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AHC Media

Supreme Court upholds the ACA — so now what?

What does the Affordable Care Act mean for quality departments?

When the Supreme Court released its opinion upholding the bulk of the Affordable Care Act (ACA) at the end of June, most of the commentary focused on what the law would mean to consumers. But it also has implications for the healthcare industry at large, including a potentially positive impact on quality improvement and patient safety departments and personnel around the country.

Hospital Peer Review asked some stakeholders what they think this game-changing law will mean to the daily life of a quality improvement manager. Here's what they had to say.

"I think the decision will change things a lot for quality improvement departments," says **Jeannie Kelly**, RN, BA, MHA, LHRM, a quality assurance officer at Soyring Consulting in St. Petersburg, FL. "For a long time, you would see a quality improvement manager who wore multiple hats in a hospital. But now this law is putting more emphasis on quality. Staff will wear only one hat — quality — and departments will be expanding."

Kelly, who has 20 years experience working in healthcare, including working on CMS provider surveys, says one reason hospitals will undoubtedly opt to beef up their quality departments is that performance information will become more accessible to the general public than ever before. "It will be easier to access; the local media will pick up on the reports and do stories on which hospitals outperform which."

Add to that the increasing financial risk for hospitals that don't perform well, and it's clear that quality is going to be at the front of mind for every level of management at a hospital, on up to the C-suite and the board of trustees. "Patient safety, quality of care, and patient satisfaction are going to be huge indicators of how you get paid by CMS and other insurers," Kelly says. "There isn't going to be just lip service to issues like the continuum of care and how to ensure that patients don't bounce back. This is for real now. And because some hospitals are behind the curve on this already, there will be a scramble among some to improve their QI and safety performance."

This is a good thing, Kelly says, because people who used to ignore the intrinsic value of having more than one person working in a qual-

ity department are shifting their thinking. But it also means that the QI staff are going to be busy. "You will have to pay a lot of attention to detail. But you will have more funding and more staff, and there will be recognition of the value that you have provided all along."

Down the road in Palm Beach, physician business coach and board certified surgeon **Michael Cassatly**, DMD, says, "The act has reaffirmed the need for quality improvement, and for QI and safety managers to put a laser focus on the areas that cause harm." And he agrees that there will be money backing up that new emphasis on safety "to keep the hospital from losing revenue" through non-reimbursement for care that is the result of hospital-acquired infections or other preventable harm.

"In 2008, the government estimated that there was $17 billion in costs from patient harm, and that doesn't include the costs of lost work or malpractice claims," Cassatly notes. The deaths due to that harm are estimated to be around 180,000, which he calls "a moral, ethical, and now a financial problem."

One hospital consortium that Cassatly is working with figures that to be viable financially, it needs to save 5% or $300,000 in costs per year. Part of that savings can come from reducing harm, he says.

The thing is, that low-hanging fruit has been plucked by the most forward thinking QI departments. The next place to look, Cassatly says, is at how to improve communication — between patients and providers, between providers and nursing, therapists, labs, and other ancillary team members, and between providers themselves during transitions of care.

The act will have "profound and far-reaching effects on quality and patient safety in acute-care hospital settings," says **Rich Temple**, executive consultant with healthcare management consulting firm Beacon Partners, based in Weymouth, MA. "[The decision by the Supreme Court] truly cements into place the myriad of incentives and reporting requirements surrounding the provision of quality care and reporting and measuring quality outcomes."

Most important to quality professionals is the concept of Accountable Care Organizations (ACOs), Temple says. "If the ACO can demonstrate cost savings, while likewise demonstrating a high quality of care, it gets to share in the cost savings through the ACO program. This will undoubtedly catalyze a focus on quality to take advantage of these benefits; it also will necessitate that hospitals look at quality holistically across all parts of a patient's continuum of care, as other providers' quality performance will have a direct impact on a hospital's ability to realize these benefits." In short, ACOs change the paradigm, he says, from one where more care and

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higher volume was always good for the hospital's bottom line.

Other areas of particular concern for hospital quality and safety officers revolve around the ACA's potential payment reductions built into it as part of the cost-saving component of the legislation, says Temple. There is the stick of reducing reimbursements, but there is also a carrot for hospitals that meet and properly report quality measures for specific conditions — AMI, heart failure, pneumonia, surgery, and healthcare-associated infections.

This carrot "will force hospitals to look at their service line offerings, their core competencies, their alignment with other provider organizations, and many other aspects of their strategic planning," he notes. "What will it take for the hospital to be successful in realizing these incentives? How is the data collected and aggregated to appropriately capture and report on these metrics? This is a big deal, and a big deal that providers will not be able to walk away from."

Temple also notes that the penalties for avoidable readmissions will impact the QI manager. "Processes need to be built to understand — in detail — where hospitals will be at risk. Analyses will likely take on many forms: by unit, by time of day, by primary physician, and many others. The infrastructure — both human and technological — that will have to be built to support this is substantial, but the risk of not going down this road is great."

It is "game changing" legislation, Temple says. "It impacts clinical care, strategic planning, revenue cycle processes, and virtually all other aspects of a hospital's operation. A provider would be very well served to undertake a detailed plan to assess its readiness to take on these new challenges in the new healthcare paradigm that the ACA has created."

While it's monumental legislation, not everyone agrees that the ACA is going to have a huge impact on quality professionals — at least not compared to other rules, regulations, and realities impacting them. "Healthcare organizations are facing a rising number of challenges that require involvement of quality professionals," says **Patrice Spath**, RHIT, a healthcare consultant with Brown-Spath & Associates of Forest Grove, OR, and the consulting editor of *HPR*. "Sure, there are some new measurement requirements and quality expectations in the Affordable Care Act, but there's much more going on right now that impacts quality professionals."

Among the examples she cites is the increased use of electronic health records in an effort to comply with the meaningful use requirements of the HITECH Act. "This transition requires that quality professionals interface with IT experts and learn how to extract reliable measurement data from electronic sources."

Still, there will, indeed, be an impact on your daily work from the ACA. For instance: The act includes a 3.5% tax on medical equipment that goes into effect in 2013. "This will result in hospitals paying more for medical equipment and they will often be unable to recoup these additional costs," says Spath. "Quality professionals will be even more involved in helping their facility identify ways to save money and improve efficiencies."

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TJC communication standards in full force

But many hospitals unaware, and unprepared

It happened six months later than first expected, but on July 1 organizations became responsible for meeting the requirements of the standards for patient-centered communications, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. An exception was the visitation standards, which went into effect July 1, 2011. While the added time was probably a blessing for many hospitals, others are probably still not ready to be held to account for all the aspects of the standards, says **Sue Dill Calloway**, RN, MSN, JD, a

nurse attorney and President of Patient Safety and Healthcare Consulting and Education.

While some of the issues that organizations face may be technical in nature — for instance, the race and ethnicity collection requirements were required for both inpatients and outpatients, and that may have caused trouble with creating a process that worked for both sets of patients — there are parts of the standards that Calloway believes are just not completely understood. There are currently five standards in four different chapters of the Joint Commission manual that make up the patient-centered communication standards. These were previously referred to as the patient providers communication standards.

One example, she says, is that human resources departments need to make sure that all interpreters used by the hospital — whether employees or not — are qualified to interpret in a healthcare setting. "If you are fluent in Spanish, that doesn't mean you are qualified to be an interpreter, and the Office of Civil Rights says that unless it is an emergency situation, you can't use a child or family member to translate for you," she says.

What makes someone qualified? For example, a deaf interpreter for a hearing impaired patient would need to be certified. A person takes a 40-hour course and passes it. This person would be qualified to be a Spanish interpreter. There are two organizations that offer an oral and written test so the qualified interpreter can become certified. Competency is a different issue from being qualified. The standards demand that you determine the competency of the translators yourself, or by using a service to determine that they have proficiency in English and the desired language of translation. *(For a list of resources related to interpreter services, see box this page.)* It used to be there was only a certification program for Spanish, but now they are available for other languages, and the number is growing.

Calloway, who conducts webinars on this subject regularly, says she still gets questions on collecting race and ethnicity information. "Some organizations don't understand that this is about self-reporting ethnicity by patients," she says. "If they say they are white and Italian, even if they never lived in Italy and we don't consider Italian an ethnicity, we have to allow them to do that."

Related to the ethnicity information you collect, Calloway says if you find you have a particular percentage of patients who need help in a particular language, you will have to have some of your documents translated for them. "If you have 5% of your population reporting as Hispanic or some other ethnicity, or at least 1,000 patients speaking a language, you will want to translate particular documents." The Joint Commission's Roadmap for Hospitals related to these standards *(available at http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf)* lists the following documents as vital:

- informed consent documents;
- complaint forms;
- information on free language assistance programs and services;
- notices of eligibility criteria for, rights in, denial or loss of or decrease in benefits or services;
- intake forms that may have clinical consequences.

The above would be among the documents you would want to have in any language that a significant number of your patients speak.

CMS's hospital transmittal on visitation was published on Dec. 2, 2011, and it was 34 pages long.

The standards on visitation are put forth in 34 pages that Calloway still shakes her head at. Despite her constant study of it, she says it is difficult to understand and could easily confuse the brightest and most competent of people. "My mom had surgery. She is competent, but my sister was her patient advocate/support person — there to ask questions, take notes, or whatever else my mom needed. CMS says that if something needs to be a consent signed, they both should sign it." That means that whatever you do that needs a patient OK must also have the

Resources related to health care translation services

- **American Translators Association** — http://www.atanet.org.
- **List of state interpreter association websites** — www.ncihc.org/mc/page.do?sitePageId=57031
- **Certification Commission for Healthcare Interpreters** — http://www.healthcareinterpretercertification.org.
- **International Medical Interpreting Association** — http://www.imiaweb.org.
- **National Board of Certification for Medical Interpreters** — http://www.certifiedmedicalinterpreters.org.
- **National Council on Interpreting in Health Care** — http://www.ncihc.org.
- **Registry of Interpreters for the Deaf** — **http://www.rid.org**

assent of the patient advocate, even if the patient herself is perfectly competent and not incapacitated. The patient advocate should also be given a copy of the written patient rights, even though the competent patient is given a copy also. "It is different from the way we have done things in the past. It is one of the hardest things I have to explain to people," she says.

Calloway recently heard from a patient advocate who mentioned in passing that their ICU policy notes that there are only two visitors permitted, and they must be spouse or next of kin. That's now a violation of CMS and Joint Commission rules. "I was shocked," she notes. Most hospitals are rewriting their visitation policies to reflect that who may or may not visit is now at the discretion of the patient. If you limit visitation in the ICU, which CMS discourages, to two visitors, the patient gets to pick who the visitors are, even if it is his or her neighbor, same-sex partner, spouse, or best friend.

Another element that gives hospitals trouble is that information on advance directives policies have to be given to all inpatients, but also for emergency department patients, observation patients, and those who are having same-day surgery. "People didn't realize that these three classes of outpatients were part of this," she says.

Some people complain about these requirements, but Calloway says there are good reasons for every element. Communication is a key to safe, high-quality care, and since there are 50 million people living in this country whose primary language isn't English, you need to be ready for that. "It doesn't matter if you have strong opinions on immigration or whatever: The law is the law no matter what you think."

That means that people who don't approve of same-sex relationships have to swallow their feelings and make sure that their policies and procedures and the people who implement them follow the rules related to gay, lesbian, bisexual, and transgender patients. "It's called patient-centered because it's about what the patient wants, not what we want," she notes.

These changes don't have to be onerous or expensive. The increasing use of technologies like video conferencing or phone language lines allows translators to be anywhere and still be there in the patient's room. And hospitals can also band together to share the cost of qualified interpreters, she says.

Organizations had a total of 18 months to prepare for these standards, and now what a surveyor finds counts. She suggests going through the Roadmap, which has some excellent resources and checklists because, from what she can tell, there are still a lot of organizations out there that haven't got this right.

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When a score of zero is a good thing

No HAIs for years at Shore Health

Imagine going more than two years — nearing three — without a single hospital-acquired infection (HAI) in your intensive care unit (ICU). Imagine that not just one ICU, but multiple units in multiple hospitals were routinely making it months, and even years, without a single infection that could cause harm to a patient and have financial repercussions for the hospital. That's exactly what is happening at Shore Health System in Maryland, where **Robert Carroll**, MBA, CPHQ, MHP, the director of performance measurement and improvement, and **Julie Bryan**, RN, director of infection prevention, have presided over some amazing results from a top-down determination to "make zero happen."

The attitude a few years back was that infections are just something that happens, says Carroll. And while the rates in the system weren't awful, Carroll and some others felt that zero was achievable, and not just for a minute or a day, but for extended periods of time. "Nine months was the initial goal," he says. As of the middle of July, one ICU had gone more than 1,000 days since the last ventilator-associated pneumonia (VAP) infection; another had made it 888 days. Central line-associated blood stream infections (CLABSI) have been absent for over 740 days in one unit, and 950 in the other; catheter-associated urinary tract infections (CAUTI) had disappeared for 500 days in the first unit, and 811 in the second.

But more than just ICUs, this program has spread throughout both hospitals and a home health agency in the system. Estimated savings to the system are more than $1 million, Carroll estimates.

And nothing they did was out of the ordinary.

It was all based on literature reviews of best practices, says Bryan, and a lot of education. Just about every unit has gone at least one year without bugs, and enjoyed a lunchtime celebration for making it to that mark without CAUTI or CLABSI (VAP rates are only measured in the ICU). And the goal remains the same — not no infections, but doing everything that they know prevents infections every single time.

Carroll says that leadership allowed them to build a strong team who went out and did 50 structured interviews with people throughout the organization — nurses, physicians, staff at every level. "We asked them what they thought were the strengths and weaknesses and what they saw as the problems in infection control."

He says that by interviewing every stripe of stakeholder, the team made it immediately clear that this wasn't a single unit, department, or class of employee issue, but everyone's.

They collected data related to infections and made sure to share it with everyone. Carroll says that was a key to getting buy-in. "We knew we had achieved a culture change when departments started reacting to the data we gave them." The biggest problem with sharing information was figuring out how to show the data to each department in a way that made sense to them. "Initially we did what most infection control teams do: We showed them the rates per 1,000 patient days or patient device days." That wasn't speaking to them, so they changed it to absolute numbers of infections and the number of days since the last one.

If it was in the literature as something that reduced HAI, Shore Health tried it. If there were new bundles or different products that were touted as helping, they did a trial to see if it would work for their patients in their hospitals. If those bundles or products worked in the pilot unit, they were rolled out systemwide. Checklists, protocols, and computer reminders were developed, implemented, and used. And while they don't have a culture of blame at Shore Health, the Target Zero program and infection rates are used as part of staff performance goals.

Bryan says that there is a lot of electronic monitoring of the practices they developed and implemented, and the system even engaged patients and families as watchdogs, encouraging them to ask providers if they washed their hands. Handwashing rates have been over 90% for nearly three years now, much of that time over 95%.

"People were telling us this was impossible," Bryan recalls. "But the literature says if we change our practices, we can decrease infections. So we plowed ahead." It helped that both hospitals are Magnet-recognized facilities. "Nurses here have a big focus on quality, and they have a framework in place for them to work to improve safety and improve quality. This played right into what we wanted to do."

Indeed, believing in the possibility is one of the key elements that Carroll says led to the program's success. Another part was making it fun. To that end, the program was launched with the chief nursing officer running around the hospital dressed as a giant bug. The team asked employees to come up with 100 ideas to reduce infections in 100 days. It actually took just 58 days, and every single idea was followed up on. "We admitted that we don't know all the right or best things," Carroll says. "We need to know from front-line staff what they know that we don't, what they see that we can't."

Some of the ideas were used, but some — like decolonizing each patient room using expensive techniques — were just too impractical, he says. But everyone who participated in the 100 ideas project was recognized and his or her name was included in a prize drawing.

The hospitals started a "catch you in the act" program where people who were caught washing their hands had their names entered for a drawing. "We did things constantly to keep this effort at the front of everyone's mind," says Bryan.

And when an infection does occur, it is studied rigorously, she says, to make sure that they understand what happened. For example, the last CLABSI infection they had on a particular unit ended up being the result of inadequate training of weekend staff on dressing changes. A mini root-cause analysis led to the discovery, and improved training led to a new no-infection streak.

While he thinks any organization can aspire to zero and develop a program that works, he doesn't think everything they did will translate to other facilities — the two hospitals are relatively rural and serve a population of about 150,000. "These were our problems, and we solved them our way. It's an ambitious project that doesn't have an end. You can't copy and paste it to fit you; it's all local."

That said, he does have some advice that he's eager to give: Take a page from the book of the marketing geniuses at Shore Health. They kept the

Target Zero program in front of the entire hospital community's eyes with regular stories in newsletters, puzzles, posters, and prize patrols. "Keeping them engaged means we get a lot of good ideas — not just for this project either, but for others. I don't have to ask for input anymore. They want to be part of our efforts."

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Are you ready for an OCR audit?

If you aren't, it could cost you

It's been 17 years since the Health Insurance Portability and Accountability Act (HIPAA) was signed into law, but despite that, there are still plenty of organizations that aren't complying with its rules and are ending up paying millions in fines for their errors. **Chris Apgar**, president and CEO of Apgar and Associates of Portland, OR, works with organizations to become HIPAA compliant, and he cites some scary figures. A case in Alaska resulted in $1.7 million in civil penalties; an Arizona medical practice was fined six figures; one Blue Cross/Blue Shield organization was fined $1.5 million. "They take a very dim view if you appear to be ignoring the security and privacy rules."

Only another 100 or so audits are expected this year, he says, so the chances are fairly small that your hospital will be subject to one. But if you add the potential to be audited with the likelihood that you have to report a data breach, it's in your interest to be ready at all times for an Office of Civil Rights (OCR) audit of your HIPAA compliance.

An audit is formal — the accounting and consulting firm KPMG will ask for various documentation and give you 10 days to provide it, and they will do a site visit whose length increases with the size of the organization. They will provide a preliminary report and give you 10 days to comment on it before it is sent on to the OCR, which will review it and make a determination. If there is significant non-compliance — and that's not something that's ever been defined — then the OCR will do its own investigation and compliance assessment. If what was found in the report is true, the OCR may assess a fine, Apgar says.

The more likely event is that you will have a breach, he says. If you have more than 500 people involved in the data breach, you have 60 days from the discovery of the breach to report it to the OCR. They will contact you within two weeks of notification and ask for policies, the results of your risk analysis reports, training guidelines, and the breach notification/incident response forms. If you aren't compliant or the documents you submit are lacking, you may be fined.

There are still organizations for which the things the OCR may ask for are but a fuzzy memory, says Apgar. Others may think that having created a policy or procedure a few years back is good enough. The worst cases are those who think that there's no way they could ever have a breach. Because if you think that, Apgar says, you aren't looking hard enough. Just about every organization of size has breaches.

So how can you correct what's incorrect and be ready for either an audit or to provide relevant information following a breach? Apgar says to start by centralizing all policies and procedures. "Make sure they are correct," he says. "Make sure you have a disaster recovery and business continuity plan. You need to have an audit program that looks at user log-ins; you need to ask if you are doing everything you should be doing."

The are some good checklists available for this basic start of readiness on state health department websites *(West Virginia's is here http://www.wvdhhr.org/han/security/HIPAASecurityChecklistLHDsv2.pdf)* or at the website of other professional organizations like the American Health Information Management Association *(http://library.ahima.org/xpedio/groups/public/documents/ahima/bok2_000583.hcsp?dDocName=bok2_000583)*.

Along with the federal rules, you also have to understand different state regulations. Some states have different classes of patients on which are conferred special protections. HIV patients, minors, people with mental health problems, cases involving birth control or genetics, or alcohol and chemical dependency patients are examples. Information for these classes is even more stringently protected than under HIPAA, and whichever rule is the strictest is the one that matters. Apgar

says Texas (in effect Sept. 1,2012), California and Massachusetts are particularly rigorous. In California, if there is a breach, the rule there says you have to notify all the individuals involved in a case. And while Oregon says if you have to notify a bunch of people you can put notices in the newspaper rather than send a first-class letter to each person, some states make you send that letter. Washington State residents who think their privacy has been violated can sue. Your local association chapters are a good resource for information.

"Everyone has to report something at some point," Apgar says. "Some incidents will only involve one or two people, and then you can have until the end of the year to report it to the OCR. But if it's 500 or more, report it immediately. And if you can't find anything to report, you aren't looking hard enough."

Apgar says the most common error he sees is incomplete, inaccurate, or outdated policies and procedures. "You should be looking at this once a year at least. You may not have to alter anything, but there is enough change in technology and in law that it merits a regular look." And you don't need to document the review of every policy, but you should note somewhere that you reviewed your policy and include a list of anything that was altered or updated.

Everyone but me

If you think you aren't likely to have a breach, consider the common rule that no one can use personal phones or tablets at a hospital. "You can say you have a policy that precludes it, but you won't be able to stop it all," says Apgar. "Docs will use their own iPads and may have patient information on it. Maybe it gets stolen, but the physician isn't reporting it to you because they forget."

Or a hospital may have a research division that one employee leaves. But no one tells IT and that person still has access to patient information

Questions to ask about your HIPAA compliance

1. If you were asked to make all of your policies, procedures and compliance documentation available to OCR or a state's attorney general, how long would it take? Are you sure all is current and accurate?

2. Does your employee training include all of the new HITECH requirements? When was the last time you trained all employees?

3. Do you have a formal audit program (usually every 30 or 90 days), and is all documented? Do you review all of the audit logs in your systems and network? If not, it's all discoverable, and if you're sued, a breach is found and you didn't look at it, you'll likely lose the case.

4. Have you tested your incident response including breach notification plan recently?

5. Have you conducted a risk analysis within the last year?

6. Are you after meaningful use dollars and have you launched your complete risk management program? If you haven't, you're missing a core measure requirement. Attesting without meeting all measures can get very expensive if CMS shows up.

7. If you prohibit storing of personal health information on tablets, laptops and smart phones (especially personally owned ones), how are you enforcing the prohibition? Lost or stolen mobile devices and unencrypted personal health information don't go together.

8. Have all of your business associate contracts been updated to include breach indemnification language?

9. Are you sure all personal health information is encrypted when it's transmitted outside your organization?

10. If you prohibit sending personal health information via email, do you audit email, and how do you know it's not being sent?

11. Are you certain your patients and other unwanted individuals aren't getting into areas they are not supposed to?

12. Are you sure you can recover the personal health information you backed up that's critical to patient care? If you don't regularly test data recovery, you don't know if it is actually recoverable.

13. Are you sure your staff is correctly informing patients of their privacy rights? It's not OK to just post your notice of privacy practices. You need to hand it to them.

14. Are your staff reviewing medical charts or accessing your EHR in the local coffee shop? "Shoulder surfing" can be costly, especially when your patients find out.

because that ex-employee's log-in hasn't been cancelled. If it's a disgruntled former employee, you may have a bigger problem.

There are questions you can ask that can help you see all the areas that are ripe for a breach — like how do you guarantee that there are no personal devices used? How do you enforce that no one stores personal information on devices? How do you make sure that no patient information is sent via email, even from physician to physician? When was your last risk analysis?

If you can't answer "one year or less" to that last question, Apgar considers that you are engaging in "willful neglect." The case in Alaska that cost the department of health there a cool million plus? It was all related to an alleged failure to do a risk analysis. One more thing you should know: All that fine money goes right back to the OCR for further enforcement. That means the more fines they levy, the more money they have to look for organizations that aren't in compliance.

Apgar says there is plenty you can do, and plenty of resources that will help you do it. He suggests starting by answering the questions in the box on page 92.

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CDC and ACS partner for improvement program

Program aims to improve coordination

Three years ago, the Centers for Disease Control and Prevention (CDC) and the American College of Surgeons (ACS) each brought a proposal to the National Quality Forum (NQF) related to measuring surgical-site infections. Neither organization was aware of what the other was doing. It was eye-opening, and when the NQF suggested they work together to come up with a measure, they both jumped at the chance, says **Bruce Lee Hall**, MD, PhD, MBA, FACS, a professor of surgery at Washington University in St. Louis, who headed up the efforts for the ACS.

So the two parties — ACS National Surgical Quality Improvement Program (ACS NSQIP®) and the CDC's National Center for Emerging and Zoonotic Infectious Diseases, Division of Health Care Quality Promotion (DHQP) — sat down and familiarized each other with how each organization worked, their views on measuring surgical-site infections and how they gather and analyze data. They talked together about how the data were reported and, importantly, the CDC familiarized the ACS with working with more of an eye on the impact of what they do on regulations related to Medicare. "The relationship they had with [the Centers for Medicare & Medicaid Services — CMS] and the government, and how they fit into ongoing programs and legislation and healthcare reform was very educational for us," says Hall.

The two surgeries mentioned in the measure — hysterectomies and colon operations — are intended to be used as the framework for measures in other surgical procedures. For now, NQF has approved the measures for the first two, and they apply to the current reporting period for CMS.

One of the reasons working together seemed like a good idea was that both organizations wanted to harmonize definitions and technical specifications so that there can be easy transfer of data between ACS and the CDC's National Healthcare Safety Network. This is good news for hospitals and the people responsible for collecting and analyzing data: By working together, they can concentrate on how to minimize the data collection burden, Hall says. "We want to achieve the same thing as before, but we want to streamline it." He says the current data collection and reporting requirements are beyond burdensome and are approaching unbearable. "We see this as a way to improve the rigor of the information provided, but also reduce the work. You won't have to report this now to two different systems, or compile two different data sets. This is a shining example of two huge organizations investing time in this."

The CDC has expressed a desire to work with other organizations, beyond the ACS, although Hall says the two will continue to partner. Next up is the framework expansion and also participating with CDC in the Healthcare Infections Control Practices Advisory Committee (HICPAC). This will provide more surgical input in that group moving forward.

The organizations have committed to working together for the next three years at least. ■

How mobility can shorten stay, improve outcomes

Organization started by defining mobility

Every now and then at Sunnybrook Health Sciences in Toronto, Canada, there was talk about getting ventilated patients up and about even if they were still intubated. Some people thought that the patients should be weaned off the ventilator first, some thought after, says **Linda Nusdorfer**, RN, MSN, an advanced practice nurse for critical care and cardiovascular care at the facility. Still others wanted to work on weaning and mobility at the same time. But what did mobility mean? Is it passive range of motion exercises or walking?

"We would have these quality walkabouts every month, and once, we spent it asking nurses for the definition of mobility," she explains. "One of the answers was that it was using a lift to put a patient in the chair."

The idea of improving mobility — and the way caregivers thought of it — burbled along without resolution until 2011, when Nusdorfer and her colleague **Angie Jeffs**, RN, MSN, the patient care manager for critical and cardiac care, attended an Institute for Healthcare Improvement conference. "It was inspiring," Jeffs says. "When we were trained in the 1980s, we were taught to sedate ICU patients as much as possible. We were told they wouldn't want to remember they were here, and besides we should rest their lungs."

The IHI conference gave the women and the others from Sunnybrook added information and the confidence they needed to try to do something different — to get the patients up and moving as soon as possible. The potential benefits included less time being intubated, less delirium, reduced DVT risk, less potential for bed sores, and better patient and family satisfaction. "The families like to see the progress," Nusdorfer says. "The patients like to be up and around." Although there is not proof yet, she thinks they may even have a reduced rate of ventilator-associated pneumonia (VAP) because the patients spend less time horizontal, less time intubated, and have a greater degree of muscle strength that helps them clear their lungs.

Once they got back to Sunnybrook, Jeffs says they were a little overwhelmed with how to convince their peers that this was a good idea. "We chose our first candidates carefully, to make sure that they were stable," she says. "But we saw at the conference that this could be done, so we moved forward."

Two nurses, a physical therapist, a respiratory therapist, and Jeffs and Nusdorfer met regularly and started to go out as a team to identify likely candidates. "We talked to the physicians on rounds about getting people up, as well as other nurses and therapists." While the physicians were all for it, there was resistance from some nurses and therapists. "They wanted to take it slowly," Nusdorfer says.

For instance, there might be a patient in a collar who a physicians says can tolerate mobility, but somehow, it would never get done, Nusdorfer says. "PT would have to take the bull by the horns and just get that patient up." Or a patient would be up in a chair, and the nurses would argue that they were mobile, but they were being lifted into the chair mechanically. They were not using their own muscle power to do anything.

Leading by example

Having a nurse manager there to help with education was key in convincing recalcitrant people to take this chance. "We led by example," Nusdorfer says. "And then, once they saw it could be done, and the benefits that accrued to the patients, they were much more interested in getting on board." They also noted successes in a very public way — taking pictures of walking patients, celebrating the first walk down the hall, or even sitting up in a chair for the first time. They take videos of patients, and every couple months when a new batch of residents cycles through the ICU, they do an in-service education module to dismiss the myth that ventilated patients can't be mobilized.

Whenever anyone suggested that they were willing, if only there was a team that could put the idea into place, Nusdorfer informed those staff members that they were the team. "They had the best knowledge of the patient, not some group of outsiders. They were best placed to coordinate this."

Not just any patient is pulled out of bed for a saunter through the ward. Nusdorfer says they use a safe mobility tool to assess the level of consciousness in a patient, which helps determine

the level of activity appropriate for the patient. It might be that one patient can dangle but isn't ready to sit in a chair, while another one, who is so soon out of surgery you don't think he or she would want to do anything but moan in bed, is raring to get up and move.

There is a database collecting pertinent information, including when is the patient medically stable, whether the patient was mobilized within 24 hours of admission or of being deemed medically stable (the definition of early mobilization), intubation data, mode of ventilation, how much oxygen the patient was on at the time of early mobility, progression of mobility from passive range of motion to walking. They look at the resources used when walking — one nurse, two nurses, PT, RT, aide, family member, any tube losses during mobilization (to date there have been none). They are looking at whether there were any pressure ulcers at admission and on discharge, delirium rates, sedation, and restraint use.

Jeffs says a year ago, a delirious patient would have been restrained. Now, the first thing they do is get them up and moving. "The staff really sees the benefits of that." She also says they note how much more alert patients get just from sitting up. "All of a sudden their eyes get wide. It's

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
- Improving throughput
- The best in discharge planning
- Implementing an employee flu vaccine program

CNE QUESTIONS

1. The ACA will impact medical equipment costs in 2013 by:
   a. increasing costs 5%
   b. decreasing reimbursement 3.5%
   c. taxing purchases 3.5%
   d. taxing companies 3.5%

2. Among the vital documents that you should consider translating to oft-used languages in your hospital are:
   a. informed consent documents
   b. advance directives
   c. pamphlets related to common ailments like diabetes
   d. menus

3. Who did Shore Health make part of the hand washing patrol at its hospitals?
   a. supervisors
   b. infection control staff
   c. patients and families
   c. the chief nursing officer

4. HIPAA requires you send notice of a breach in privacy:
   a. at the end of the year for breaches affecting a dozen people
   b. within 10 business days
   c. two weeks after notification
   d. 30 or 90 days

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.

almost like there is this synapse [that] wasn't connecting, and now it's on by helping them move." They notice, too, that the patients who are moving more are sleeping better and move more easily back into a regular routine.

Nusdorfer says they are doing a chart review now of a period from before they implemented the early mobilization program about 15 months ago so that they can compare things like pressure ulcer rates.

"Our slogan is 'Time is Muscle,'" she says. "You hear it as a cardiac phrase, but we should remember it's true for all muscle in the hospital."

For more information on this topic, contact:

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CNE INSTRUCTIONS

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

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