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AHC Media

The Joint Commission is tired of fatigue-related events

New alert encourages attention

Almost everyone who has been in healthcare for long enough can tell a story about a tired physician or worn-out nurse who has either made a mistake or come this close to it due to fatigue. Studies have shown that nurses working longer than 12 hours and residents who worked multiple 24-hour shifts were involved in three times the fatigue-related adverse events than others. Overtired providers are also more likely to get injured on the job. The concern over the link between being tired and adverse events led The Joint Commission to issue a sentinel event alert on healthcare worker fatigue and patient safety in December.

In the alert, the JC recommends that organizations:

- assess fatigue-related risks such as off-shift hours, consecutive shift work and staffing levels;
- examine processes when patients are handed off or transitioned from one caregiver to another, a time of risk that is compounded by fatigue;
- seek staff input on how to design work schedules that minimize the potential for fatigue and provide opportunities for staff to express concerns about fatigue;
- create and implement a fatigue management plan that includes scientific strategies for fighting fatigue such as engaging in conversation, physical activity, strategic caffeine consumption and short naps;
- educate staff about good sleep habits and the effects of fatigue on patient safety.

Much of what is recommended is already in place in the Anne Arundel Health System, says **Shirley Knelly**, CPHQ, LCADC, MS, vice president of quality and patient safety for the Annapolis, MD-based system.

Productivity reports

Using the payroll program, they monitor employee hours every two weeks, with notations of every employee who works longer than 12-hour shifts. "That's the first line of defense: to know if they are scheduled for eight or 10 or 12 hours and work longer," she says. They look to see if there are particular staff members or units that are prone to this over-

work, and whether it is a short-term occurrence or a long-term trend. Directors and managers then investigate what the reason is behind the longer shift.

Productivity reports for departments look at hours paid, the number of full-time employees (FTEs), and any variances. Knelly says these reports encourage managers and directors to look at whether a unit is consistently short-staffed. "If one is constantly over FTE, why are they over? Maybe they need more employees because you are working others too hard."

The organization also requires a review of employee hours as part of its root-cause analyses in any incident where harm occurred. This is done for all employees involved and includes how far into their shift they were, their individual patient loads, and staffing requirements for the units.

Anne Arundel is ahead of the curve on The Joint Commission's handoff recommendations, too, says Knelly. "We have a structured and standardized method," she says. Information is pooled from all parts of the patient record, shift reports have to be verbal — not just written — and they have begun doing bedside reporting with the patients, their families, and nurses all present.

The new alert will still have an impact: Knelly says they will pull together a team to look at what Anne Arundel has in place and do a gap analysis of that compared to The Joint Commission recommendations.

A task force will then create and put any new policies and procedures in place. At press time, the gap analysis meeting was scheduled but had not occurred.

One change already anticipated is to invite medical staff into the process as well. "We do not monitor the hours of non-employee physicians, but we think they should be part of the discussions, too," says Knelly.

On-call physicians

For physicians, the biggest issue is probably call, says **Matthew Phillips**, MD, president of Austin Heart, a Texas cardiology practice. "People always talk about the toll on residents to be up day after day, but no one talks about all the physicians who still work like that." He notes that half the cardiologists in the country are over 50 and often work all day, all night, and all the next day.

His practice includes 46 physicians covering an area of Texas the size of Maryland, including many small towns that have limited resources for complex heart patients. The sickest of the patients will be transferred to a tertiary care facility where they could end up under the care of a very tired physician, says Phillips.

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Austin Heart implemented a program called Deep Night eight years ago. About three times a year, each cardiologist will spend a week — Sunday through Thursday — working from 6 p.m. to 7 a.m. They lose the daytime production by not working the day shift after the night shift, which means there is a cost to the individual physicians, and to the practice which essentially has to have an extra employee to make the program work.

Phillips says he doesn't know of other practices doing this — indeed, other cardiology groups in his market complain that Austin Heart does this at all. "We see patients often 12 hours earlier because we have a physician there, on site, every night. CMS says you have to see them within 24 hours, and other practices often won't go in during the night, but will wait until 8 a.m. the next morning. I'll see you at 8 p.m. when you come in."

The practice has a backup on-call physician who can come in if needed — for instance, if an invasive cardiologist is needed to put in a stent, then he or she will come in. Indeed, if necessary, any of the team will come in to assist if it is a particularly busy night.

How to measure?

One issue that organizations will face is how to measure fatigue. "It's individual for every person — one person may need six hours sleep to function, and another may need nine," Knelly says, adding that the best option is probably to look at various measures that surround fatigue — incident reports, hours worked, days in a row worked, staffing levels, and how busy a unit is. Employee satisfaction surveys might also help.

Knelly says Anne Arundel is looking at adding questions about fatigue to several surveys, including the safety culture survey and the annual nursing survey.

"This has always been a concern," says Knelly. "We are no different than any other hospital. If someone says they do not have this problem, I do not believe it. Every hospital has this issue." And it is one that not only affects patients, but staff. To that end, Anne Arundel also requires that staff take scheduled breaks and lunches, and staff members may not skip a break or lunch in order to leave early.

Austin Heart has used length of stay (LOS) measures to see if their program works. They have noted not only a shorter LOS for their patients, but Phillips thinks Austin Heart's heart attack death rate — the lowest in the nation — is at least in part due to the physicians seeing patients earlier and being completely awake and alert when they do. "You can't be awake every third night with a high-acuity patient and expect to be at your best," Phillips says.

But perhaps the best way to measure success is to look at how soon patients are seen compared to providers who do not have this kind of scheduling in place, he says. The difference is clear, and as any cardiologist will tell you, time is heart muscle.

Ask physicians what they hate, Phillips recommends. They'll probably all say call and the inhuman hours. His staffing program is certainly one way to address that. While it is dependent on independent practices implementing the change, it is certainly something that a hospital can suggest, or consider doing for their own employed physicians and other staff. Indeed, Phillips is concerned about the fatigue of ancillary staff members who assist cardiologists and might not be at their best in the middle of the night. The cost is worth it, he notes, in terms of improved patient safety and quality of life for providers.

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How to give the board the data it wants

Provide data in an understandable format

A typical hospital collects hundreds, if not thousands, of data points for reporting to state, federal, and accreditation agencies. It's so much information that trying to determine what is most important to share with a hospital board could become a tedious chore. What is useful? What is important? And what is accessible? And

are all those mutually exclusive?

All are issues that **Tricia Kassab**, RN, MS, CPHQ, HACP, vice president of quality and patient safety at City of Hope Hospital in Duarte, CA, thinks about regularly. And what she thinks her board should know now is likely to change in the future. "We have always been responsive, not proactive in this area," says Kassab, who notes that historically, comprehensive cancer centers have been exempt from reporting much of the data that a standard hospital has to collect and report. But with health reform is the thought that such exemptions will end, and so cancer hospitals as a group are beginning to look at issues surrounding data collection to determine just what measures not only are important now, but will be important in the near future.

"We haven't had to worry about core measures like AMI," says Kassab. "But now our group of hospitals has a quality and value committee, and we are looking at the National Quality Forum [NQF] metrics pertaining to oncology, and other outcomes measures and process measures to determine what we should focus on."

City of Hope and the other comprehensive cancer centers had a group of physicians and quality specialists work to determine what was most important, and they came up with three buckets of metrics. First is the NQF-endorsed cancer metrics for breast cancer, lung cancer, and prostate cancer. The second bucket is of cancer metrics that weren't endorsed by NQF, but were endorsed by another group, such as the American Society of Clinical Oncology. "Many of these, we wonder why they aren't endorsed by NQF, but it can be a huge endeavor to do so — someone has to write a paper, including information on every data element, the usability, feasibility, and scientific applicability of the measure. It's a massive undertaking."

Among those measures are KRAS testing of colorectal cancer patients prior to inhibitor therapy. "It's very specific, but for our community, it's a critical measure." The cancer hospitals together have hired someone to work on the effort to get this particular measure endorsed by NQF.

Lastly, the hospitals are looking at completely new metrics. Kassab says one of the things they are looking at is patient perception with cosmetic reconstruction after surgery. "We do not measure that — how patients feel about having it done, or how they feel after. And individual physicians vary on whether or when they offer it."

Although all of these data points are of value to someone within City of Hope, not all of it is of use to the board. Kassab says she shares the five oncology metrics that will be required for public reporting in 2014 — two for breast cancer: combination chemotherapy for T1c N0 M0 or stage 2 or 3 hormone-receptor negative breast cancer and hormone therapy for T1c N0 M0 or stage 2 or 3 hormone receptor negative breast cancer; one for colon cancer: adjuvant chemotherapy for lymp-positive colon cancer; and two infection-related metrics: urinary tract infections and central line-associated bloodstream infections in the ICU.

Kassab also reports issues that affect risk management — falls, medication events, hospital-associated infections. Patient satisfaction is always on the list, too. In all cases, she makes sure that there is comparative data to other like organizations.

Be careful with that comparative data, says **Cathy Newhouse**, RN, BSN, MA, senior vice president of clinical programs and innovation at LHC Group in Lafayette, LA, which includes long-term acute care hospitals. "There might be a couple of quarters lag with CMS data, but you know yours in real time," she says. Make sure you are comparing like with like — not just in terms of kind of facility but the period studied.

Pillars of success

"We focus on our key drivers," explains **Airica Steed**, Ed.D, MBA, RN, vice president of professional services at Advocate Condell Medical Center in Libertyville, IL. These drivers fit into several buckets:

- patient satisfaction, including HCAP scores;
- physician and workforce satisfaction, including survey scores, turnover rates, time to hire, and vacancy rates;
- financial data;
- efficiency data, including length of stay, throughput, wait time, utilization, and capacity;
- quality and health outcome data, related to CMS, Joint Commission, and other requirements, as well as facility goals.

Steed says her board gets a monthly scorecard on key metrics, with more in-depth data avail-

able if requested. The board receives education on the issues annually so they are engaged in what is presented to them.

Kassab agrees that it is a good idea to ensure you have a knowledgeable board that will understand the data you put before them. To that end City of Hope does some rounding with board members. But many of them are lay people without a scientific background. "We make sure we tell them why something is important. Then we show them where we are, how we compare, whether any change is statistically significant, and what we are doing around the metric." Statistical terms like confidence intervals are left out, unless someone specifically asks. "You do not want it too dumb, but also do not want it too complex."

Not everyone on a board has an understanding of clinical issues and statistics, Newhouse agrees. "The amount of data you can give them is overwhelming. There is the data by which we are evaluated and data we collect, but that isn't required. Then there is the data that is publicly reported and is supposedly of interest to the public, but may not be as important to them as we think."

Some of the more complex data are best saved for committees and subcommittees that deal with specific topics, says Newhouse.

Make sure you provide an analysis that makes sense of the information, says **Lisa Snyder**, MD MD, MPH, senior vice president and chief quality officer at Select Medical of Mechanicsburg, PA. "You can have a spike in a certain measure that looks alarming. Explain whether it is a true increase, or an increase in reporting. As the presenter, you have to know the data and its meaning backwards and forwards. You can't just take a trend graph and assume that's all you need to give them. You need to be able to tell the board members what makes up the trend and why it's important."

Over time, your board will become more educated and you'll be able to be more esoteric with the kinds of data you present and how you present it, says Snyder.

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Nine tips for choosing what to share

The most important consideration is to figure out what story you are trying to tell, says **Lisa Snyder**, MD MD, MPH, senior vice president and chief quality officer at Select Medical of Mechanicsburg, PA. "The person collecting the data should step back and ask what gives the biggest, most accurate, and clearest pictures," she says. "Introduce that information first. Then you can add supplemental data that adds to that picture."

Drawing the picture is easier if you follow some simple rules, says Snyder.

1. Group like with like.

Snyder says you should always think about how various data points work together to tell your story. Put risk measures like falls and medication errors in the same place, and make sure that all your infection measures appear together.

2. Explain the nuances.

Providing random bits and pieces can lead to incorrect conclusions, Snyder warns. "Let's say you have a trend graph of three measures related to infection data. One infection rate is going up and two are going down. You can't let them assume the trend is downward. You need to include information on the total number of infections."

3. Provide multiple entries to the data.

Snyder likes to use several data points to explain trends, often using more than one mechanism to do so — raw numbers, bar charts, pie charts, and trend graphs may all be used, she says.

4. Add contextual information.

For instance, Select Medical operates long-

term acute care facilities, which have the sickest of sick patients. Data from those facilities on mortality or infection rates may look poor compared to a community hospital whose patients aren't as ill. "What you show them should be the data that applies to the bulk of your patients, the bump in the middle of the bell curve, not the tails," Snyder says.

5. Make it relevant.

If something is hot in the research world, you want to include data that relates to that topic. For example, readmission rates, hospital-acquired infections, and antibiotic stewardship are all issues that are on the radar of regulatory agencies and research bodies. Likewise, Snyder says with a body as august as the Agency for Healthcare Research and Quality, it would be silly not to include metrics that are on its radar. Issues that are of import in your particular facility should also be included. If you have been working to address a problem, put data related to that in front of the board.

6. Be patient-centered.

Snyder says that data that focus on the patient and improving quality of care are a great place to create a basic bundle of metrics to share.

"Data can provoke questions, and sometimes another piece of data will help you answer those questions," she says. "Decide what creates the clearest picture of the way you care for your patients."

7. Do not leave out the bad stuff.

The board makes decisions on the information you give them, Snyder says. "They have to see the entire picture, not just the good stuff, not just what's rosy." Pull the punches now and you'll end up having to do more explaining later.

8. Include benchmarks.

Having a trend graph of catheter-associated urinary tract infections is interesting. But to add meaning, you need to include national benchmarks that give a sense of how you are doing compared to where you ought to be. "The benchmark may be zero. This way they can follow your drive towards that goal," Snyder says.

9. Run a rehearsal.

Show someone not involved with the board what you are thinking of presenting to them. A spouse is a great option, says Snyder. "This will allow you to determine if what you have chosen will tell your story." ■

Is your health IT a danger to patients?

IOM report doubts you're doing all you should

The Institute of Medicine (IOM) released a report in December that was critical of efforts made thus far to ensure medical errors associated with the use of health IT are minimized. It calls for greater oversight by the public and private sectors, and suggests that the Department of Health and Human Services (HHS) publish a plan within a year on minimizing risks associated with health IT, along with annual updates of progress made.

While billions are being invested in health IT by both public and private entities, the report notes that there is no solid evidence that using technology will improve quality of care and patient safety, and there is concern that some technologies may actually lead to harm being done to patients. The report notes that there has been little published about the risks associated with health IT, in part because some vendors don't like for safety-related information to be freely disclosed.

Knowledge is power, though, and vendors and users alike need to report any deaths, injuries, or other events related to health IT, the report continues, adding that Congress should establish an independent federal organization to investigate these adverse events.

Automated systems not inherently safer

While of interest and important, the report doesn't include software for medical devices, says **Christina Thielst**, MHA, FACHE, an independent health administration consultant based in Santa Barbara, CA, with more than three decades of experience in hospital administration, risk management, and patient safety.

"Bedside and other medical devices are increasingly embedded with software that captures patient health information and data and also interfaces with EHRs and other health IT," she says. "This means that the worlds of biomed and IT will have to merge and interface, as well. If these two hospital departments are not working together to ensure safety, there could be problems." On a positive note, the FDA has begun to look more closely at the

topic, which could be a reason it was left out of the report.

Thielst says that the notion that just because we are moving from a paper to a computerized system doesn't mean it is inherently safer. "You are changing from humans dealing with paper to humans dealing with machines. There are still humans involved and we make mistakes whether we write something down or enter it into a computer or forget it altogether," she says. It's true that some programs make it a lot harder to leave some important field incomplete, but the accuracy of the data input into the field is just as important.

It seems logical that something printed will be easier to read and thus less prone to errors than something scribbled in a physician's notoriously illegible hand. "But there isn't really any solid evidence that an electronic record is safer," says **Yosef D. Dlugacz**, PhD, of the Krasnoff Quality Management Institute at North Shore-Long Island Jewish Health System in New Hyde Park, NY.

Having mechanisms that automate entry, libraries that provide information about dosages and side effects while you are inputting information, and automatic calculations for dosage conversions all potentially help patients. But the problem is that humans are fallible, as Thielst says.

Another issue is that because errors don't always lead to adverse events, the electronic record could just as easily become a database for errors you don't look for. The assumption is that it's better than a handwritten record, he says, so why look for a problem there?

People have been waxing poetic about the benefits of computerized physician order entry (CPOE) for years. "One attractive thing about it is that there is software that checks for errors and problems," says Thielst. "But humans create the templates and order sets. It is also fairly rigid and doesn't accommodate even appropriate deviations."

For instance, a physician may want to use a dose of medication or a different medication based on information that is relatively new and the CPOE system hasn't been updated. "If it's not in the system the way the physician orders it, he can't override it. That can end up causing delays in treatment."

Providers also don't have adequate access to support. Because many of these systems are new — and they change rapidly — a 24/7 support system is imperative, Thielst says. "If a physician is working on a weekend night and can't remember his password, he can try so many times that he's locked out of the system," she says. "You don't want to keep that care from the patient because a doctor doesn't know what to do next." Some physicians are so flummoxed by new technology that they have another physician or a nurse take care of it for them. "Then you are adding another human into the mix and a new layer of risk."

A newer risk that Thielst says she is hearing more about are malicious data breaches and attacks on systems. "This is an issue in the future," she says. "How will you protect against that?" Authentication of users and of the data will be a big issue going forward.

Health IT is all about data-driven reporting and decisions. "Right now, there is a shift in paradigms. Physicians have gone from a system that emphasized knowledge, experience, and expertise to a system where they trust data," says Thielst, "But what about their instincts? What should they do when their gut disagrees with the data?"

Another issue is trust in the people making the technology. For some companies, the money being invested in health IT is a giant draw into an industry they don't have experience with. Thielst warns: "You have to make sure that what you buy is built by people who understand your needs. Do they have the expertise to make a good, safe, quality product?"

And if there are adverse events, Thielst isn't sure that another entity to which you should report it is a good idea — or even necessary. "We already report patient deaths, injuries, and other events to state and federal organizations," she says. More important would be noting that technology was part of the adverse event. Creating a way to track that is something that can happen much sooner than a new body can be created.

What to do now?

Dlugacz says he'd love to see every high risk environment — oncology, chemotherapy, dialysis, intensive care and the emergency department — have a Pharm.D. "If there is someone who can give ongoing assistance in delivering different drugs, who can oversee the smart pumps

and other technology that is designed to prevent errors, I think we can get better information on near misses and where errors occur." People only report things that happen if something bad results, he says, but errors happen all the time, at every hospital. Knowing where they occur is important to preventing them, and no machine will be able to catch near misses as well as a trained professional.

Dlugacz notes that most experts agree that when you do something a lot — such as giving medication in an acute care setting — you can expect an error rate of about 2%. But no hospital will show that kind of medication error rate. "We just aren't in tune to looking for all of our errors, and they think that technology can't make a mistake." He adds that he would like to see an organization that admitted to a 20% error rate because its leadership and clinical staff would know they had something to work on.

He'd like to see an audit of all medications — who gave them, the dosage, why, and how that compares to what is appropriate. The Pharm.D. can then pinpoint where the potential for harm existed, even if none occurred, says Dlugacz. See how that matches up with the drug reactions you have documented — are the things that happened in the documented cases similar to things that the Pharm.D. found in the audit that didn't cause harm? If so, you may be able to pinpoint a problem that no electronic health record could.

Time outs

Hospitals should also audit the medications received by a random selection of patients who had their dosages computed by technology, not a person, Dlugacz says; then you should look to see if the calculations were correct.

One idea that Dlugacz thinks would be great to steal from surgeons is the time out. "ICUs have a lot of technology and are highly complex. You have very smart people working to take care of the sickest patients. But how many of them stop to think before they give a medication? People are busy in a hospital, but shouldn't they stop and check, like they do with surgery patients?"

Thielst says you should pull together a workgroup with the specific purpose of assessing the risk to the organization from health IT. That group, made up of key stakeholders, should prioritize what needs to be addressed first. "Some things will be issues like integrating electronic patient safety into your existing patient safety program," she says. "How will you do that? How often will you look at it?"

Second, she recommends that physicians and other providers have a strong training program that they are required to attend and complete — no leaving in the middle because of a call — and that there is back up support always available for them.

Third, she says you should look at workflow issues and make sure that templates and order sets that go with any electronic process are clean and fit with the way care is delivered in your organization. "Assuming you are going to purchase a program, plug it in and go is asking for problems. Make sure it works for your specific needs."

Finally, Thielst says everyone should read the Joint Commission alert from Dec. 11, 2008, on the topic. More information is also found at her website and associated blog at http://thielst.typepad.com.

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Getting it right on readmissions

What didn't work is helping discover what does

If you say it out loud, people will agree intuitively: You can learn more from your failures than from your successes. But that doesn't mean people want to trumpet what doesn't work. That makes what's happening at Henry Ford Health System in Detroit so special: They are actively looking at what is still wrong as they try to get a handle on unplanned readmissions so that they can figure out what's right.

Long before payers started saying they'd stop paying for unplanned 30-day readmissions, the leadership at Henry Ford Health System decided to look at the topic, says **Beth Anctil**, RN, MSN, Director for Care Coordination for the system. "Our CEO thought we should tighten up our processes for discharging patients," she says, noting that over four years, the rate hasn't changed — or at least not enough, or not for long enough. "It will be down for three or four months, and then it pops back up again."

Anctil says she gets that it is complex — part is culture and getting people to change the way they do things. Part of it is that every patient who bounces back is different and figuring out which variable led to the readmission is hard. "We study it and it seems like everything we do is more complex than we thought initially."

Currently, there is a bundle that is considered standard of care, based on Institute of Healthcare Improvement suggestions. This includes doing a risk assessment for readmission and flagging the charts of patients considered at risk; providing education for patient and care provider; doing a medication reconciliation and consultation; ensuring a follow-up appointment within a specified time period; and providing discharge instructions and a summary to the patient and next provider.

"It's not rocket science, but it is different than what we did before, and there are barriers to it at every turn," she says, noting that she is trying to implement this in five hospitals, including two community hospitals and one medical-group based hospital. "I don't have the same control at the community hospitals I do with the staff model hospital."

What has been particularly difficult to get right is ensuring that patients have a timely follow-up appointment with their community care provider. "There are four drivers to that," says Anctil. "The hospital processes to facilitate the appointment and information flow; physician issues; patient/family issues; and financial issues."

In the first instance, there was no place in the record to capture who the primary care provider is, nor was there an obvious place to flag patients who were deemed by assessment to be at higher risk for readmission, she says. That meant that high-risk patients either weren't having appointments made because no one knew who to call, or because someone didn't realize they were at high risk. There was also an issue of ensuring a physician was available to see the patient in three to five days, she says, and if an appointment is made, how do you ensure that all the documentation — which in the past might have taken a week or more for a physician to complete — is done within the time period and delivered to the primary care physician? "In the regulatory world, they have 30 days to proof and sign their notes. Now we are telling them to do that on the day of discharge, and to make sure that it includes information on pending test results and how the attending physician thinks the primary care doctor should proceed."

What happens if the appointment isn't kept? Anctil asks. Who is supposed to follow up — the physician or the case manager? "We told them that until the handoff to the primary care physician is successful, they still have ownership of the patient." Not all the physicians agree. "Most would agree it's a good idea, but putting systems in place is hard. What do we expect them to do — drag the patient in?"

Further, each of these items is variable depending on the physician, the patient, the patient's support network, and insurance. In the latter category, Anctil notes that some may provide an outpatient case manager, and some may not. "You have to get buy in, you have to know if they have transportation, and whether they have money to pay the copay for their doctor," she says.

All of these areas of conflict and trouble have plagued Anctil's efforts to reduce readmission rates. But they keep plugging away.

Currently, they are asking every patient who is readmitted within 30 days of discharge why they think they were readmitted and what they might have done differently to avoid it. Often, the reason is medication-related.

"Patients won't take them or they have a generic at home and a name brand here and when they get home they take both, which is a double dose of something. We have to spend a lot more time educating patients now. We ask them what their goals are. If they are on 15 medications, they might say they want to only take two, because that's all they can afford." While the patient decision is based on money, that may not be the best decision for their health. If they will only take two medications, it's better that a provider determine the two

most important medications to take.

Another issue they have struggled with at Henry Ford is how much attention to give to those at the far end of the bell curve. "If the tail end of the bell curve is 75% of the readmissions, though, you have to address it. The issue is, though, that you need a completely different strategy to deal with the patients who are far outside the norm than with the patients in the middle. There is a group of people in the inner city who come back into the hospital as a respite. I think you have to have separate programs for them than for the other readmissions."

Anctil has also taken a page from an article she read last year in the *New Yorker* that talked about hot spots — how a group of people who were falling and being readmitted to a hospital in Camden, NJ, all came from a single apartment building (http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande). Thinking of the readmissions as some sort of cohesive group — hot spotters rather than frequent fliers — is allowing Anctil to better profile the group. She knows, for instance, that a third of them have end-stage renal disease; two thirds have some sort of addiction issue or mental health problem. "That's only 92 patients last year who had six or more readmissions within 30 days — and probably more besides that. Those patients were responsible for over 2,000 admissions last year. And for all I know, they are at another hospital if they aren't here."

Even among that group of patients, only 4% are uninsured. "Our efforts with them will focus on end-stage renal disease, which should hit a third of the patients." One thing research has shown is that some of those patients aren't getting their full dialysis — they leave early or come late, dependent on someone else to drive them and at the mercy of that driver's imperative to be somewhere else. "We are actually working on a checklist to capture the reasons for under-dialysis."

They have also found a problem with how well they communicate dry weight changes to the dialysis center, Anctil adds.

"We have a cross functional team now that is looking at solutions," she says. On the table is mentoring and starting a primary care clinic in the dialysis center so that comorbidities can be addressed while the audience is captive, as it were.

The initial bundle includes a home care visit paid for by Henry Ford if the patient doesn't have insurance to cover it. "The reality is we have to be frugal, so I don't know that we will need a social worker at the dialysis center, and a mentor, and a home care visit. But I don't know which will work. We'll be able to evaluate some of it by looking at compliance and measures of other health status," says Anctil.

Shortly, Anctil says they will begin following a group of patients from home to dialysis — some who are compliant and some who are not. Patients on home dialysis will be monitored, too, so that they can see if those patients have something to teach about end-stage renal patients who can't stay out of the hospital.

As for that bump in the middle? Anctil knows something isn't working there, either. Part of the problem is that not all aspects of that five-pronged bundle have been implemented consistently, she says. "We want to flag those high-risk patients, but we couldn't find a good place to do it. On the chart? Where on the chart? On the board? There are pockets of providers who do this well and always have, but others don't. The only thing we can do now is track it and publicly show who is doing well and who isn't. We'll make it competitive, hospital to hospital. We'll tell Henry Ford Hospital that someone else is doing it better and they'll figure out a way to get it done." For a list of items that lead to flagging, see box below.

Diagnosis:
- Acute myocardial infarction
- Congestive heart failure
- Pneumonia

Medications:
- More than 12 medications

Health history:
- Hospital admission in the last six months

Living situation:
- Lives alone

Source: Henry Ford Health System

They are also doing additional disease education in the hospital, and then doing it again post-discharge, she says. "It is the same education in all settings." A pharmacy consultation and home health referral are also provided, and if the home care visit isn't covered, Henry Ford will pay for at least one visit. "It costs less than a readmission," says Anctil."

They are looking at how they perform on all these processes, and then looking to see if there is movement in the readmission rates. "If we end up doing this all and still getting a high rate, then something isn't working. But we aren't there yet. Three of the five things are in place — we still have to work on the follow up appointment and pharmacy consultation. There just isn't an easy way to determine if those things happened yet. But I think if we do all these things, we will have good results."

Anctil says that without a system readmission team headed up by CEO Nancy Schlichtin and chief quality officer Bill Conway, MD, she wouldn't hear about all of the various pilots and tests. "We all learn from each other and call the question about what should be standard work processes for the system." She also says that the system case manager council group, who work through the specific improvement efforts and reach a consensus on definitions of process measures are helpful.

Each of the five hospitals has its own team working on readmissions, too, and data are sent out monthly to the system and hospital leadership. It's on everyone's radar. One thing she thinks would probably be as good a predictor as anything else would be to ask the care team, "Do you think this patient will be readmitted in the next 30 days? You'll find the team generally

COMING IN FUTURE MONTHS

- Becoming the best in surgical patient improvement
- More from the JC survey trenches
- How to handle incident reporting effectively

CNE QUESTIONS

1. The Joint Commission says that nurses who work more than 12 hours and residents with multiple 24-hour shifts are how much more likely to be involved in an event?
a. 5 times
b. 30 times
c. 1.5 times
d. 3 times

2. According to Tricia Kassab, there are how many cancer metrics that will be required for public reporting in 2014?
a. 5
b. 4
c. 8
d. 3

3. The natural rate of error for repetitive processes, according to Yosef Dlugacz, Ph.D. is
a. 12%
b. 22%
c. 2%
d. 20%

4. Henry Ford Health System has 92 patients who were responsible for at least how many admissions last year?
a. 2,000
b. 200
c. 3000
d. 10,000

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.

knows the answer."

For more information about this story contact Beth Anctil, RN, MSN, Director for Care Coordination, Henry Ford Health System, Detroit, MI. Telephone: (313) 874-2490. ■

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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%.
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2011 SALARY SURVEY RESULTS

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Quality improvement professionals are becoming more tech savvy

Electronic health records have quality pros working more closely with IT

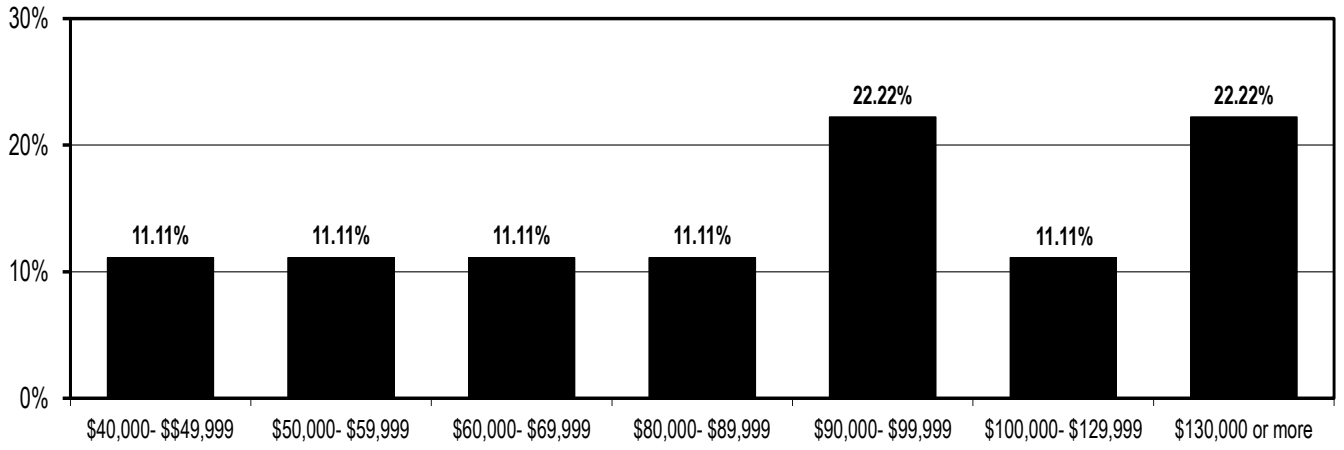
As technology continues to evolve, so does its usage in the healthcare setting. Quality professionals are becoming more IT savvy as electronic health records become the new industry norm. Instead of flipping through paper charts and files, health information is searchable through electronic databases.

"For the last few years, the industry has turned more quantitative over qualitative," says **Patrice Spath** of Brown-Spath & Associates. "Quality management professionals are needing to have data management skills and IT skills, especially as the health records become computerized. Quality professionals are no longer using paper-based records as their data source — they're using EHRs. If they're not doing that now, they will be doing that in the future."

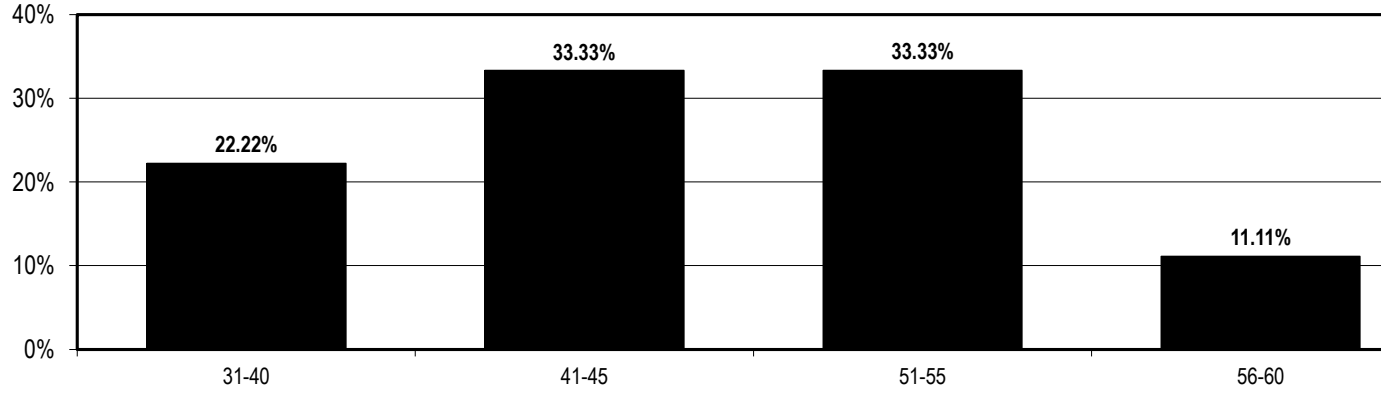
"The seasoned professionals learned to get teams together and do the qualitative things about changing the culture and making changes in an organization," Spath continues. "Now they're being challenged to be quantitative and to gather data and present in a way that makes sense and use statistical analysis techniques."

Although data retrieval is more streamlined with EHRs, long-time quality managers

What Is Your Annual Gross Income?



How Many Hours a Week Do You Work?



may not be as familiar with new technology. Managers have to learn how to use the new systems, how searches are set up and how to find data — and become more familiar with the IT department.

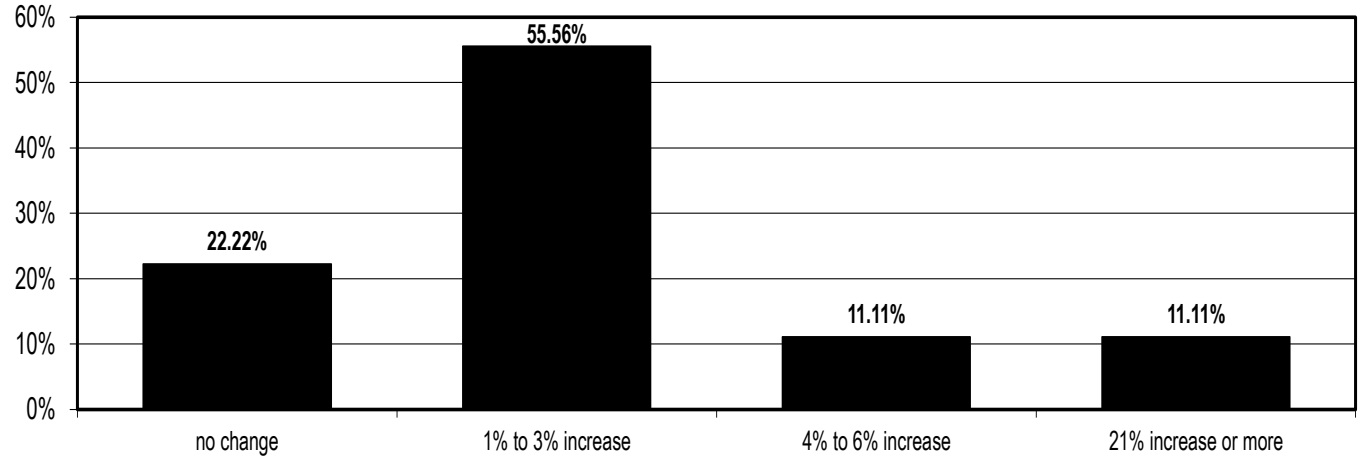
"The upside is that information can be more easily obtained in a more efficient manner — instead of pawing through paper records to look through data elements, you can do a query and find them electronically," Spath says. "In order to do that efficiently, quality professionals need to work closely with IT and health managers to extract that info. Quality managers will have to be more IT savvy, whereas in the past, everybody knew where to find patient data in a record. If it's in a server, how do you extract that data?"

While it may seem that retrieving data from an electronic record would be quicker than leafing through a paper file, there's more to gathering info than a click of a button. Systems must be implemented, data sets defined and collection measures translated to and implemented by the IT department. And organizations such as the National Quality Forum are beginning to set standards for electronic collection of quality measures.

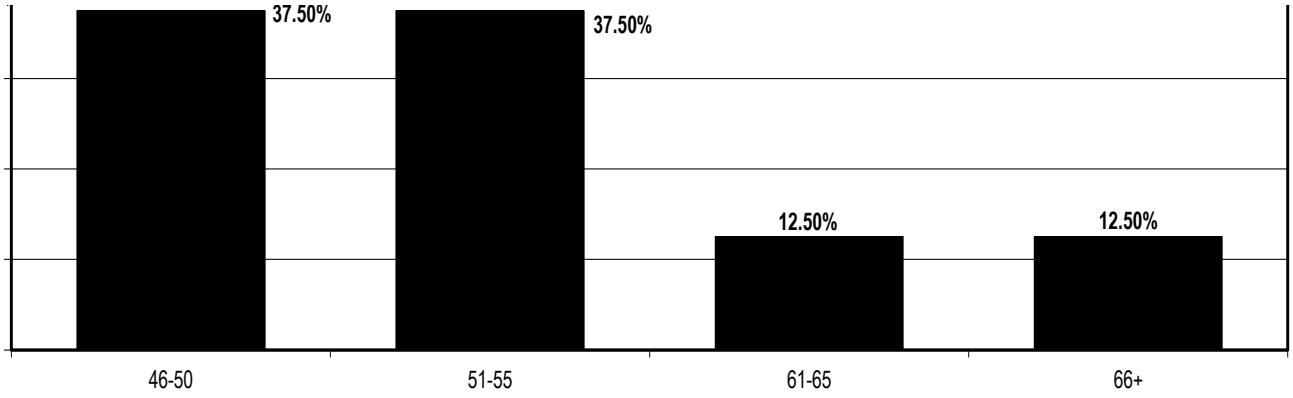
Quality expanding to other departments

"The National Quality Forum has an initiative to translate quality measures to eMeasures — data that can be extracted from an electronic health record," Spath explains. "It's a very detailed process of dividing what the data measures are and how to find them in the record

In the Last Year, How Has Your Salary Changed?



What Is Your Age?



and those kinds of things. These are the things to become aware of — how to translate their measures they have to collect manually and how to collect them electronically. The quality measures have to be translated to IT to capture that information. Mapping the data elements into the computer system is not as simple as it appears to be."

According to *Hospital Peer Review*'s 2011 Salary Survey, a growing number of quality professionals are newcomers to the field, with 44% reporting they have been in the field for 1-6 years. These new pros are entering during the transition and may have an advantage to learning the new technology. "These are younger people who may be more electronically oriented," Spath says.

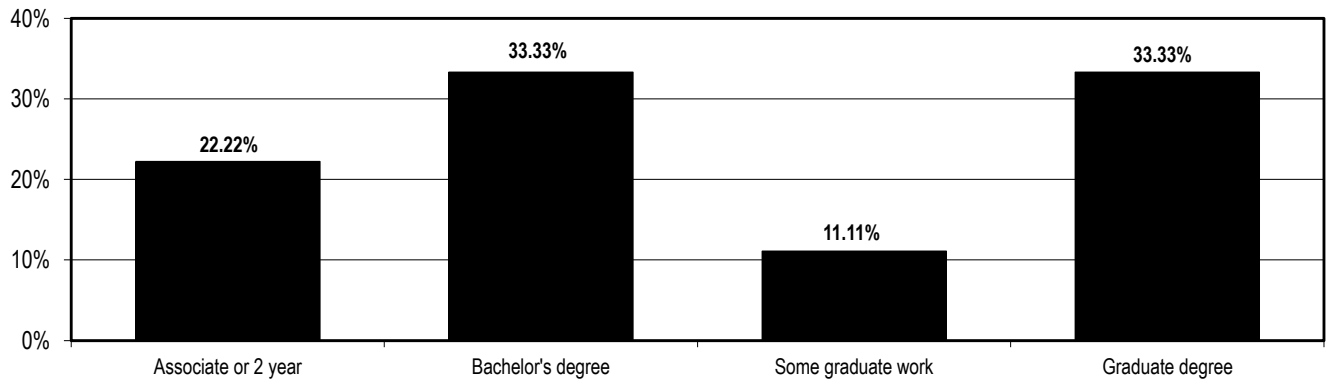
Quality improvement and patient safety aren't just for the quality department anymore. More and more, other hospital departments are stepping up to implement new quality regulations "I think the emphasis has been placed on quality, patient safety and productivity, lean projects and such," Spath says. "Not all of those have been delegated to the quality department. The pressure to keep up with all of the demands with improving quality may be spread throughout the organization and not just the quality department."

Thinking strategically

For instance, nurses may be asked to take on the role of quality coordinators, or as patient advocates. "In the past, a lot of places may have said 'there's a new regulation, call the quality department and let them handle it,'" Spath says. "Now they think more strategically — where's the best place to send the new regulation and have it complied with? It may be more efficiently dealt with in another department — I think we're moving in that direction."

The survey also revealed an increasing number of quality professionals are working 50-60

What Is Your Highest Degree?



hours in a week.

"The only thing I heard from people is, 'I have more work than I can humanly get done,'" Spath says. "I don't think the amount of hours has necessarily changed, but there's more and more to do and not enough hours to do it. I think that affects quality professionals — it's hard to make time for all the volunteer activities throughout the organization and go to professional meetings. It seems like no one has time to do the extracurriculars for professional development, like going to networking groups. I'm on a listserv for NAHQ and there's hardly any discussion on the listserv, like there's no time to bring up issues anymore. They have their nose to the grindstone so much and it's to the detriment of our profession to not do the networking like in the past." ■

How long have you worked in quality?