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AHC Media

What do the CMS rules mean to you?

Focus on readmissions, practice implementation now

April and May were busy months for the Centers for Medicare & Medicaid Services (CMS), which issued several proposed and final rules that will affect hospitals and other healthcare organizations for years to come. Two are of specific concern to acute care settings. One will affect how hospitals are paid under the Inpatient Prospective Payment System (IPPS), strengthen the value-based purchasing program (VBP), and add new measures related to central-line infections. The second proposed rule would standardize the identifiers healthcare organizations use with third-party payers and also delay implementation of the new set of codes, ICD-10, for a year.

The first rule, available to view at http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1, provides a 2.3% increase in payments to hospitals and puts more focus on the VBP program by emphasizing certain performance metrics. One of the new ones in the proposed rule is spending per beneficiary from three days prior to hospitalization to 30 days post-discharge. They will also focus on central-line-associated bloodstream infections (CLABSI), perinatal care, hip and knee replacement surgery, and the use of checklists in the operating room. A new survey measure for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) aims to assess care transitions. Hospitals that have excess readmissions for heart failure, heart attack, and pneumonia face financial punishment starting in the next fiscal year, which begins Oct. 1, 2012. The proposed rule provides the algorithm for determining how much money those hospitals will lose.

Cancer hospitals that are currently exempt from PPS will also come under a quality measure reporting program, and ambulatory surgery centers will have additional requirements added to their program.

"I think one thing it does is add another dimensionality to what quality professionals do," says **Kunal Pandya,** a senior analyst for healthcare, insurance and payments at Aite Group in Chicago. "The proposed rules add another layer to providing better quality care. It will take more time to manage all the rules. But it will be beneficial to patient care. The rules will ensure that certain areas aren't overlooked because you aren't gathering information on them."

Pandya says smart hospitals will start piloting these rules quickly so that they can work out any kinks before the requirements are mandatory. "I

think that larger hospitals are already pretty prepared. But I'm not sure how smaller facilities will fare. They have lagged behind in some of these issues."

Certainly not every hospital is going to win at the new rules. A recent survey of 79 hospitals done by Zynx Health of Los Angeles found that there are great gaps even now in how hospitals use clinical decision support (CDS) in the electronic health record (EHR) to address conditions of interest to CMS, such as heart failure and pneumonia, says **David C. Rhew**, MD, vice president and chief medical officer at the company. The voluntary audit indicates that there is on average a 30-40% "quality" gap in the CDS (e.g., order sets, plans of care, rules, structured documentation, dashboards, policies and procedures) that is being implemented in hospital EHRs across the country, and this gap translates to significant opportunities to improve patient care and reduce costs.

There are some 20 metrics related to heart failure that could be included in a facility's electronic health record, but in just about every case, the gap of 30-40% was the same, whether it was a large hospital or a small, rural or academic medical center. No one used all of the processes proven to improve outcomes.

"It's not obvious to some that pay for performance is set up so that you have money pulled out up front and have to earn it back, and even if you do relatively well, you may not earn it all back," he says. According to Rhew, 40% of hospitals will get less money than they did before. And the scores a hospital needs to break even — 41 next fiscal year — are set to go up, reaching 85 by 2017.

"You have to do exceptionally well on the metrics," he says. "You will have to do better than a large number of hospitals on process of care measures to do well financially. And next fiscal year, they will add additional metrics, which will continue to expand." If hospitals aren't hitting their clinical process metrics now, how likely is it that they will hit all the metrics they need to in a year or two to make the same amount of money they are now?

Rhew says that given how competitive the system is designed to be, with hospitals essentially competing against each other for a closed pool of dollars, they need to start right now to do everything they can to maximize performance. "You want the best outcomes, the lowest mortality, the highest level for process measures, the lowest readmissions," he says. "Identify the broader set of things beyond core measures that you need to look at and standardize care to the highest degree."

The change to the daily lives of quality professionals won't be as massive as some fear, says **Jon Elion**, MD, FACC, CEO, ChartWise Medical Systems, Wakefield, RI, who also practices cardiac

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Editor: Lisa Hubbell

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

Associate Managing Editor: Jill Drachenberg, (404) 262-5508 (jill.drachenberg@ahcmedia.com).

Editorial Questions

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

medicine at an area academic medical center and is an associate professor at Brown University. "All the things you've been doing will now translate to dollars and cents," Elion says. "That's cool. And it's also now getting attention at the c-suite level that it didn't get before there was money involved." What might have been viewed at one time as nice aspirations but something of a luxury is now going to be required to maintain a facility's financial health.

What he hopes people will recognize is that despite the 30% emphasis on patient experience and new questions on the HCAHPS survey, paying too much attention to that aspect will get you nowhere fast. "If you go to a fast food restaurant and it's clean and you get your meal fast, you're happy," he says. "If you go to an expensive restaurant and you think it took too long, you might rate it lower than the fast food joint. But where would you rather eat?" he asks. "If you have two patients in the same room, with the same nurse, the same care, both waiting for results of a lung biopsy and one gets good news and the other bad, which one will rate the patient experience better? When the cancer patient comes in for chemo and you ask him about his patient experience, he's hardly going to say fabulous. A lot of things have to go right for a patient to be satisfied."

Similarly if you spend a lot of money and attention on a lovely facility, a room with amenities, restaurant-quality food and sweet nurses, you might get good patient satisfaction scores. But who cares if the patient dies of untreated pneumonia? "If you get a lot of grumpy scores, of course you should look at it. And if they are high, you're doing something right. But the other measures should take more of your attention," Elion says.

The best advice he has is to work on standardization. "If you do the right thing at the right time for the right reason all the time, you'll have good outcomes far more often than not." But that's not the end of the matter. Elion also says that people often forget to continually monitor progress. If a quality improvement program is based on the Plan, Do, Check, Act model, he says, people often stop after the plan and do parts. Checking results and acting on any that seem out of sync with expectations is imperative to having the kind of improvement these rules require for hospitals to do well financially.

Elion also suggests focusing on a new set of goal words. Length of stay is often an issue with administrators. But you shouldn't blindly try to make stays as short as possible. "If you have a patient with open heart surgery, there is a move to get them home sooner and reduce length of stay. But reducing is the wrong thing to focus on. You should be optimizing it." If you release the patient too early, you may end up with a bounce back. Part of the problem is that even under the new rules, there is no cost-per-day calculation. If there was, the goal would be not to shorten the last part of the stay but the first, since most care is done in the first couple of days of a hospitalization. The last two or three days are relatively cheap, so getting them out too early saves you far less than you think, he says. And if a patient bounces back, it will certainly cost you more than you saved.

Because there is some leeway in the new rules for readmissions related to some conditions, you want to be sure you track and code them properly, too, Elion notes. "Heart failure patients are typically readmitted for their comorbidities. I treat them for heart failure and a week later they come back in for a hot gall bladder. I shouldn't be dinged for that. Make sure the primary diagnosis is correct."

Look for patients who are at high risk for readmissions, he says, as well as the attending and referring physicians associated with 30-day readmits. You might find some actionable data there.

With the future of health reform up in the air right now, many quality professionals might be unsure of how to proceed, says **Wayne J. Miller**, Esq., partner at the Compliance Law Group in Los Angeles. But even if there is a negative decision by the Supreme Court in June, the theme of reducing costs and improving quality will continue in whatever comes next.

If the VBP and hospital readmission reduction programs are implemented, QI professionals may focus on those potential heart attack and pneumonia readmissions, says Miller. "This will mean scrutiny of cases for potential heart or respiratory complications resulting in possible longer initial stays to rule out these complications." On the other end, staff may be asked to highlight potential readmits that may fall into these categories. But there is a downside, he continues: "The focus on avoiding readmissions may detract from other quality initiatives and efforts that you will need to make to avoid patient readmit 'dumping' on other facilities and negative payment consequences."

For now, review case histories to evaluate the historical short readmission experience at a facility and its potential impact on payments based on the rule, Miller advises. Review the types of cases that may trigger readmissions as well as the procedures in place to address heart and respiratory issues in a single admission rather than multiple ones.

Rhew says he doesn't think there will be as much pushback with the VBP rules as there was with the ICD-10 code changes — uproar that ultimately led to another one-year delay. "That required organizations to do some very labor-intensive things that were outside their core mission," he says. "These things are all about patient care. It's about outcomes, mortality, readmissions — although that's based on cost metrics." But this stuff matters for patients and providers alike.

Not that everyone is happy. "The new rules change the width of the goalposts and the number of time-outs per half, but they do not change the game," says **J. Deane Waldman**, MD, MBA, a professor of pediatrics, pathology and decision science at the University of New Mexico. "Thus, the players will still be gaming the system so that they win, but their winning or losing does not connect with whether the patients win or lose."

Putting it more plainly, Waldman says that the quality the new rules ask for isn't the quality that really matters: good patient outcomes. "They still use rule-following as a surrogate for the desired results, and the surrogate doesn't work. Until the system starts directly measuring and tracking positive patient outcomes, and then linking incentives to those, the quality we want from the system will not be enhanced."

For more information on this topic, contact:

- *Kunal Pandya, Senior Analyst, Healthcare Insurance and Payments, Aite Group, Chicago. Email: kpandya@aitegroup.com.*
- *J. Deane Waldman, MD, MBA, Professor of Pediatrics, Pathology & Decision Science, University of New Mexico. Email: DWaldman@thesystemmd.com.*
- *David Rhew, MD, Senior Vice President and Chief Medical Officer, Zynx Health, Los Angeles. Email: drhew@zynx.com.*
- *Jon Elion, MD, FACC, CEO, ChartWise Medical Systems, Wakefield, RI. Telephone: (401) 473-2020.*
- *Wayne J. Miller, Esq., partner, Compliance Law Group, Los Angeles. Email: wjm@complianceawgroup.com.* ■

ICD-10 delayed another year

Although many hospitals worked hard to be ready for the implementation of ICD-10 coding to replace the decades-old ICD-9, the Centers for Medicare & Medicaid Services (CMS) has delayed final implementation until Oct. 1, 2013.

That announcement was made as part of a proposed rule, which can be viewed at www.ofr.gov/inspection.aspx, that also requires payees to have a "unique health plan identifier," thus standardizing the many versions of differing length and makeup that payers are forced to accommodate.

Jon Elion, MD, FACC, CEO of ChartWise Medical Systems in Wakefield, RI, says he doubts the delay will help those who aren't ready. "I think it is the outpatient arena which was driving the call to wait, and insurance companies are afraid of chaos, which is what it is right now. They want order."

The value of the new codes is evident to any who have studied them. "ICD-9 is archaic," says Elion, whose company sells a computer program designed to help improve the accuracy and precision of physician notes so they include the diagnostic specificity coders want. "There are pages and pages of codes for tuberculosis, and just one single code for HIV. There is one code for coronary angioplasty in 9, 1,700 in 10. That allows you to use a different code for each location in the artery. The old coding system didn't reflect what was going on with the patient, so you can't really analyze data with what we have."

Given the emphasis on using data to improve quality, that matters, Elion says. ■

Skinny is good for management, too

Lean practices can work well in healthcare

When the National Committee for Quality Assurance (NCQA) named **Patricia Gabow**, MD, CEO of the Denver Health and Hospital Authority, one of the winners of its National Quality Awards, it didn't shock the people she works with. She has been pushing Denver Health from success to success for years

with her pioneering use of Lean management techniques more often associated with industry than healthcare.

Her Lean journey started several years ago when she was talking with some of her colleagues about how, in the 40 years since her internship, not a whole lot had changed in the way things were done. "That can't be right," she says. "We hadn't really stepped back to look at what we do."

After getting a grant from the Agency for Healthcare Research and Quality, Gabow put together an external advisory group to look at systems and processes. Rather than gather people from only like organizations around the table, though, she chose participants such as the head of global health for Microsoft, someone from the FedEx center for supply chain management, the head of labor for Ritz-Carlton, and the Institute for Healthcare Improvement's Don Berwick, MD. They looked at operations for companies like Dell and FedEx, and health systems in countries like Sweden. "One of my docs said of all the craziest ideas I had, this was the stupidest, because patients aren't packages." After the trip to the FedEx operation, though, he came to Gabow again, pining about how nice it would be to know as much about patients as FedEx knew about its packages.

She led focus groups with patients in Spanish and English, with every level of staff from housekeeping through the C-suite, with insured and uninsured patients. She asked them what they saw that was wrong with the patient experience. An industrial engineer was hired to map everything from the food service tray line to the 24-hour shift of a trauma resident. The latter showed more than 8.5 miles of walking, which, while great for health, uncovered a lot of inefficiency. "Every diagram he brought me was so inefficient," Gabow says.

One of the things they realized after a year of study was that many things needed to be addressed. One of them was finding the right processes. "Lean appealed to me as having a toolset that was intuitive, that can involve the whole workforce in a meaningful way."

By 2006 the journey had begun. Gabow says that the Lean philosophy is built on respect for people and continuous improvement. Waste is disrespectful, whether it is of resources or of the time and labor of employees. While work with no meaning is what a company like Toyota would define as waste, in a hospital setting, Gabow says it is process with no value. If it isn't doing something good for the patients, it doesn't have value. So when a diagram of movements in the OR comes to her attention and looks more like a plate of spaghetti than anything else, Gabow knows there is something to fix. "That's not something anyone would design."

Rapid improvement events

One of the outcomes of Lean has been a series of rapid improvement events, where eight to 10 people work for a single week on a single problem. There have been around 400 of them so far, with more than 2,000 employees involved. People who have never gotten up in front of an audience confidently talk to executives about their event, Gabow says. It is incredibly empowering for staff at all levels. According to Denver Health staff surveys, 78% report they understand how Lean helps to improve things.

While initially Gabow thought she'd use her 25 handpicked Black Belts to run the rapid improvement events, she quickly realized "these amazing people have day jobs." So there are now eight full-time facilitators to run the events. And while she started out thinking they could do Lean project by project, "I realized that at that rate I'd be dead before there was transformation." They needed to embed them in the system. So she created some 16 areas of focus, and over the course of six years, there have been at least $158 million in benefits. Gabow says a third of that amount is in hard cash savings — they have the lowest supply costs in the University Health System Consortium (UHC) and the lowest antibiotic costs, too; a third is increased productivity, which allowed some 30,000 more clinic visits, which translates into more revenue; and a third came from the ability to enroll more people into Medicaid and CHIP.

Gabow knows that some people believe if you lower cost, it must come at the expense of quality. "My response is to ask them to explain how waste improves quality," she says. "There isn't anything about a bad process that makes quality better." Then she points at the Denver Health standings for quality or mortality in the UHC. "The graph of that looks the same as the financial benefit graph. We have gotten better every year."

As for some specific projects on which Lean

was used, Gabow points to developing registries.

The system mapped a process of antibiotic use for surgical patients that led to the antibiotics being given by the anesthesiologists rather than by a nurse on the unit.

They have used Lean to attack deep vein thrombosis (DVT). "It can add days to hospitalization and lead to increased mortality. Everyone had their own horse to champion. But Lean is about standardizing work. We got six or eight physicians together to work on this. We found that the anticoagulation service was using the highest-cost drug, often inappropriately. We lowered costs and lowered DVT."

Part of Lean's value, she says, is its demand for transparency. "You have to have visual management. So for vent-associated pneumonia, all our patients, families, and visitors can see our protocols. The same with OB patients or for catheter-associated urinary tract infections. If you bury the information, you don't get transformation."

The costs of Lean are quickly made up. The participants on the rapid improvement event teams are not backfilled except for nurses. It's viewed as an additional activity for all other participants.

Lean training for Black Belts is spread out over the course of six or seven weeks, a couple of days at a time. Not everyone gets training, either. Gabow says she wants a third of the rapid improvement events teams to be new to Lean. Why? If you train people in skills they won't use for a few months, they have forgotten it. Better they learn it as it is needed. And nothing is so difficult to learn that it detracts from the potential improvement.

The only exception to limited training was a module for a visual management tool, a two-hour course for all mid-level managers. Every one of them was asked to do a so-called 5S project — Sort, Set in Order, Shine, Standardize, Sustain. That spread the method quickly throughout the organization, and Gabow still gets comments from people that they have "5S'd their basement."

There was little pushback — partly, Gabow says, because the physicians are employees. And they are academics, which means they naturally love data. "This is a mode of research for them," she says. "They publish this stuff."

For more information on this topic, contact:

• *Patricia Gabow, MD, CEO, Denver Health and Hospital Authority, Denver, CO. Telephone: 303-436-6000.* ■

Health system builds on success with Lean

Employees involved in decision making

In its sixth year as a Lean organization, MemorialCare in Southern California refers to Lean as its management system, not a quality improvement method, says **Diana Hendel**, Pharm.D., CEO of Long Beach Memorial Medical Center, Miller Children's Hospital and Community Hospital — both also of Long Beach. While she acknowledges that some people find it odd to take a system used in manufacturing and use it for healthcare, there are similarities in process flows.

Like Denver Health, MemorialCare hadn't changed the way things were done in a long time. "The value to the patient wasn't always considered," Hendel says. That has changed.

The biggest impact she likes to talk about came at Long Beach Memorial Medical Center, one of the busiest level-two trauma centers on the West Coast, with some 100,000 visits per year. The average wait time for a patient to be discharged was about six hours. Within a week of taking on the project for rapid improvement, that was down to less than four hours. For patients who are admitted, the wait time could often be up to eight hours to see a physician, while the best hospitals manage that in three.

They looked for bottlenecks for patients who were being admitted or discharged and found that the usual process — to triage the patient first through a nurse, then through admitting, and then for another screening before seeing a physician — was rife with waste. They decided to reverse the order. Now a physician sees the patient first, making earlier determinations on whether the patient needs to be admitted or can be sent home, says Hendel.

Tamra Kaplan, Pharm.D., COO of Long Beach Memorial, says another great Lean project worked on physician-to-physician communication. "If you want to call an attending physician or a hospitalist to warn of an impending patient, you would often have this tag team of phone calls between them and their offices or answering services," Kaplan explains. The solution: Give all attendings and ED physicians cell phones so that there is direct contact.

Kaplan had a background in Lean, which was critical to the success of the program, says Hendel. Now, all managers go through the training, which

Kaplan says you can tell just by listening in on conversations. "All our vocabulary is around Lean. We have visibility boards in most departments that talk about current state, target conditions, and barriers."

Employees are incredibly engaged in Lean, Kaplan says. "We are allowing them to be involved in the decision making that transforms what they do every day. We can solve difficult problems quickly because now we have a methodology to figure out a different way to do things."

This isn't a short-term project or campaign, says Hendel. It's not something you do on the side. "This is our management system, our way of thinking. We believe in it because we have seen the 70 workshops we have done eliminate a tremendous amount of waste. That converts to value to the patients. It is a journey. It is small steps leading to big change."

Lean isn't for everything. There are elements of change in the system that are governed by other management techniques. But Hendel says if there is something involving a large number of people — the OR, ED, patient flow — Lean works well.

Unity Health in Rochester, NY, has been using Lean for five years now, says **Catherine Lee**, MS, MT, a Lean Six Sigma Master Black Belt and director of operational process improvement at the system.

She doesn't rely totally on Lean as a system for change, but, as her credentials imply, also uses Six Sigma, as well as change management. But what Lee likes about them all is that they have a set of tools that can be applied in a disciplined way to create great improvement.

Lean isn't used just in the clinical arena at Unity, but across the system. Its success is largely predicated on the quality and nursing departments agreeing to give it a try, Lee says. "Their openness to try something different was there, even though people kept telling me that people aren't widgets." More than 100 projects later, the early successes led to much greater acceptance of Lean.

"If you can get a few champions and a few targeted projects where you can build on success, you'll be able to bring people on board," says **Lori Lewandowski**, RN, quality improvement and public reporting coordinator at Unity Hospital.

One of the early successes was a reduction in door-to-balloon time for percutaneous coronary intervention (PCI). The Joint Commission wants to see a 90-minute door-to-balloon time. With processes Lewandowski calls "all over the map," the average time at Unity was 110 minutes.

"Lean was a great choice for this because we could look at timed events that happened in sequence through the journey from the ED to the cath lab," Lewandowski says. They looked at several steps: door to EKG, EKG to provider notified, provider notified to cath lab, cath lab to balloon. Using value stream maps, they looked at what happened within each process. In the end, they cut the door-to-balloon time by 17 minutes.

Among the issues uncovered, Lewandowski says, is how patients are triaged and whether they were casting too wide or too narrow a net for patients. They found that physicians were using their watches to mark down time, when one watch might have a different time from another. Now they all use the same clock. She says they implemented a pull system, so that when the cath lab was ready, if the patient wasn't, they would go to the ED to see what they could do to prep the patient so they weren't standing around waiting. They implemented standardized education for reading EKGs and a new process for when to call the interventional cardiologist. "We used to have a process where the cardiologist on call would be called first, and he or she would determine whether to call the interventional cardiologist. But the interventional cardiologist is the one who makes the call."

There is signage in the ED reminding everyone who to call, and a way to get an EKG faxed to a physician at home if necessary. But Lewandowski did bring elements of change management into the program, too, as a way to modulate the communication between physicians. "We are always looking for more minutes," she says, noting that CMS wants to see the door-to-balloon time move to 60 minutes eventually. "We do this consistently well, now, and most of our cases are within range. But there are still some differences and things we need to tweak. We look after every case, and when there is an outlier, we do a root-cause analysis."

She says there will always be people who don't want to follow a new course, but it's much easier to convince them if the process is endorsed from the top down and if you have some early successes you can point to. "It can take time to embrace change," says Lewandowski. "But we have had some great projects because of this."

For more information on this topic, contact:

• Tamra Kaplan, Pharm.D., Chief Operating Officer, Long Beach Memorial Hospital, Long Beach, CA. Email: tkaplan@memorialcare.org

• Diana Hendel, Pharm.D., Chief Executive Officer, Long Beach Memorial Medical Center,

Miller Children's Hospital Long Beach and Community Hospital Long Beach, Long Beach, CA. Email: dhendel@memorialcare.org.

• *Catherine Lee, MS, MT, Lean Six Sigma Master Black Belt, Director of Operational Process, Unity Health, Rochester, NY. Telephone: (585) 368-4436. Email: Clee02@unityhealth.org.*

• *Lori Lewandowski, Quality Improvement & Public Reporting Coordinator, Unity Hospital, Rochester, NY. Telephone: (585) 723-7000.* ■

Looking for a few good people

Find the ones to lead transformation

Sometimes, you need someone to lead a project. Sometimes, it's easy. But what about those times when you just can't find someone to take the helm? **Helen Macfie**, Pharm.D., senior vice president of performance improvement at the six-hospital MemorialCare Health System in Southern California thinks she's got it figured out. She has a top 10 list that might help others, too.

1. **Play the outcomes card.** Physicians care deeply about patient outcomes. If you can couch your project in terms that make it an imperative for improving them, you're more likely to get a physician on board, says Macfie. "Put it in terms of helping patients."

2. **Find their passion.** If you know a physician is a closet geek, that person might be a good pick for an IT-based project. Is there someone you call "Gadget Man" because he always has the latest tech device? Put him on a project that looks at how handhelds or tablets can be leveraged to improve efficiency or quality.

3. **Take names.** If you tell a physician that a respected peer thinks he or she would be ideal for a project, you are more likely to get that physician's help. Ask for nominations, says Macfie. The 2,000-member physician society at the system has a list of projects for the coming year for which physicians are welcome and encouraged to nominate champions. "When your peers see you as an expert, you are more likely to say yes."

4. **Get introduced.** If you have a name but don't know the physician personally, ask for a formal introduction. Who are you more likely to hire — the salesman who cold calls you looking for a job, or the one who is introduced by a trusted friend? Macfie says that can give you an edge in asking about a project that you might not have if you cold-called the physician.

5. **Be selective.** Don't ask the same people over and over again. "They have their own business to attend to, as well," she says.

6. **Be courteous.** If you want a physician to participate, make it convenient. If you routinely schedule meetings for the middle of their work day, they aren't likely to volunteer again. Macfie says they do their QI work in the evening, with dinner brought in for the people working on the project.

7. **Put what matters to them at the top.** Prioritize with physicians, says Macfie. If you have a list of goals that they have helped create, they are more likely to take part.

8. **Reward inclusion.** Some organizations pay physicians for this work. Some provide a gift card or other little reward. MemorialCare provides a small stipend for the chairs of the best practice teams. They also publicize teams in the organization newsletter and the intranet. Macfie says just saying "thank you" can go a long way.

9. **Be efficient.** Macfie says physicians like to be involved in projects where they can make a difference but where their time isn't wasted. Have a well-run agenda and prepare the data in advance so that all the physician has to do is come to a meeting and give his or her advice.

10. **Start small.** If a physician is busy and says he or she can't help, try to get him or her to participate in a smaller way. Ask if the physician will act as a liaison, or review the output. He or she is likely to be more welcoming of that, says Macfie, and might be more willing to take on more next time. "Groom them for more later," she says.

11. **Listen to reason.** If they still say no, ask why not. They may give you insight into something you can do differently to encourage greater participation, she says.

12. **Take advantage of rules.** If you don't get enough volunteers, you may have to rely on regulations — some organizations mandate that physicians spend a certain amount of time on quality improvement projects or various committees. At MemorialCare, the physicians get points for participation under peer review. While it is a tool in the kit, Macfie says it's better to get volunteers.

For more information on this topic, contact Helen Macfie, Pharm.D., Senior Vice President, Performance Improvement, MemorialCare Health System , Fountain Valley, CA. Telephone: (714) 377-2900. ■

Program inspires fall prevention project

Big topic at MPSC

It was a summer of crime in Washington, DC, and area police agencies collaborated to implement a crime prevention program called All Hands On Deck. Washington Hospital Center was having a problem with falls. Would a program based on the idea of putting everyone to work to prevent falls help keep patients safe?

It was what **Leslie Smith**, RN, AOCNS, an oncology clinical specialist at Washington Hospital Center and her nursing director **Stefanie Lescallett** hoped. They presented the program they came up with at the recent Eighth Annual Maryland Patient Safety Conference.

The fall rate at the hospital was as high as 3.4 per 1,000 patient days. The goal was to get down to 2.0. So Lescallett and a committee of staff nurses, transporters, and physical and occupational therapists looked at trending. They made an interesting discovery: Most falls were happening during change of shift, between 7:00 and 7:30 a.m., 3:00 and 3:30 p.m., and 11:00 and 11:30 p.m. The day of the week didn't matter, nor did the traditional risk factors of the patients. This trend was outside of that.

At the time, handoffs were done in a break or conference room. With no one in the hallways, the patients were using call bells that weren't heard. And if they did get up on their own, the bed alarms weren't heard. It was a situation that demanded all hands on deck — no one elsewhere, everyone there, everyone vigilant, Lescallett says.

At report, they required every nurse and patient care technician to be out of the break room. Report was done in the hallways or patient rooms where call lights could be seen and alarms heard, says Smith.

They did leadership forums and implemented the program on the units. Every unit leader explained why no one was allowed in break rooms during the change of shift. It worked. Fall rates came down dramatically, to 2.6 per 1,000 days and none with severe injury.

They also started doing rounding at least once an hour, says Smith. At each round the patients are asked if they need to go to the bathroom, if they want to sit, whether they have anything they would like the care provider to get for them. "We monitor them much more closely, regardless of the acuity of their fall risk score."

Each room has a rounding sheet, says Lescallett, and a nurse or patient care tech has to sign it after each round. Whoever enters a room looks to see when the patient was last questioned. If no nurse or tech has checked the rounding sheet, the caregiver goes through the list of questions.

Smith says it's unlikely they'll ever reach zero falls for any length of time. "You will always have patients who won't call out to ask for assistance, or someone who wants to get up without help. But our goal is to be lower. As we develop more processes — right now we are working to troubleshoot each incidence — we hope to get lower."

As an example of how they do that, Lescallett mentions a unit that took each occurrence and posted it in a break room with a form that listed why the patient fell and how it could be prevented. The next month, that unit had no falls. Another unit is doing a poster on scoring patients for fall risk. "It rethinks the issue," she says. Rather than asking for interventions only if there is a certain level of risk, this scores patients as high, medium, or low risk. High-risk patients get certain interventions, medium-risk fewer, low-risk maybe none. It makes nurses look at this in a different way.

Patients and families are also part of the effort. Each is given a brochure on the risk of falls and the importance for asking for help. The nurses then reeducate high-risk patients at every change of shift.

The patient safety conference highlighted the work of a number of other hospitals working to reduce falls. At the University of Maryland Medical System's 12 member hospitals, a fall prevention team worked to improve compliance with core measures related to falls by doing a literature review, reviewed fall prevention tools, and is working to come up with a customized education and patient awareness program for each of the hospitals.

The health system monitors progress with monthly reporting and quarterly report cards and shares results and best practices across the system. More on this effort is available at http://www.marylandpatientsafety.org/html/education/solutions/2012/documents/Using_System_Synergy_to_Achieve.pdf.

Sinai Hospital in Baltimore created the Call Don't Fall program to reduce its 1.53 falls per 1,000 patient days down to a benchmark of 1.00.

To achieve the goal, they evaluated fall events to try to determine the reasons behind them. During one particular week, an interdisciplinary "SWAT team" investigated each event, interviewed the patient, and determined what happened. After that week, they analyzed trends and came up with a variety of interventions — from culture change to improved education. Administration made fall prevention an annual goal; they educated staff on everyone's role in fall prevention; and there was an element of accountability included for management-level employees. All frontline staff were required to take a fall prevention education module, and even providers were involved in the education efforts. Falls and their reasons were reported monthly. Any unit with too many falls was required to audit 10 charts for missed opportunities to implement fall prevention programs.

Over nearly two years, the fall rate declined from 1.03 at the start of the program to about 0.30 last fall. Sinai maintains a fall prevention team in place to continually review fall rates and interventions. More information on this project is available at http://www.marylandpatientsafety.org/html/education/solutions/2012/documents/Call_Dont_Fall_Initiative.pdf.

At the University of Maryland Medical Center, they were concerned with falls in the cardiac surgery step-down unit — particularly those related to getting up from chairs. Using the Morse Fall Risk tool to determine which patients needed intervention, UMMC made sure that patients who needed it received chair alarms. There were audits and rounding in which patients were reevaluated for alarm needs, and all shift changes began with a statement of when the last fall was and ended with the rallying cry, "Call, don't fall."

While fall rates in the step-down unit were stubborn, by the second quarter of 2012 they were running below benchmark. The team continues to evaluate opportunities for patient and family education, patient audits, and nurse and other staff training. More information on this project is available at http://www.marylandpatientsafety.org/html/education/solutions/2012/documents/Jacks_Crown_and_Jills_Hip_Revisited.pdf.

For more information on this topic, contact:

• *Leslie D. Smith, RN, AOCNS, Oncology Clinical Specialist and Stefanie Lescallett, RN, MSN, Nursing Director, Washington Hospital Center, Washington, DC. Telephone: (202) 877-2221.* ■

A new way to figure out what went wrong

It's SWIFT — just like it implies

Most organizations that are looking for what went wrong after an error are familiar with the Failure Mode and Effects Analysis (FMEA) method.

It's widely used by risk management. But a method used in the United Kingdom is catching on here and may also be of use to quality improvement and patient safety professionals.

Alan Card, MPH, a consultant based in Granger, IN, published a paper about the new method, called the Structured What If Technique (SWIFT) in a recent issue of the *Journal of Risk Management*.[1]

The new method came out of efforts in the United Kingdom to create a new toolkit for doing prospective hazard analysis (PHA) for pointing out potential risks.

To use this method, include members of all the groups that use a system or process, says Card. It is most akin to a brainstorming session. While using SWIFT for risk analysis focuses on what might go wrong, for quality professionals it could be used as a method for figuring out potential solutions to problems.

"If you come up with an intervention, then you ask what are the barriers to that intervention, what are the bad things that could happen," he says. "None of the other techniques really go the extra step of asking what you do about a risk or barrier."

While SWIFT does have some specific tools associated with it, Card says that there is a pilot study in the UK that is looking at this approach in a more generic fashion.

"We are investing so much time here in FMEA, and it's seen as the gold standard," he says. "But there are no indications that that extra time leads to better results. I think SWIFT could be well accepted here because it is so much faster."

For more information on this topic, contact Alan Card, MPH, Granger, IN. Telephone: (863) 877-0122.

REFERENCE

1. Card, AJ, Ward JR, Clarkson PJ. Beyond FMEA: The structured what-if technique. *J Healthc Risk Manag.* 2012;31(4):23-9. doi: 10.1002/jhrm.20101. ■

Gown use for isolation remains a judgment call

The question of gown use when entering patient isolation rooms is a recurrent one, so it is worth noting that this is the current thinking of The Joint Commission on the subject:

Standard IC.01.05.01 EP 1 states: "When developing infection prevention and control activities, the organization uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus." The guideline that addresses contact precautions is published by the CDC's Healthcare Infection Control Practice Advisory Committee (HICPAC).

Recommendation V.B.3.b.i. from the HICPAC guideline states, "Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment."

Each organization may decide what guidance to provide to its healthcare workers within the parameters provided by HICPAC. However, TJC encourages organizations to consider the high morbidity and mortality of healthcare-associated infections when deciding what constitutes "anticipated contact" in each facility. Organizations may also want to discourage non-essential personnel from entering the rooms of patients on isolation precautions. ■

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 Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- Accreditation field reports
- Healthcare innovation awards
- New throughput standards

CNE QUESTIONS

1. Which of these is not subject to financial penalties for excess readmissions?
A. CHF
B. AMI
C. Pneumonia
D. CLABSI

2. In the 5S visual management technique for Lean, which one of these is not an S?
A. Sort
B. Select
C. Shine
D. Sustain

3. If a doctor says no to working on a QI project, Helen Macfie, Pharm.D, suggests you:
A. Never ask him again
B. Ask a peer why he said no
C. Ask him to do something smaller
D. Make rules that they have to participate

4. To reduce falls, Washington Hospital Center did which of these?
A. Started doing change of shift at the bedside
B. Banned breaks
C. Closed the break room
D. Used more patient restraints

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.

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. ■