system for automatic home care visits — patients all get them unless otherwise specified;
9. follow-up phone calls within 48 hours of discharge;
10. ensuring you have a specific project goal related to lowering readmission rates, not a general idea to decrease it. ■

So much data, so little idea of what to do with it

External reporting inspires improvement

No one would argue that the amount of data a hospital has to collect and report is significant, often duplicated, and never declines. But there are plenty of reasons why putting quality and patient safety data out there for public consumption serves the greater good. "There is a strong body of literature that shows providers and health plans use this information to drive quality improvement," says **Lise Rybowski**, proprietor of The Severyn Group and content manager for the Agency for Healthcare Research Quality (AHRQ) Talking Quality website (www.talkingquality.ahrq.gov). "Even if consumers do not look at the information, it impacts an organi-

zation or provider's reputation," Rybowski says. "There is always a level of competition, and they want to look good compared to others."

Providers have often balked at public reporting of quality data, particularly if it in any way identifies them. "But I think most realize now that this has real value, and I think pushback is declining," she says. Rybowski acknowledges that there is still argument over what is the right thing to report and how well it reflects the true quality of care. But data are improving — it's easier to pull information right from medical records, as opposed to claims data, which many dismiss as providing imperfect information at best.

There is no template for reporting that works for everyone, but AHRQ has developed a program for any who want a template called MONAHRQ (*for more on the program, see sidebar page 138*), which can be customized and is based on existing AHRQ tools. Rybowski says that many want to know if there is some list of things that makes for good public reporting that will positively affect quality of care and adequately inform the public. "The problem is that what is easy for lay people to use may be too basic for everyone. Abilities and interest varies. Some people may want more data than others.

There is also tension between what is useful to providers and what is useful for that lay audience. "Providers need useful measures and numbers," says Rybowski. "They want to know where the numbers come from and whether they are risk adjusted. But that's not helpful to most consumers. Some of that deep data wouldn't be helpful at all for assisting a consumer in making a decision."

The other issue is what to use for comparisons. One hospital may have multiple "like" facilities — academic should be compared to academic, but there are regional differences that matter, too, she says. An academic teaching facility may still want to compare with a community hospital in the same city because those facilities will still compete on some level, even though they are very different kinds of hospitals.

Among those who have studied the effect of publicly reported quality data is **Judith H. Hibbard**, DrPh, professor emeritus of health policy at the University of Oregon in Eugene. "There are plenty of studies that show there is no effect from publishing this data," she says. "But that's only true of the reports that are hard to understand. If you have a report that is not easily understood, it won't result in a change of behavior." What makes providers change their actions and work to improve quality is having the public have access to easily understood quality reports where someone can quickly and easily discern which are the top and bottom performers. "Most reports do not do that, though."

The reason why simplicity is not the rule, says Hibbard, is that providers push back. They want the data to be complex and reflect what they say is the true situation. But it is that very complexity that turns off the public and renders the information useless from both an informational perspective and as a way to improve quality of care.

Another example of bad reporting are sites that compartmentalize the data elements so that they can't easily be brought together. "People really want to know what is the best hospital," she says. "If you have safety over here, and experience over there, but do not show it in one place, it's not effective."

Perhaps the best comparative website Hibbard knows of is www.Calhospitalcompare.org, which is condition-specific, but also easy to understand. Hibbard also found in one study that people like to be able to look at a summarized report on a facility or provider. This can make providers uncomfortable, but it can also spur them to change behaviors because they know that there will be some sort of simplistic method of judging their performance compared to peers.

When gearing up to put your data in the public arena, Rybowski says to remember who your audience is. If you have multiple audiences, make sure that you address the needs of all of them. "If you want a way to help people choose a doctor or a hospital, you want to include measures that are meaningful for that," she says. "Providers will need far more information. But if you show people too much or make it too hard to find, they will give up."

You also have to understand that what your public thinks of as a quality measure may be very different from what your providers think. Be aware of those differences and provide appropriate information based on their needs.

Lastly, she suggests that organizations remember they have another audience for this information that is often overlooked: the media. They may not look at the same things or in the same way that the general public or providers look at the data, but they will look and report on what they find — or what they do not find.

"This is a way to show how you are doing, to differentiate yourself from others, and also a way to draw attention from your internal audience that people are looking at this data and you need to be working to improve it," Rybowski says. "This is how quality improvement happens. Focus on the things you will be reporting."

Hibbard says remembering who your audience is and what they want makes a difference. "If you are going to spend the resources on this, remember that it only works if you do it right."

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Program aims to promote quality data

For those who want to ensure that stakeholders and the general public alike have access to quality data, the Agency for Healthcare Research and Quality (AHRQ) has created MONAHRQ, a web development software package that hospitals, health plans and other entities can use to help create usable and meaningful portals for publishing quality data. The program uses hospital administrative data to compare quality in four areas: hospital ratings, utilizations, preventable hospitalizations, and rates of conditions and procedures. Most of the initial users have been state and local data organizations that provide hospital-to-hospital comparisons.

But the program, which was initially released a year ago, would be great for hospitals, says **Anne Elixhauser**, PhD, senior research scientist at AHRQ. "They could put their data into MONAHRQ and view hospital-level statistics. Health systems could use it to put all of their hospitals' data on a single site. And this is not just about transparency for the consumer, but a way to improve quality of care through public reporting."

Currently four states are making active use of the MONAHRQ program — Maine, Hawaii, Kentucky, and Nevada. Arkansas and Utah are on the cusp of making it public. Texas is evaluating the program now. Indiana and New York are making use of the program internally, and others may be using the program in non-public ways, too. But Elixhauser says they have no way of knowing who or how many might be doing so.

It takes about a day to go through the user's manual and generate a site at its quickest, she says. Most take a little longer. Those with questions can get technical assistance, often the same day as they pose a question, but "always within two." There are certainly organizations that will opt to build their own website, but in a time of tight budgets and limited time, this is a way to create and maintain one with minimal time and expenditure.

Elixhauser says they created the program after a hospital CEO in Chicago mentioned wanting to take quality data and make it publicly available. "But it took them a year and over $300,000 to put it together. And that was just one hospital. Around the country, there are so many others. But we had tools that were already developed. If we could put them together, we could help organizations who do not have the right personnel or the money to contract with programmers."

Visit the MONAHRQ website for complete information at www.monahrq.ahrq.gov.

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Unit-based teams get results at Penn

Teams helped health system reach multiple goals

It's kind of like that old ad for Reese's Peanut Butter Cups: Peanut butter is great, chocolate is great, but imagine what can happen if they get mixed together. That's what happened when the chief nursing officer and chief medical officer of the University of Pennsylvania Health System got together to work on quality improvement projects. "We had an old quality model that used champions and experts. Sometimes they worked with physicians, sometimes with nurses," says **Jeffrey I. Rohrbach**, MSN, project manager for quality and safety at the University

of Pennsylvania Health System. "But what if they worked together?"

Creating unit-based leadership teams consisting of a physician, a nurse, and a quality leader led to changes in the way every subsequent quality project was done and spurred projects that have had a far-reaching positive effect on patient care. In the old system, Rohrbach says, working to reduce bloodstream infections might be an imperative for leadership, but it was not even known at the bedside. "Trickle down did not work," he says. But by putting the onus on individual units, there is only so far the word has to go before it reaches the bedside, and the route that each triad takes to achieve the goal can take into account the particular needs of a unit: Cutting readmissions for oncology patients might require different actions from cutting readmissions for the transplant unit. "What works on one might not even be applicable on another, so looking for a global solution to a local problem doesn't work."

Under the new system, not only can those local problems have local solutions, but Rohrbach notes that the people working at the bedside are more comfortable sharing their own ideas with people they know well and who understand the particulars of the work environment. Team members exchange ideas in both formal and informal settings, sharing information both within and across units. Often, units work together on projects, as well, he says.

Each team consists of a physician leader, a nurse leader, and one of four quality/safety project managers. As the program has evolved, other disciplines have asked to participate — pharmacists are often included, as are other clinical specialists. Piloted in just five units, there are now 18 teams responsible for 22 units, including five intensive care units and a women's health service. One team covers two general medicine units, and another covers three oncology units. The surgical team has a slightly different make up — two physician co-leaders. No member of the team outranks any other, says Rohrbach, or has a voice that carries more weight than his or her counterparts.

The roles are different, though, with the physician responsible for communicating about the project to other physicians; the nurse manager in charge of implementing projects and communicating with frontline staff; and the leader gathering data, creating action plans, and project management. Because the quality leaders work across units, Rohrbach says they can often suggest that units work together on particular issues.

The teams meet weekly to look at trend reports and determine if anything needs particular attention. There is also informal communication between team members to discuss ongoing projects or issues that arise between meetings. Every month, groups of unit teams meet with the chief medical officer and chief nursing executive to present information on existing projects or ask for assistance.

There is also communication across the various hospitals in the health system with teams from one facility often hosting teams from another to talk about their efforts and accomplishments. Further cross-pollination happens through the chief nursing executive and chief medical officer councils involving senior clinical leadership from around the health system.

The program hasn't been without hiccups, Rohrbach notes. "We had a lot of pull from the nurses, who were very interested in it, but still have to do some pushing with the physicians. Some were interested and have become champions." Others, however, were coerced to participate through use of a stipend paid for participation on the teams. "We are buying their time and their work, and they are held accountable for that. They have to create baseline goals, ways to measure their success, and a list of projects to work on."

What has provided more pull than the stipends has been the astounding success the triads have achieved. When they started with five units in 2007, Penn Health concentrated on rounding with teams and central line-associated bloodstream infections (CLABSI). "We chose to work with units who had the strongest physician buy-in and the units with the highest infection rates," he says. Before the pilot had run its course, news of its success was spreading and other units were asking to participate. Now in its fifth year, every inpatient unit at the three-system hospitals has the leadership groups. Next up is expanding it to the emergency department and the cardiac catheterization lab. In the future, other system parts such as skilled nursing may be included, Rohrbach says.

If I had it to do over…

One thing that he wishes he'd done differently

was to make sure the physician role is structured. "They were given a stipend; they were told to participate. But how to do that was not laid out," says Rohrbach. "So there were varying degrees of participation. Some teams met weekly. Some did not. Some would say, 'Oh, there's nothing to discuss this week,' and skip a meeting."

And while some physicians did not do much more than attend meetings, others took on additional work, went to faculty meetings to talk about initiatives and generally proved themselves superstars. "Now we have the work plans, the goals they have to submit, and quarterly meetings with the associate chief medical officer. If they do not meet their goals, they are dropped, and we start looking for physicians who are more interested in what we do."

They also created a rotating weekly agenda to help keep all the teams on track. Every week there is something specific to talk about. In one group, Rohrbach explains, it might be patient satisfaction and incident reports in week one. A quality champion might bring data to go over on week two. The following week might be a look at all the infections that there had been in the last month. "You have to create something to talk about."

Lastly, he counsels against limiting numbers. While the troika of nurse/physician/quality manager works, it doesn't include others that may have important input like pharmacists, discharge planners, or social workers. "We made it exclusive initially, which limited effectiveness, and it excluded people who were interested and wanted to help."

The results have been impressive. "When we started, our chief medical officer wanted to eliminate CLABSI and everyone laughed out loud." Now, a bloodstream infection is such a rarity that they count cases, not rates, and every single one merits a close look. One unit has been infection-free since January 2008, Rohrbach notes.

Indeed, the first indication that the unit-based leadership model was worth expanding came through a look at CLABSI rates. All units lowered their rates thanks to a facilitywide effort. But the units with the leadership teams? They saw even fewer infections. The total decrease in CLABSI rates since the inception of the program is from 6.75% in 2007, to 0.5% in 2009. Days since the last infection ranged between 300 and 1,210 days as of May 31, 2011; four units have gone more than 1,000 days without an infection.

Other benefits of the program include a decline in pressure ulcers of more than 20% in medical/surgical units and nearly 16% in critical care units between 2008 and 2009. The overall rate as of mid-2011 has fallen 40% since the unit teams started.

Urinary tract infections have declined by 30%, with some units going longer than a year since the last infection; ventilator-associated pneumonia has been absent for between 95 and 650 days on five units; medication reconciliation has improved from 55.3% to 79.6% of patients having a reconciliation within 24 hours of admission; errors and near misses are reported more often; patient satisfaction has improved; and providers think there is better teamwork and communication.

The work continues, Rohrbach says, with the latest project being attention to 30-day unplanned readmissions. Every patient who is discharged is checked to see if he or she was in the hospital within the previous 30 days. If so, Rohrbach says, "we do a mini-root cause analysis to drill down and look at why."

Other facilities are taking notice. Recently a Penn team flew to the University of Nebraska to talk about what they created. Word is that they will soon implement something similar. The system is also spreading the word locally to hospitals that come calling to see what they did. And they continue to present their findings at a variety of forums.

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Updated advice for adverse events

Second edition of IHI paper won't be last reissue

In the year since it was published by the Institute for Healthcare Improvement, there have been tens of thousands of views of "Respectful Management of Serious Clinical Adverse Events"[1], and along with those views have come comments, suggestions, and anecdotes that made it imperative for the institute to look again at the topic and update it.

Presented in mid-October by author and senior IHI fellow **Jim Conway** at the American Society for Healthcare Risk Management conference, the biggest differences of note are a new foreword, a section on reimbursement and compensation and one on disclosure of errors that have occurred at another institution.

Conway was also pleased that Stanford University Medical Center shared information on the results of the process it uses to determine if a particular outcome was preventable. The Process for Early Assessment and Resolution of Loss (PEARL) is a seven-day investigation. If deemed preventable, then Stanford estimates compensation and sends an apology and the results of the PEARL investigation to the patient or family members. Since it was implemented, there has been a drop of more than a third in the frequency of claims, with an estimated savings of $3.2 million per fiscal year.

Conway has personal experience dealing with adverse events: He was the executive vice president and chief operating officer of Dana-Farber Cancer Institute for 10 years, his term overarching the period when Betsy Lehman and Maureen Bateman died from medication errors in 1994. He notes that most hospitals think that their disaster plans will work fine for this special kind of disaster, but they may not. Indeed, he says that maybe only a quarter of American hospitals have any kind of plan in place for the aftermath of a serious adverse event. And not responding appropriately can compound the hurt to patients, family, staff involved in an event, and the organization as a whole.

These problems won't just go away if you try to hide from them, Conway says. If you do not handle it well, it will likely get bigger. "Think about how you would want to be treated in the situation," he says.

Among the suggestions the paper outlines:

1. Have a plan for clinical adverse events.
2. Have a crisis management team, which should include your media relations person.
3. Test your crisis management plan and team using the most recent adverse event or near miss.
4. Ask what worked and what did not for that test.
5. Concentrate on what happened, not who was responsible.
6. Make the apology sincere: A stiff apology is "a second insult."
7. Start root-cause analyses immediately using a trained facilitator.
8. Create a media action plan before you have a crisis.
9. Learn from events at other organizations; ask them what they learned.
10. Ask if such events can happen at your organization.

Conway says he's sure that the input levels will continue, and that in another year or two, this white paper will again be updated. It's an evolving document, not a static one, he says.

Checklist for crisis management: The patient

Source: Institute for Healthcare Improvement

- Who is the organizational 24/7 contact person for the patient and family?
- Has the organization acknowledged the pain, expressed empathy and regret?
- Are the immediate needs of the patient and family met?
- Has the patient had a full clinical assessment?
- Has the organization assessed the personal safety of the patient and family?
- Has the patient's primary care physician and extended care team been notified?
- What is being heard from the patient and family?
- Has the organization apologized, as appropriate?
- Does the organization understand what the patient and family want said to others about the event?
- Is the organization providing ongoing support to the patient and family, including reimbursement of out-of-pocket expenses?
- Is the organization prepared to have open discussions about compensation, if deemed appropriate?
- Has the family been engaged in the immediate investigation and then invited to participate in the root-cause analysis (RCA) of the event?
- Has the organization suppressed all normal PR and other communications to the patient or family that could inflict further pain? ■

The entire white paper is available for download, along with useable checklists, at www.ihi.org.

REFERENCE
1. Conway J, Federico F, Stewart K, Campbell M. Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org) ■

Joint Commission offers ISO certification

Starting early next year, hospitals that are interested can achieve both accreditation and ISO certification in various best practices. The Joint Commission is joining with SGS for the program, which will ensure that facilities meet both quality and safety standards mandated by TJC, as well as performance measures related to ISO standards.

ISO standards relate to management systems and efficiencies, as well as effect on the environment. They can be applied across every department and are increasingly popular with hospitals, says **Ann Scott Blouin**, RN, Ph.D., FACHE, executive vice president of accreditation and certification operations for The Joint Commission.

The ISO certification can be customized based on hospital preferences to include the entire facility, a whole system, or just particular departments. They can also choose from among several ISO certifications, including 9001 for quality management systems, ISO 14001 for environmental management, ISO 27001 for information security, OSHAS 18001 for occupational health and safety, ISO 17025 for testing and calibration laboratories, and certification for food safety testing and certification.

The Joint Commission accreditation decision and the SGS ISO certification decision are separate. The survey activities of SGS and The Joint Commission can be combined during the organization's routine accreditation survey approximately every three years. A surveillance or recertification audit is conducted by SGS annually. ■

HAIs in AHRQ's sights with new grants

The Agency for Healthcare Research and Quality (AHRQ) has awarded $34 million in grants to a variety of healthcare organizations to work on ways to fight healthcare-associated infections (HAIs).

According to AHRQ, nearly one in 20 patients in hospitals will get such an infection. The hope is to reduce the incidence and the costs associated with such infections. These awards include projects to develop, test and spread the use of new modules of the Comprehensive Unit-based Safety Program (CUSP), a proven method to prevent and reduce healthcare-associated infections. The new modules target catheter-associated urinary tract infections, surgical-site infections, and ventilator-associated pneumonia. The latter module will be tested in two states with money from the HHS Office of Healthcare Quality. The CUSP program is already being used for bloodstream infections related to central lines.

CUSP is a multi-pronged program that promotes a culture of patient safety, improved communication and teamwork among unit staff members, and the use of tools, including checklists, to support implementation of evidence-based HAI prevention practices, such as hand-washing and removing unnecessary catheters, that are based on guidelines from the Centers for Disease Control and Prevention (CDC). A recent report from the ongoing AHRQ-funded project that is implementing CUSP to reduce CLABSI found that these infections were reduced by an average of 33%.

Other newly funded projects include research on ways of reducing infections with methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*; the use of healthcare facility design to reduce HAIs; and alignment of work system factors to maximize and sustain successful HAI reduction efforts. A novel 36-month project will synthesize the results of AHRQ-funded HAI projects in fiscal years 2007-2010. The goals of the project are to identify and promote the application of effective HAI prevention approaches and to identify gaps in the HAI science base that can be filled with additional research.

The agency's ongoing work helps attain the goals of the Partnership for Patients, a national,

public-private partnership of hospitals, employers, physicians, nurses, consumers, state and federal governments and other key stakeholders. The partnership aims to reduce the incidence of HAIs and other preventable hospital-acquired conditions by 40% (compared with 2010 rates) by 2013 through widespread adoption of evidence-based practices. Achieving this goal should result in approximately 1.8 million fewer injuries and illnesses to patients and more than 60,000 lives saved. ■

CMS approves 500 FQHCs

The Centers for Medicare & Medicaid Services (CMS) announced in late October 2011 that 500 federally qualified health centers (FQHCs) were selected for the FQHC advanced primary care practice (APCP) demonstration project. The goal is to evaluate the effect of an advanced primary care practice model, called the patient-centered medical home, on improving health, quality and coordination of care, and lowering the cost of care provided to Medicare beneficiaries.

Funded through the Affordable Care Act, the CMS Innovation Center will offer technical support to providers to improve their coordination of care and spread to others the lessons and best practices they've learned.

The APCP demonstration will assess the effect of Medicare paying a care coordination fee to participating FQHC practices for all care coordination and management services. The APCPs are required to offer enhanced access to care through expanded hours, same-day appointments, or priority appointments so patients do not need to seek more costly urgent care services. Also, the APCPs will use a team approach, including nurse coordinators, physician assistants, pharmacists, and social workers, to coordinate health care and other services. A physician or nurse practitioner oversee all services.

FQHCs can access core training modules on topics essential to performing as a patient-centered medical home, including patient-centered care, team-based delivery, use of data/performance feedback for continuous quality improve-

CNE QUESTIONS

1. The Connecticut consortium on readmission rates focuses on five strategies including:
   A. discharge planning
   B. medication reconciliation
   C. enhanced admissions assessments of discharge needs
   D. a ride to the doctor

2. Physicians often object to public reporting of data because
   A. it includes information that makes them look bad
   B. it is not often risk adjusted
   C. it comes from claims data
   D. it comes from chart reviews

3. The University of Pennsylvania Health System's unit based leadership teams always include:
   A. a quality leader
   B. a pharmacist
   C. two physicians
   D. clinical specialists

4. According to IHI's Jim Conway, what percent of hospitals have adverse event plans in place?
   A. 75
   B. 50
   C. 35
   D. 25

COMING IN FUTURE MONTHS

■ OIG report on adverse events

■ ISO certification: Is it for you?

■ Survey field report

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

ment, and improving care transitions.

Participating FQHCs will be required to implement practice changes necessary to transform into advanced primary care practices, and CMS will monitor each center's transformative progress by comparing readiness assessment scores at baseline with readiness assessment scores updated every six months.

For more information about medical homes or the program, visit the Innovation Center online at http://innovations.cms.gov/. ■

BINDERS AVAILABLE

HOSPITAL PEER REVIEW has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail binders@ahcmedia.com. Please be sure to include the name of the newsletter, the subscriber number and your full address.

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CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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