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IN THIS ISSUE

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AHC Media

Are your people too afraid to report errors?

AHRQ finds many employees think hospital culture is too punitive

Perhaps the saddest thing about the Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report, released in February by the Agency for Healthcare Research and Quality (AHRQ) is not that so many people believe the culture in their hospitals is an impediment to error reporting, but that so many people who work in the patient safety arena are not surprised at the high number of people responding that way.

The survey included about four dozen questions about the safety culture, including queries about overall perceptions, staffing, communications, and transitions. *(For a list of some of the questions, see box page 39.)* For example, nearly two-thirds of respondents think it is pure luck that more errors do not happen and that there are safety issues on their unit; fewer than half those responding feel free to question those above them, even if they think they might be making a mistake, and 63% are afraid to ask questions if something seems off. Half the respondents think their mistakes are held against them, and nearly as many think the organization looks for a person to blame, rather than a problem to solve. In the last year, none of those numbers had moved in a positive way more than 2%, and most were unchanged from the previous year. *(The complete report is available online at http://www.ahrq.gov/qual/hospsurvey12/.)*

"If something is not obviously the result of a process breakdown, people like someone to blame if something goes wrong," says **Frances Montoya**, manager of the patient safety program for Presbyterian Healthcare Services in Albuquerque, NM.

Barbara Rebold, RN, MHA, CPHQ, director of operations at the ECRI Institute Patient Safety Organization in Plymouth Meeting, PA, agrees. "It is human nature to find someone to blame and make an example of them, rather than looking at the system and why the system might be an issue."

Often, Rebold says, management will object to creating an organization that has an open and non-punitive culture, saying it lacks accountability. "But there is a difference between accountability and blame," she says. "It is a fine line, but there is a difference." Accountability

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means people feel responsible for making things happen, bringing hazards to light, and stopping activity if necessary. "People have to be empowered to be accountable. It is easier to blame a person, or educate, train, or discipline him, than to create the systems that empower them. But despite the effort, it is better in the long run to help them be willing to report errors and near misses."

"Dr. [W. Edwards] Deming said that errors are usually the responsibility of the system, not the worker," explains **Cary Gutbezahl**, MD, president and CEO of Compass Clinical Consulting of Cincinnati, OH. Gutbezahl consults with many organizations about creating a non-punitive culture for error reporting. "But that does not fit well with healthcare. We do not have well-designed systems, but rather we rely on good people to implement processes. We have an operator-dependent system, and that does not create teamwork, transparency, or effective error-proofing."

The number of employees who feel they work in a punitive environment? It is not surprising, he says, in context of the kind of industry healthcare is and the place on the quality path where it is at this point.

That does not mean you can't create an environment where the survey numbers seem wrong, sad, or ridiculous. Montoya says Presbyterian Healthcare Services started working on rolling out a Just Culture program in 2009. Based in part on training from the Institute for Healthcare Improvement, it started with an in-depth look at the constraints that existed around not identifying potential places of harm. "You have to know first where you are harming people," she says. "Then you can determine how to prevent that harm."

The worry that many had was that you would end up with a system that had no accountability, but Montoya says they got around that by making the message clear. "We recognize that healthcare is complex, with a lot of changes and handoffs. There will be mistakes. But we will be transparent, share where there are areas where we are prone to mistakes and figure out how to fix them. If you speak up about an error or near miss, we will use that as a learning experience. This is not a blame-free culture, but we want you to speak up. If you do, you will not be punished."

The initial inquiry into errors focused on pressure ulcers, surgical-site infections and other problems that could be identified using existing coding to capture. "We did quarterly reviews," Montoya says. "We sent them to the boards, and while at first they wanted to know who was making mistakes, over time they stopped."

Next, Montoya says they put together a

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Editor: Lisa Hubbell

Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Associate Managing Editor: Jill Von Wedel, (404) 262-5508 (jill.vonwedel@ahcmedia.com).

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Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

Significant Clinical Review Team. "Before, it was just one person who dealt with events. The team included risk management, nursing, pharmacy, and HR." They began to notice trends — things that happened more than once, providers who had the same problem repeatedly. They created Red Rules — the things for which providers are responsible 100% of the time and if not done result in some sort of remediation, punishment, perhaps even termination.

Gutbezahl spent some of his clinical life managing a blood bank. Red Rules there included following strict procedures for releasing blood from the bank to the nurses and up to a unit. If they were not followed every single time, it led to immediate termination.

One of the first Red Rules Montoya says they implemented in Albuquerque related to hand hygiene; another related to positive patient identification using name and date of birth. While things have improved in the year since the rules were rolled out, Montoya says they still struggle with the line between accountability and blame, even with the Red Rules. Who has to see you not washing your hands? If you have a verbal reminder, is that considered breaking the rule, even if you haven't touched a patient yet? What if it is a particularly frantic day and you miss something, but then come back and correct yourself, but your manager notices? A recent outbreak of norovirus allowed them to revisit the importance of hand hygiene. "If employees had been more accountable for this, maybe it wouldn't have spread so far," Montoya says.

Still, she counts the program as a success. "We have a safety culture now, not just a culture. And it is not about what just happened, but about the next patient. It is not about your role or relative position with the person you are questioning or correcting. It might sound like a no-brainer to call each other on hand-washing, but it does not always happen. So we have to give them better tools on how to approach their peers and co-workers. And we have to have the rules and hold every person accountable the same way — doctors and nurses."

Rebold says the key to implementing a nonpunitive culture is making sure that from the very top down, everyone supports the idea that you aren't looking for the person whose head needs to roll. When people talk about errors — and they talk about them whether you have a punitive culture or not — the conversation will include whether someone was scape-goated. When you stop blaming individuals and start looking at systemic reasons for errors, that word will spread. People will, over time, begin to feel more comfortable reporting mistakes. "Staff will begin to see there is no reason to

Select questions from AHRQ

Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report

Percent Responding Yes

Overall Perceptions of Patient Safety
1. It is just by chance that more serious mistakes do not happen around here. 62%
2. Patient safety is never sacrificed to get more work done. 64%
3. We have patient safety problems in this unit. 64%
4. Our procedures and systems are good at preventing errors from happening. 72%

Feedback & Communication About Error
1. We are given feedback about changes put into place based on event reports. 56%
2. We are informed about errors that happen in this unit. 65%
3. In this unit, we discuss ways to prevent errors from happening again. 72%

Frequency of Events Reported
1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? 57%
2. When a mistake is made, but has no potential to harm the patient, how often is this reported? 59%
3. When a mistake is made that could harm the patient, but does not, how often is this reported? 74%

Communication Openness
1. Staff will freely speak up if they see something that may negatively affect patient care. 75%
2. Staff feel free to question the decisions or actions of those with more authority. 47%
3. Staff are afraid to ask questions when something does not seem right. 63%

Nonpunitive Response to Error
1. Staff feel like their mistakes are held against them. 50%
2. When an event is reported, it feels like the person is being written up, not the problem. 46%
3. Staff worry that mistakes they make are kept in their personnel file. 35%

keep secrets and hide reports," says Rebold. "They will understand that the risk is patient safety, not job or income security."

You also have to have good ways to determine if there was any intentional human error, Rebold notes. "And that's not as easy as you think." There are tools that come from other industries that can help. ECRI has one available through its website. Another important tool, she says, is something that evaluates the various corrective actions you can take. ECRI has one of those, too, which outlines low-, medium- and high-impact methods of effecting change. Most people stick to things such as education and remediation, which are on the low end. "You need to choose actions that have higher impact, like optimizing redundancy through second checks, minimizing choices, or standardization." Those fall into the medium category. Failsafe mechanisms like Red Rules, stopping the line or automation are high-level actions. "Do not do something on the low end alone. If you do those alone, you will not have improvement."

Gutbezahl recommends talking to employees first to get their opinion on your culture. Then create your message and disseminate it. It could be as simple as "We work as a team, and any member of the team can speak up." Ensure acceptance at the top and roll it out to management — not just senior management, but managers from every level of the organization — before expanding it to everyone. Buy-in is crucial, he says.

"Fear is the enemy of quality," he says. "If people are afraid, they cover up errors and you get under-reporting of problems." That can lead to poor mortality and readmission rates; quality improvement departments will not know what needs fixing, either at the system level or even at the individual patient level.

Expect the changes to take about a year to percolate through your organization, Gutbezahl concludes. Reassure your staff that you are committed to changing the culture and when events happen, encourage discussion. "Say you used to have surgeons come in and complain about nurses who raise questions. You do not fire the nurse though. You talk about teamwork with the doctor and the nurses and how to have constructive conversations in surgery. People will hear about that. They will know that the nurse raised a concern and nothing bad happened."

For more information about this topic, contact:

- *Frances Montoya MT(ASCP), Manager, Patient Safety Program, Presbyterian Healthcare Services, Albuquerque, NM. Telephone: (505) 724-7909.*
- *Barbara Rebold, RN, MHA, CPHQ, Director of Operations, ECRI Institute Patient Safety Organization, Plymouth Meeting, PA. Telephone: (610) 585-5881.*
- *Cary Gutbezahl, MD, President and CEO, Compass Clinical Consulting, Cincinnati, OH. Telephone: (513) 702-5654. Email: CGutbezahl@compassgroupinc.com*

Further Internet Resources:

Just Culture website: http://www.justculture.org/default.aspx

ECRI Institute website: http://www.ECRI.org

California Hospital Patient Safety Organization website: http://www.chpso.org/index.php

Compass Clinical Consulting resource links: http://www.compass-clinical.com/resources/ ■

Letting it all hang out does not seem to matter

Study: Reporting made little difference in mortality

It has been seven years since Medicare started requiring hospitals to publicly report their performance for core measures related to heart attack, heart failure and pneumonia. Ask the hospitals participating in Hospital Compare whether this has affected their quality improvement and patient safety efforts and the vast majority will answer in the affirmative. But does that mean that what they do is resulting in better outcomes, in lower mortality? Not according to a new study in the March issue of *Health Affairs*[1].

Researchers looked at data from 2000 to 2008 for hospitalized Medicare patients with heart attack, heart failure, or pneumonia, and also patients who were admitted for conditions that were not reported to Hospital Compare — stroke, hip fracture, and gastrointestinal hemorrhage. The goal was to see if the public reporting of data for the three former conditions led to any statistically significant change in mortality rates compared to those conditions

for which data was not publicly reported. The timeline of the patient base straddled the time when data collection was first required and when it was mandated to be publicly reported in 2005.

The results showed a decline in mortality rates across all three of the reported conditions, but after controlling for existing trends to lower morbidity, that decline was not attributable to the public reporting of Hospital Compare data and all but disappeared for heart attack and pneumonia, and was minimal for heart failure. The researchers could find no movement of patients from poorly performing hospitals to better performing ones, and it could be that patients weren't using the data to choose providers at all. "To the extent that Hospital Compare reduced mortality, this was a result of within-hospital quality improvement," the study concludes, "which has been noted as a mechanism for quality improvement in other public reporting programs."

Author **Andrew M. Ryan**, Ph.D., assistant professor of public health at Weill Cornell Graduate School of Medical Sciences in New York City, says the question is not really about the effect that is or is not there, but about why we aren't seeing any effect. Everyone can agree that more people are reporting that they are meeting the requirements of the core measures. The numbers are going up for things like aspirin for stroke and heart attack patients. "Compliance with a lot started out so low," he says. "It makes it look like a success that these numbers went up. And maybe it is a success. But is the success a function of clinical or administrative activities?"

Hospitals wanted to do better on these measures, but it is possible the improvement was merely based on better documentation, and hospitals were already doing the things clinically that they were finally writing down, says Ryan.

The underlying logic of the measures is sound, he continues. They are based on peer-reviewed consensus evidence, and in trial settings each of them resulted in better outcomes. "But clinical trial settings are different," Ryan notes. "You have more discretion to exclude patients." The indicators are also pretty narrow and do not effect whole system change. "It is like teaching to the test."

He also says to remember that the study period was only a couple years into the public reporting and did not yet include public reporting of readmission and mortality rates. That those are now part of the record any consumer can check may positively impact those rates in the future.

The measures themselves

Not everyone thinks this is some sort of fluke that does not mean the indicators aren't good to consider and study. For some, the quality measures as they exist in hospitals are "completely perverse." That's the opinion of **J. Deane Waldman**, MD, MBA, a professor of pediatric medicine, pathology and decision science at the University of New Mexico in Albuquerque and author of the book *Uproot U.S. Healthcare,* which offers extensive critique of the way quality improvement is conducted currently.

Mortality is viewed as bad, and thus the opposite of it must be good, he says. But what people want is not the opposite of mortality. They want restored function and long life. Waldman also objects to the timeline associated with most quality measures. They do not look at things such as long-term survival rates or how the hip replacement patient does after two years, but in-hospital death and 30-day readmissions.

They are, he says, the easy things to measure and rely more on processes than outcomes, and if they are outcomes measures, they are not the outcomes that really matter to people. "No one ever asks the customers what they think quality is," says Waldman. Those things include ease of getting into and navigating the system, knowing what will happen next and a timeline of reasonable expectations. Patients want a smooth recovery if they are sick or an easy experience of the routine. "But medicine makes it hard." They want to see a physician in a timely manner, not the days or weeks it sometimes takes to see a specialist.

Waldman acknowledges that issues like parking, nice nurses, and decent food are real issues to patients. But they are not the important things. They are just the easiest ones to measure and correct, he says.

What hospitals should be doing is looking beyond regulatory compliance because the desired outcome shouldn't be compliance, Waldman notes. And while it is logical that following many if not all of the standards from

The Joint Commission or the Conditions of Participation from the Centers for Medicare & Medicaid Services (CMS) will improve quality, no one has ever proved that case.

And they should do this, Waldman continues, because eventually, looking at positive outcomes measures over a longer timeline will be something that is required. Meanwhile, doing these hard measures is a way of differentiating yourself from the competition. Payers will eventually respond to that.

Give providers incentives to do the things that improve these long-term positive outcomes measures, Waldman says. "What if you gave them an incentive to come up with ways to reduce infections or range of motion in ortho patients? You could save a vast amount of money by reducing your length of stay. If you have a fixed reimbursement for a procedure, you still get paid the same regardless of how long they stay." But for the patient, getting out sooner, being able to move more easily? Priceless.

Far to go, but do not despair

Not everyone is that pessimistic. "Over the last ten years, as a result of having a common set of data for all hospitals and physicians, we can finally have some meaningful conversations about quality across institutions," says **Apruv Gupta**, MD, MPH, managing partner at the Boston-based Physician Performance Improvement Institute. Yes, there are limitations — among them the fact that the data are out-dated when posted and have limited severity adjustment. "One of the biggest limitations of the data from a quality standpoint is that they can be improved in documentation, but without any corresponding change in practice — which means that even though it appears that process measures are improving, if there is no actual change in care, then outcomes measures such as mortality will not change," Gupta says. "The fallacy is in our belief that the process measures are necessarily linked to the outcomes measures, which they are not. But in any case, the great value of the data is in the quality movement that it has fostered, including transparency, and accountability. Real results will still take many more years to attain."

Gupta takes heart in how seriously hospitals take the measures that are required. "They are trying to develop a culture of measurement and systems for improvement. That's an OK place to be given when we started. We are building the measuring infrastructure. In a decade, there will be significant movement."

He knows that things are moving forward just from how much more willing providers are to discuss measures and report them. "Five years ago, docs would argue with you about what to measure, but now they do not actively fight you," Gupta says. "They are willing to sit at the table — not leading the efforts, but not fighting the efforts. You just have to figure out a way to engage with them."

According to Gupta, these things we are measuring may not be optimal, but they are still important, and it is beneficial to look at them, even if they do not move outcomes as much or as fast as you thought they would. "Improved documentation is critical because you are building a system that is necessary to impact quality. These core measures were what could be used to compare hospitals and gathered pretty easily."

If you are comfortable with the existing measures, Gupta suggests moving beyond them. For heart failure, there are other things you can measure and see if that helps you improve further. But for a regulatory body to mandate 15 measures for one disease alone? That wouldn't have flown.

Ryan does not believe that hospitals should stop doing what they've been doing because they do not believe it has an impact. "Hospital Compare is a good thing. It has raised the profile of quality of care and gotten people to focus on issues that for a long time were taken for granted."

For now, this is a good first step. "As it evolves, it may better engage patients, which it hasn't yet," he says. "And it does not mean it hasn't benefited the individual patient."

For more information on this topic, contact:

• *Andrew M. Ryan, Ph.D., Assistant Professor of Public Health, Weill Cornell Graduate School of Medical Sciences New York, NY. Email: amr2015@med.cornell.edu.*

• *J. Deane Waldman, MD, MBA, Professor of Pediatrics, Pathology and Decision Science, University of New Mexico, Albuquerque, NM. Email:dwaldman@thesystemmd.com.*

• *Apurv Gupta, MD, MPH, Managing Partner, Physician Performance Improvement Institute, Boston, MA. Email: agupta@ppiinst.org*

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Improving emergency department wait times

Expert tips to help things move faster

If you have patients waiting for long periods of time in your emergency department, you better start thinking about ways to cut those times. The Centers for Medicare & Medicaid Services is requiring hospitals to report two measures related to ED wait times — median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED, and median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status.

Perhaps the most effective measure you can do is to put a provider in triage and make sure the patient sees him or her as soon as he or she walks in the door — before the patient fills out financial forms or gets settled in the waiting room, says **John Shufeldt**, MD, JD, MBA, FACEP, a principal at his eponymous consulting firm in Scottsdale, AZ, and an emergency physician at St. Joseph's Hospital in Phoenix. Half the people who show up in the ED probably do not need to be there, he says. "The ones who come in with the flu, we can see them in triage. If they need a prescription, you can take care of it right then," he says. The trick is keeping them vertical. "Once they are horizontal, friction and gravity take over."

For patients who do need further care, Shufeldt says that you can move them on in the process. Patients may wait hours after that initial contact with a provider, he says, but they do not feel as though they are waiting because someone has seen them. Door-to-doc times at the hospital are down from hours to minutes. "If someone waits 30 minutes, that's an outlier," he says.

Providers were surprisingly willing to do this — they were there anyway, they now have fewer patients to deal with, and many fewer patients are leaving without being seen, Shufeldt says. Where the percentage of patients who left without been seen was 5-6%, it sits well below 2% now. "Now, if there is a 10-minute wait out there, providers want to jump on it. Their mentality is changed."

Part of the open-mindedness among the providers was that they are paid based on productivity, not hourly. The pay change led to a little pushback, he says, "but they ended up liking it." Initially, the new situation was difficult. "The first week was hell. We wanted to change back to the old system. But within a month we hit our stride."

One unexpected consequence of a short waiting time is an increase in volume in the ED. "The word gets out that they have docs waiting to see you," Shufeldt says.

While the CMS reporting requirements may inspire many hospitals to work on ED wait times, there are plenty of other reasons to consider it. First and foremost, the ED is the front door to the hospital, he says. "It is the way the community sees you." So being efficient and not having hours-long waits for sick patients? It creates goodwill in the community.

This will not solve the entire wait time problem, says Shufeldt. If you have a lot of patients coming through your ED, you may end up with a bed problem for that 20% you want to admit. "You can know in a couple minutes that someone needs to go upstairs," Shufeldt says. "But you may have a four-hour wait for a bed."

The problem is what you do with those patients. If you do not keep something of a lid on those throughput issues, you could see the waits creeping back up in the lobby, no matter how efficient your triaging system is, he says. "We have parked patients in the halls to encourage nurses to find them beds, and we've even reserved beds with phantom patients. If we know there will be 40 or 50 patients admitted that day, who cares what the names are? We'll just reserve them in advance."

At University of California, San Francisco's (UCSF) Fresno facility, they have the same issues with waiting and boarding and throughput that every busy ED has, says **Greg Hendey**, MD, professor of clinical emergency medicine at UCSF Fresno. He thinks physicians are more amenable to implementing triaging systems in part because they help keep patients from getting angry at long waits. "Docs do not like angry patients," he says.

They have gone through several iterations of triaging in Fresno and struggle most with where to put them once you know you want to admit them. "The issue is less with the ones you can deal with right now or put in a chair. It is those 10 or 20 or 50 patients who need a bed right now," says Hendey. "If you do not find someplace to put them, the whole thing grinds to a halt."

Putting patients in hallways on the units is a current favorite tactic, Hendey says. "They have nicer hallways than we do."

One innovation they have tried is to do a minimal screening exam and then immediately refer appropriate patients out to an urgent care clinic or physician office. "We tell them we are over capacity and are only taking dire emergencies," Hendey says. It is not the most patient-friendly response, but sometimes it has to be done. They have one urgent care center across the street, and they are considering how to ensure that these patients they refer out actually have access to care in a timely manner. There is some talk of putting an urgent care center on site so that patients could simply be shifted to another room, perhaps seeing some of the same providers who staff the ED.

"We live in a drive-through culture where people do not want to wait to see their physician or do not want to give up a work day to make an appointment," says Hendey. "Even if they have insurance, sometimes they come here because it is more convenient for them." Meanwhile, the ED is required to see anyone, any time, and provide that basic health screening exam.

Physicians are under pressure to not miss something, and with all the bells and whistles available in the ED, there is the temptation to over-test. "You can't miss something, you can't make a delayed diagnosis — and it is more complicated than just defensive medicine," Hendey says. All of this adds to pressure on the ED, with more people coming in, more people waiting, and more being done to those who make it through even the most robust triaging.

So they keep trying new things, hoping something will work better — although Hendey says no one believes that there will ever be no wait in a typical urban emergency room. Next up in Fresno is a docket triaging system in which a physician will start preliminary orders and does a basic screening. Some patients will be referred out to the hospital's own or an affiliated urgent care clinic, others processed through. There is some loss in revenue associated with getting those patients to urgent care, where there is less payment, but also fewer requirements for documentation and staffing.

They also keep looking at places that have done really well, Hendey says — Arrowhead Regional Medical Center in the Los Angeles area is one that has made an art of evaluating patients at the door, and Santa Clara Valley Medical Center. "They are aggressive in getting people right at the door and putting them through a series of stations," he says. "And it has paid off."

Hendey is kind of happy that there is going to be this increased push to be more efficient. "They will want us to move patients faster, but I want that to happen anyway. And when we have regulations forcing us to make changes, the hospital becomes very interested in helping us make changes."

For more information on this topic contact:

• *John Shufeldt, MD, JD, MBA, FACEP, Principal, Shufeldt Consulting, LLC, Scottsdale, AZ. Telephone: (480) 221-8059.*

• *Gregory W. Hendey, MD, Professor of Clinical Emergency Medicine, UCSF Fresno Medical Education Program, Fresno, CA. Email: ghendey@fresno.ucsf.edu.* ■

Why do it if you can't measure it?

Helping outcomes, even if you can't prove it

With all the talk about needing more outcomes measures rather than process measures, there are some well-loved projects that could get left out in the cold, simply because it is hard to prove they have a direct impact on improved outcomes. And given the tighter purse strings in hospitals, if you can't prove it helps, and it is not required, you may end up cutting a program.

But there are champions of programs, particularly those that engage patients in their care, who say you should stick with these projects. It could be some day you'll find a way to measure the impact, but even if you can't, the goodwill

they build, the opportunity to get a different view of the care you provide, makes it worth it.

One program at Dartmouth Hitchcock Medical Center in Lebanon, NH, that fits this description is the shared decision-making project, says **William Abdu**, MD, associate professor at the Dartmouth Institute and associate professor of orthopedic surgery at Dartmouth Medical School. Abdu is also medical director of the Spine Center at Dartmouth Hitchcock. Abdu and his colleagues have been collecting data for a dozen years on patients with three different conditions. "We are $30 million into it and outcomes are patient-reported data like pain relief," he explains. "It is easy to see how the outcomes improved, but compared to what?"

They took part of the group and put them through a shared decision-making program, through which they evaluated their values and preferences and were educated on spine surgery. All met the criteria for surgery, but a quarter of them changed their minds and opted not to have it, says Abdu. And nearly everyone found the program useful.

Did those people have better outcomes because they went through the shared decision-making program? No, he says. But they were better informed. "To find out if it really worked, we would have to have a huge multicenter trial that would require a great deal of investment," says Abdu. "It could be done with registries, but even those are still at the infancy stage."

For now, they content themselves with knowing that there are data that show involved patients do better, and they are spreading the involvement: Other departments and units are creating similar surveys for patients. The Center for Shared Decision Making at Dartmouth Hitchcock (http://patients.dartmouth-hitchcock.org/shared_decision_making.html) has some of the decision aids that are used throughout the organization now. It includes questions patients answer before they come in about their condition and what they hope to achieve. "I can't do anything about a herniated disc without an MRI," Abdu says. "The health survey information is used the same way."

And if there is never a way to tell that this kind of patient engagement really works, Abdu will make due with surrogates: satisfaction scores and the fact that "if we did a lousy job, we wouldn't get the amount of referrals we do. Even if we did great research on this, I think people would still question what we do. Part of this is art."

Follow makes leader

Kaiser Permanente has found a way to make use of patient experiences that, likewise, has little way of being measured for its impact: video ethnography. But they are happy to continue with it anyway, says **Estee Neuwirth**, Ph.D, director of field studies, evaluation and analytics for KP's Care Management Institute in Oakland, CA.

"We had been using mixed methods to find out how patients experience our programs so that we could learn from them, get ideas for change, and build the will for change," says Neuwirth. But by following the patients and getting their experience on video, "we can really help catalyze the changes" they want to make. The patient voice is powerful. It is powerful on paper, but it is even more powerful on tape, speaking as the patient encounter is unfolding. It does not replace other methods of gauging patient experience, she adds. It is added to other shadowing and survey programs. "The resonance we get from this is much more profound."

The videos are taken in hospitals, clinics, and even at home post-discharge. Usually, Neuwirth says, it is done over the course of a couple days with multiple patients. Then the video is dissected by a team of analysts, which also takes a couple days. Someone edits it, and about a week after the patients were filmed, you have a product that will bring home to providers just what it is like to be on the other side of the encounter.

Analysts look for patterns of behavior, as well as overt statements of what is not going right with the patient experience.

Making it happen

So far, 150 Kaiser people have been trained in video ethnography. "We know it has impact because the popularity is expanding," she says. After they are trained, they are contacted again, and all have talked about the huge impact what they are filming is having."

It does not take a lot to make it happen — you can hire a consultant to do it, or do it with

a simple hand-held commercial-grade video camera. No professional equipment is needed, says Neuwirth. Editing can be done with simple software, or you can hire someone.

What to measure?

The Care Management Institute has an online toolkit that anyone can use, she adds. It is available at http://kpcmi.org/cmi-news/tool-kits/.

At the Kasier Permanente Roseville Medical Center in the Sacramento area, they used it in the surgical department to figure out what patients needed. "It can take a long time to figure out exactly what is needed," says **Ryan Darke**, MHA, performance improvement director at the hospital.

But with the video program, it was much easier because the patients they followed around were quick to mention the things that irked them. They had hours of footage that were boiled down to seven minutes, he says. In those seven minutes, patient and family voices told providers and other staff exactly how to improve the experience. The waiting room was cluttered and chaotic; there was no place for pediatric patients to wait that was appropriate; the preoperative area was not really private and did not allow a lot of space for patients and their families to be together before surgery. So they have changed the waiting room, improved patient flow, and created a separate pediatric waiting room.

The staff loved it, says Darke. "It is a great way to find things to improve."

But what to measure? Certainly patient satisfaction scores are part of it. But mostly they look at process measures, he says.

What might be more easily measured is its impact on more clinical areas. Kaiser has people using it to study unplanned readmissions, says Neuwirth. Just by following patients through the process, including at home, and by interviewing family members, they have been able to identify areas to focus on. "One key issue relates to medication," she says. "That's not surprising, but hearing it from their mouths is powerful." Less surprising was that the bedside teaching was not having the effect they wanted it to. "One patient explained that she had one foot out the door when the nurse was doing her teaching," she says. So now they still do that pre-discharge education, but they do it again over the phone and during outpatient visits. That helps patients absorb it better. Given that this is something concrete that may change readmission rates, Neuwirth says it might be possible to relate it directly to this program, without which they may not have had such an a-ha moment.

Down the road at Stanford, the university's medical center has spent more than 20 years creating a customer service program whose impact on outcomes would be hard to measure, but which has evolved over time to be a huge point of pride for people who work at the facility, says **Barbara Ralston**, vice president of international medical services at the hospital.

"It is hard to say that guest services impacts outcomes," Ralston notes. "But there is something to be said for staying in close touch with patients and guiding them through a complex and often stressful system — especially for the high-end specialty care where there can be so many more handoffs and transitions."

The healthcare navigator and C-ICARE program all grew out of a humble patient library that was created 23 years ago, she says. Volunteer librarians started hearing comments and questions. Over time, more bits and pieces were added to the customer care program. Now it includes some 900 volunteers and 150 staff who help patients get through their experience with as little headache as possible. If they get lost, someone guides them to the right place; if they have a question, then any time, day or night, they can call the service and have someone answer. Patients are less likely to be late or miss appointments, which has an effect on the efficiency of the hospital. If there is something particularly aggravating to a patient, Ralston says they will tell the navigator during follow-up calls. That can help identify patterns and trends of problems which can be quickly identified and dealt with.

Connecting with patients

While most patients do not have the same navigator throughout their experience, the program is seamless, Ralston says. The staff and volunteers use a customer relationship management tool that is similar to those used in other industries. This keeps all necessary information at the fingertips of whoever answers the phone when a patient calls with a question. There are

also clinical navigators who have access to the patient's medical record, she says, and can help with clinical questions when appropriate.

The most recent part of the program is the C-ICARE. Every staff member wears a button with those letters on it. They are a reminder, Ralston says, to:

- Connect with the patient.
- Introduce yourself and your role.
- Communicate the plan of care.
- Ask permission before entering a room, examining the patient or taking any action.
- Respond to patient questions and requests promptly and anticipate needs.
- Exit courteously with an explanation of what will come next.

All of these efforts have resulted in a "dramatic" increase in patient satisfaction scores, improved reputation in the community, and more business, Ralston says. And there is an element of accountability built into the program, too: All staff and providers, including physicians, are required to participate in I-CARE huddles, rounds and meetings.

Does this, in the end, affect patient safety and outcomes? Rebold is sure it does, even if she can't prove it. "The patient, at every moment, is first and foremost. It is not always about the procedure with us. We interact more frequently and on a more personal basis. And that has to make a difference."

For more information on this topic, contact:

- *William A. Abdu, MD, Associate Professor of The Dartmouth Institute and of Orthopaedic Surgery, Dartmouth Medical School, Medical Director, Spine Center at Dartmouth Hitchcock Medical Center, Lebanon, NH. Email: william.a.abdu@hitchcock.org.*

COMING IN FUTURE MONTHS

- TJC award winners spotlight
- Dissecting sentinel event data from TJC
- Improving transitions for Medicare patients
- More from the AHRQ survey
- More from the JC survey trenches

CNE QUESTIONS

1. What percentage of survey respondents told AHRQ that hospitals hold errors against staff members?
   A. 50%
   B. 75%
   C. Two-thirds
   D. 65%

2. What year did Hospital Compare start publicly reporting core measures?
   A. 2000
   B. 2008
   C. 2005
   D. 2003

3. One commonly used successful way to improve ED wait times is to:
   A. Have patients fill out forms while they wait
   B. Have them see providers as soon as they come in
   C. Have them wait in hallways
   D. Create a boarding unit

4. One benefit of taping patient encounters is that:
   A. Words coming from the patients directly have more impact than numbers on a page
   B. You can get what you need in two days
   C. You can see when providers make mistakes
   D. It is cheaper than shadowing

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.

• *Ryan Darke, MHA, Performance Improvement Director, Kaiser Permanente, Roseville Medical Center, Roseville, CA. Telephone: (916) 223-4708.*

• *Estee Neuwirth, Ph.D. , Director of Field Studies, Evaluation & Analytics for Care Management Institute, Oakland, CA. Telephone: (510) 625-5624.*

• *Barbara Ralston, Vice President, International Medical Services, Stanford University, Stanford, CA. (650) 723-7604.* ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/.

Hospital Peer Review's executive editor Russ Underwood and associate managing editor Jill Von Wedel both contribute. ■

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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