YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

October 2012: Vol. 37, No. 10
Pages 109-120

IN THIS ISSUE

Follow us on Twitter @HospitalQI

Financial Disclosure:
Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

Joint Commission's Wyatt says collaboration is the key

Hospitals facing "perfect storm" of issues, he says

Ronald Wyatt, MD, MHA, has spent 20 years working in just about every kind of healthcare setting imaginable — primary care, emergency medicine in a VA hospital, nursing homes, as a sole practitioner and in a multispecialty setting. He's been a hospitalist, worked in a rehabilitation facility, in a community health clinic, and in medical education. It is this breadth of experience that is part of what made him a contender for his latest role, medical director for the division of healthcare improvement at The Joint Commission. And being familiar with all those healthcare settings and roles is something Wyatt thinks will give him an entrée into the organizations that seek JC accreditation and help in achieving and exceeding the standards that bring it.

"The real-world experience I have had speaks with authority about patient safety and quality," he says. "I have seen the challenges first hand, I have witnessed — and made — mistakes. I have also instructed patient safety managers in my role at the Department of Defense, and heard from them directly about the challenges they experience from process and policy perspectives. I have talked with them about how to engage patients and their families, and others in the healthcare community in the urgent need to improve quality and safety."

He calls the situation hospitals find themselves in right now a "perfect storm" of issues. "Hospitals have to lower cost, they have to show value, they have to maintain volume, and they have to respond to all of the regulatory requirements. And they have to do this while improving quality."

He mentions the recent report from the Institute of Medicine on providing the best care at the lowest cost (http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx). It talks about reducing readmissions, reducing mortality, reducing injury and the costs associated with not addressing those concerns — thousands of lives lost, millions of dollars misspent. Finding one area to focus on, even just during his first month or two, is impossible. "I think the most important thing I can do now is to help organizations focus on the areas that are the highest priorities for them."

Hospitals need to figure out how to use their resources more efficiently,

and Wyatt says part of that is re-examining the purpose behind every single project you take on. They should all relate directly to improving patient safety and quality and maximizing efficiency. No one of those things should negatively impact another. He wants organizations to look at what patients and their families are telling you about the care they get, as well as what data show. Address the things that pop up because patients have access to more data than ever about your facility and your competitors.

Wyatt describes a role for himself that seems kind of like a director. Bring out the best performance through coaching, pointing organizations to information, tools, and strategies that can help them improve, and advising them where they might want to look first. Or next. "I think we can work in a collaborative way to make healthcare safer and disseminate the information organizations have accumulated on what works."

With all the various requirements for reporting and improvement, isn't there a danger that a ball is dropped or that something gets forgotten in the shuffle? Sure, he says. Certainly what the people in their ivory towers tell you is a problem in the nation might be very different from what you experience as a problem in your hospital. That is where keeping an eye on your own data becomes vital. "There are major initiatives around certain conditions, and it may be there is a different priority on the front line than what others see. Some hospital-acquired conditions are the subject of a lot of focus, but there are others behind those. I think what will be exciting for me is to help make sure that something doesn't just fall off the radar." If you use your data correctly, you can see any emerging issues before they are problems and track things that might become vulnerabilities in the future.

Wyatt sounds fired up when he talks about these issues. His speed of speech increases and you can sense him gesticulating. "This isn't a philosophical thing for me," he says. "I think that the work we do can really change the world, and I want to contribute to that transformation in a positive way. I want to help design the pieces that are needed. I want to know that what I do every day helps make a patient's stay in the hospital safer."

He thinks everyone in healthcare should be working to answer this question: How do you figure out a way to decrease cost and increase quality and engage patients? "This requires innovative thinking and reinventing what we do." The last part — the engagement of patients — is something Wyatt sees as imperative in the process.

It used to be that The Joint Commission wasn't seen as a collaborative organization, one that was dedicated to helping hospitals and other healthcare organizations become better providers to their patients. The old JC isn't an organization that Wyatt would have fit in so comfortably, either. Before agreeing to take the job, he talked to some

Hospital Peer Review® (ISSN# 0149-2632) is published monthly and Patient Satisfaction Planner™ is published quarterly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

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.

of his mentors about what they thought of TJC. "They see it as having a different approach now that The Joint Commission recognizes that accreditation is crucial, but so is helping organizations improve for the sake of patients and families. I don't think you can do that without being a collaborative and learning organization."

So his door is open. "If you have questions or concerns, come to us. We can assist. And maybe at the same time, we can learn from what your problems or issues are. We have to listen to the voice of our customer, just like you have to listen to yours."

He suggests that everyone take a minute to re-evaluate the purpose of what you do, prioritize your work, and focus on where you can do the most good. "You can't solve every problem every day, but you can make a difference. And share what you learn. Share it internally, and externally."

For more information on this topic, contact Ronald M. Wyatt, MD, MHA, Medical Director, Division of Healthcare Improvement, Joint Commission, Oakbrook Terrace, IL. Telephone: (630) 792-5800. ■

Stroke reduction gets another weapon

TJC starts certification for stroke centers

Within days after The Joint Commission announced that it would begin certifying applicants for comprehensive stroke centers, there were dozens of hospitals either waiting for site visits or preparing their applications in the hope of getting certified this year. It is a potential boon to patients who have severe strokes. If the data from studies in Europe hold true in the United States, a patient with a complicated stroke diagnosis in need of advanced care will do better at hospitals that have achieved advanced stroke certification.

The Joint Commission and the American Heart Association/American Stroke Association joined together in the effort, which they hope will lead to hundreds of certified comprehensive stroke centers to which complicated patients can be referred. The program is based on a premise in a 2000 article in the *Journal of the American Medical Association* (*JAMA*)[1] that having hospitals become certified in providing a certain level of care for stroke patients will improve outcomes for those patients.

"The initial process of creating primary stroke centers has been wildly successful, and they do reduce morbidity," says **Mark J. Alberts**, MD, director of the stroke program at Chicago's Northwestern Memorial Hospital. Alberts was on the original Brain Attack Committee that established the protocols outlined in the *JAMA* consensus paper.

"But primary stroke centers were envisioned to treat uncomplicated stroke patients with no surgical requirement," he says. "Comprehensive stroke centers are the next step, and are designed to treat large, complicated, hemorrhagic strokes that need surgical or other fancy interventions. Certainly patients with regular ones could also be cared for there, but the high-end interventions and protocols that are required of those centers are designed around the complex patient."

Requirements

Field certification began at the start of September, and Northwestern Memorial is awaiting its visit. Hospitals hoping to achieve the certification for comprehensive stroke center have to meet all the requirements of a primary stroke center, and meet additional standards, too. They have to have protocols in place for treating complex patients, have the personnel available and trained to deal with those patients, and must also meet minimum annual volume requirements for certain kinds of patients, including:

- 20 or more patients with subarachnoid hemorrhage;
- 15 or more endovascular coiling or surgical clipping procedures for aneurysm;
- 25 intravenous tPA patients — although over two years is also acceptable for this metric, and patients who were given their tPA at another facility and transferred to the comprehensive stroke center or who were given their medicine at another facility while monitored by telemedicine at the comprehensive stroke center also count.

The requirements also mandate that the successful applicant will have advanced imaging capabilities, including carotid duplex ultrasound, catheter and CT angiography available on site at all times, day or night, and extracranial ultrasound. The facility must also have MR angiography and MRI, including diffusion weighted MRI available on site at all times, transcranial Doppler, and transesophageal and transthoracic echocardiography.

The comprehensive center will have post-

hospitalization care coordination, and a dedicated neuro-intensive care unit for complex stroke patients. That ICU will have to have trained and experienced staff available to provide the kind of critical care complex stroke patients need 24 hours a day, seven days a week. There must be a peer review process to monitor patients with ischemic stroke and subarachnoid hemorrhage and the administration of tPA. Centers have to participate in approved stroke research, and they will be required to collect all performance measures for primary stroke centers, as well as additional performance measures for comprehensive centers as they are developed. The current list of performance measures is available at http://www.jointcommission.org/certification/advanced_certification_comprehensive_stroke_centers.aspx.

One element that Alberts says is different from the primary stroke centers is that you have to do a severity assessment on every patient that comes through the door. "We do this for ischemic strokes, but we haven't been as thorough for hemorrhagic strokes in the past," he says. "Now we are. It is best for the patients, but it also gives us a way to severity adjust our outcomes. We'll be getting all the sickest patients, and their outcomes will reflect that."

Hospitals will have to know their door-to-tPA time. There is a national goal of 60 minutes or less. As a vascular neurologist, Alberts says that doesn't mean you rush to give the drug before having all the information you need. "There are good delays and bad delays. If you have to make a call for more information before you give the drug, that is a good delay. A bad one involves inefficiencies in the system, like taking too long with the head CT. Time is brain, and you want to treat it ideally within 60 minutes, but only if it is reasonable and safe to do it then."

Obviously, the parameters for volume alone will prevent many hospitals from going for this certification. "But if you have the right volume of these patients, and are a high-volume referral center that sees a lot of the sickest patients, then I think it is good for the patient, and good for the hospital to do this," Alberts says. "We know from European studies that this will improve outcomes."

"We see this as the next step in helping to support state-of-the-art care for patients with stroke," says **Jean Range**, MS, RN, CPHQ, executive director for disease specific care certification programs at The Joint Commission. "This is the second leading cause of death worldwide," she says, noting that the primary stroke certification program, which began in 2003, has been shown to improve outcomes among stroke patients here.

The importance of the programs is evident in the number of states that stratify stroke centers. Fifteen states recognize primary stroke centers, and four — Texas, New Mexico, Maryland, and Missouri — already have legislation that recognizes comprehensive stroke center certification.

From a technology and care standpoint, Range says it seemed appropriate to do something that recognized the improved science around the care of complex stroke patients. The requirements took a while to put together and will continue to evolve over time. She says they will be re-evaluated in 2013, but not necessarily every year. If some new breakthrough is reported in the literature, it would probably lead to another review.

"This certification will represent an elite group of organizations that function as regional referral centers," says Range. "We would encourage organizations that meet the volume criteria, but also play an important role in their community and region for complex stroke patients, to consider this. They will work collaboratively with primary stroke centers — they will essentially be an extension of those primary centers for patients who require advanced testing and therapies." But she doesn't want to see organizations rushing out to get certified merely as a way to differentiate themselves among competitors. "We don't want them to see this as a way to compete in your community, but as a way of providing access to high-quality care." Some areas may have more than one comprehensive stroke center, while others may have just one, she adds.

By the end of the second day after the announcement, there were 70 applications waiting for review. "This isn't a small undertaking. Those organizations that can meet the requirements have made a substantial investment in personnel, infrastructure, and equipment and have been planning on this for years." She figures there will be somewhere between 200 and 250 such centers within a few years. "But it is all speculation. There are just about 1,000 primary centers, and we continue to have interest almost 10 years later. Our research just says over 100. I think it will be interesting to see how it plays out."

For more information on this topic, contact:

• *Mark J. Alberts, MD, Professor of Neurology, Chief of Division of Stroke and Cerebral Vascular Disease, Northwestern University School*

of Medicine, and Director, Stroke Program, Northwestern Memorial Hospital. Chicago, IL. Telephone: (312) 952-0257.

• *Jean Range, M.S., RN, C.P.H.Q., executive director, Disease-Specific Care Certification Program, The Joint Commission, Mountlake Terrace, IL. Telephone: (630) 792-5800.*

REFERENCE
1. Alberts MJ, Hademenos G., Latchaw RE et al. Recommendations for the establishment of primary stroke centers. *JAMA*. 2000;283(23):3102-3109. ■

Waiting for the waiting to end

ED boarding is dangerous, and fixable

Ask passersby in a hospital hallway what they think the biggest problem is in the emergency department, and one of the most common answers will likely be something about the influx of uninsured patients who use the ED as their primary care physician. Ask an ED physician or nurse for an opinion, and the answer is much more likely to be boarding.

It is an intractable problem in many hospitals, and one that at first glance someone might think was related to a lack of patient beds. But in the United States, hospital occupancy is around 70%, and while some hospitals may be fuller, there are very few facilities that have no room at the inn at all. So what's the problem and why should you care?

According to numerous studies, boarding patients can lead to inferior care for the boarded patients, and may also affect the care provided to incoming emergency cases. Many of these studies were mentioned in an August *Health Affairs* article that looked at the dangers of boarding, the reasons behind it, and potential solutions[1].

One of the study authors, **Elaine Rabin**, MD, an assistant professor of emergency medicine at Mt. Sinai School of Medicine in New York City, says boarding seems like a big secret they aren't trying to keep in the emergency department. "What was obvious to us in this study is surprising to others," she says. The hospital community at large may know that EDs are crowded, but they don't associate that crowding with boarded patients who are waiting for a room elsewhere in the hospital.

The consensus paper on which Rabin worked noted that boarding increases length of stay and can adversely affect outcomes for patients because they may not get the attention or level of care they need while waiting in a busy ED for a bed on a quiet floor with more access to care and nursing; they may not get medicines in a timely manner; or it prevents other patients from getting access to care because the ED is too crowded — sometimes so crowded that it is closed and ambulances are put on diversion, forced to find another facility that may be precious minutes and miles away.

Among the reasons for boarding, the authors noted, are inefficiencies such as an inability to get some tests or schedule surgeries on a 24-7 basis. If a bed is reserved for an elective patient, or an emergent patient can't get an MRI as quickly on the weekend, then the whole system backs up. Some hospitals don't discharge patients on weekends, but that may be a really busy time for the ED, and since boarding mostly likely occurs when hospitals are at their busiest, but not full — usually when they are around 80-85% of capacity — the potential for boarding in those facilities is probably greater.

One interesting finding, Rabin says, is that some hospitals actually make money when their hospital is on diversion, making boarding a financial win. Emergency patients are often a loss leader for a hospital. Elective patients are worth more money. By closing the ED because it is full of boarded patients, a hospital can limit that negative mix to its income.

"It is not a completely unintended problem in some places," she says. But there are other hospitals that have shown that by solving boarding problems, they can make more money.

There are fixes that can address the problem in a dramatic way. The authors found that smoothing surgical schedules so that they are more equally spread throughout the week helps, as does moving boarded patients to inpatient hallways, which are quieter and have more available nurses. Creating a bed "czar" who will monitor and manage bed availability, having a discharge lounge for patients to wait in before leaving (rather than in their room, occupying a bed), and streamlining the admissions process all have worked. But the problem is that

few organizations are using these strategies to address the problem of boarding.

The *Health Affairs* article noted that in the United Kingdom, press stories about long waits in emergency rooms led to patient uproar and eventually rules that require patients to be seen within a specified time. While there hasn't been patient outcry in this country, Rabin thinks that if something isn't done soon, we are moving to a time when there will have to be some legislative fix to this problem.

"I don't know if we need new legislation, but there will have to be an external force to do this," she says. "All these answers are out there and they haven't been picked up. Hospitals always have a list of things they have to do, that are mandated. Maybe getting to the things they should do but aren't mandated is too hard."

One of the facilities that addressed the problem using surgical schedule smoothing was Boston Medical Center, which accepted a $250,000 grant from Robert Wood Johnson Foundation to implement the program. It took a lot of "good diplomacy" to get the program up and running, says Rabin, but it worked and is part of the lore of ED boarding success stories.

One of the people who followed that project closely is **Jeremiah Schuur**, MD, MHS, FACEP, director of quality, patient safety and performance, department of emergency medicine at Brigham and Women's Hospital in Boston. He has written about the problems that come with boarding[2]. "The most dangerous place to be in a hospital is the ED," he says. "When a patient has been admitted, they need more care, and that is best provided by another unit in the hospital. They aren't getting that care because they aren't on the right ward, they aren't where the physicians are or the nurses are who can best meet their needs." Emergency physicians are trained to provide a certain kind of care — diagnosis and rapid treatment. And if a quarter of the ED is taken up with patients who need to be somewhere else, who isn't getting in to see an emergency room physician? he asks.

The American College of Emergency Physicians (ACEP) has long had tools and strategies available to address the problem. Schuur has his favorites, including Boston Medical Center's surgical schedule smoothing, and SUNY Stoneybrook's tactic of putting boarded patients in the hallways of inpatient units. "At some point, they are going to the floor anyway," he says. "It is safer for them there, and quieter. Once they get on the floor, it is amazing how fast things can happen to get them a bed."

Cutting out admission steps, combining them, or waiting to do some of those things until a patient has a bed also works for some organizations. One thing he's not a fan of is mandating a maximum wait time for admission. "It can lead to perverse decisions as you near the time limit for admitting a patient. Some patients may not be admitted who ought to be, for instance, or you might admit others who with a little more time, you would determine could just go home."

What might work better is to make the time boarded and number boarded a reportable statistic that people in the community can see. "If you say this is a bad thing and it is publicized, it might force the issue," Schuur says.

At Brigham and Women's Hospital, there is a surgical pod that can be activated and opened within the emergency department as needed, which can help take up any slack that comes from no room in other operating theaters. And they also have streamlined processes to get inpatient teams to take care of the patients as early as possible, whether the patients are still in the ED or not.

The reason that his ED has been able to address the problem is that the leadership responds to and respects the leadership in that department. It is something Schuur says isn't true everywhere. For organizations that might have administrators who are blind to the program, he recommends having them come down to talk to patients and family members of patients who are boarding or who have boarded. That might make them see the issue differently.

Making the most of other changes

At St. Clair Hospital in Pittsburgh, an emergency department expansion project provided a time and a chance to help address boarding, says **Tania Lyon**, PhD, director of organizational performance improvement at the hospital. "We overhauled our staffing model, standardized our intake process, launched an inpatient throughput initiative that included a change in our daily bed meetings, and added an electronic status board to the department

to track patient status in real time," she says. Wait times plunged, even before the new wing of the ED was opened, and patient satisfaction went from 14% nationally to 99% in about 18 months, door-to-physician time is nearly half of its previous level at 41 minutes; left-without-being-seen numbers dropped from 130 per month to 15 per month, and door-to-room times went from 54 minutes to 18 in the ED itself. Boarding? It is been virtually eliminated.

The changes in the ED led the hospital to win a gold Fine Award in 2009, and another in 2011 for sustaining the improvement, even while the number of people being seen has increased by 20% and not a single inpatient bed was added.

Boarding rates aren't something that many hospitals — including St. Clair's — measure. But before the improvements it was an issue, "and now it isn't. We doubled the size of the ED, which means there is a lot more space. But if we hadn't fixed this problem, then we would have just shifted the waiting area."

Part of the success was that throughput for all patients was a project — not just ED patients, but every patient. The goal was to figure out how to get them out of the hospital as fast as possible while giving them all the care they need and the highest quality of care. "Getting someone out of the hospital frees up a bed and gets someone out of the ED," Lyon says. "We looked at the discharge process first, at the end. We looked at the unnecessary delays in getting patients out."

One solution was to overhaul the culture of case managers, changing their focus to working with the physicians to establish parameters for discharge. What has to happen to get this patient home? What tests, what environmental assurances, what improvements in their status had to occur for the physician to send one out the door? Is what they need something they have to get in the hospital, or can they get it at home? Those goals are documented in the patient chart, along with the diagnosis and treatment plan.

Another change, which was simple and cheap, was to change the focus of the morning bed meeting. Despite being called bed meetings, they had devolved to a discussion of what staffing was needed, what the patient census looked like, where there was a shortage of nurses, and who could fill that gap. Now, the bed manager focuses on how and where to move patients around at twice-daily meetings — in the morning and late afternoon. They last five minutes, and attendees talk about who will be discharged and which beds will open up that day. "The focus is on pulling people out, not pushing them in. We made this a hospital problem, not an ED problem."

People thought that boarding and crowding were ED problems, she continues. But they are not. They are an issue of throughput. The bed meetings affected that culture by changing the focus and attitudes of nursing leadership on down the line. "Now we have nurses and doctors talking very differently with each other," Lyon says. It took two years to make all the changes and develop a smooth process that focuses on parameters for discharge. After piloting on a single unit, that program is now spreading facilitywide.

Special patients, special needs

At UC San Francisco, boarding of pediatric patients was an issue that **Arpi Bekmezian**, MD, an assistant professor, looked at in a study that found that boarding patients costs more, leads to longer length of stay, and has higher mortality and morbidity[3]. One thing she found was that even the less severely ill patients are likely to suffer when they board. "They are more likely to be ignored because they aren't seen as critically ill," she says.

Bekmezian's work on the topic in the past has shown that certain groups of people are more likely than others to be at risk for boarding. Hispanic patients may wait longer for a bed because there isn't a ready interpreter. Patients who come in the early morning and the winter are more likely to board, possibly due to inadequate staffing in the wee hours or inability to plan for busy seasons — such as in a pediatric hospital during the winter flu season.

One fix that is specific to pediatrics is having a pediatric team available in a general ED that sees kids. "Not all staff is comfortable treating kids," she says. "Having someone conversant in dealing with children who need complex care can help." They have a pediatric resident, attending, and nurse who deal with boarding kids to make sure that they aren't lacking appropriate care while they wait for a bed. It might translate to other special populations — geriatric, for instance — if you see a lot of

a particular kind of patient in the ED and you have a boarding problem. It might work in general to have a few people who are dedicated just to boarding patients while other fixes are being worked out. "It is an expensive solution, but it provides the attention the boarding population needs," she says.

Bekmezian has worked in an ED where there were boarders, and on a ward where there was a patient of hers waiting for a bed. Either way, boarding is distracting. If she's a physician in the ED, she can't pay as much attention to the boarded patient as that patient needs, or if she does, she is leaving some emergent patient without care. On the ward, she is too far from her patient to give proper care without leaving her other patients in the lurch.

Another special population whose boarding needs should be addressed is psychiatric patients, says **Muhamad Aly Rifai**, MD, CPE, the chairman of the department of psychiatry in the Blue Mountain Health System in Pennsylvania. Also a professor of clinical psychiatry and medicine at the Commonwealth Medical College, Rifai says psychiatric patients were being boarded for five times longer than other ED patients — as long as 15 hours. Those patients experienced more agitation, were more likely to need restraints and isolation, and were more likely to be involved in staff member injuries.

"On the month prior to initiating our project for reducing the length of stay, there were five nurses who were out on disability related to injuries they sustained while caring for patients with psychiatric complaints being boarded," Rifai says.

The problem was clear to everyone. Initially, leadership responded by arming security personnel with stun guns, which resulted in five patients being stunned in a three-month period. The Joint Commission and Department of Health investigated as a result. Stun guns were not the answer, he says, so they created a joint task force from the department of psychiatry and the department of emergency medicine to see what might work to reduce the boarding problem.

In 2007, the group evaluated patient flow and started tracking length of stay and boarding. They created an alert system to improve communication regarding psychiatric patient volumes. The collaborative group met regularly and implemented changes including scheduling discharges effectively, improving flow, combining electronic medical records and multitasking. Physicians and staff were educated and supported to improve and standardize the evidence-based assessments dealing with acute patients who had suicidal or homicidal ideation. Algorithmic evidence-based management strategies of acutely agitated patient were implemented.

While psychiatric patient volumes actually increased by nearly a quarter between 2007 and 2010, the length of stay decreased by a third, to 10 hours. Patient boarding decreased by 40%, and there was an 85% decrease in staff injuries and 50% reduction in seclusion and restraint use among boarded patients, Rifai notes. The project was presented to the American College of Physician Executives annual meeting. A poster presentation can be viewed at http://net.acpe.org/Current_Materials/Summit/Share%20_Your_Story/Posters/Rifai.pdf.

The key lesson from Rifai's perspective is teamwork. The problem doesn't belong just to the emergency department, but to the whole facility or system.

The point Rabin would like to make is that there are solutions that work out there, and they should be used more frequently. If they aren't, then calls for mandatory interventions will only increase.

"Hard time frames may become necessary in the future," says Schuur. "But we should start by actively pushing for public reporting of measures related to boarding first. It is an invisible problem. Making it visible will be a major incentive to address it. Then, if that doesn't work, maybe we move on to time limits."

For more information on this topic, contact:

- *Muhamad Aly Rifai, MD, CPE, Chairman, Department of Psychiatry, Blue Mountain Health System and Clinical Professor Psychiatry and Medicine, The Commonwealth Medical College, Leighton, PA. Email: DrRifai@alyrifai.com.*
- *Arpi Bekmezian, MD, Assistant Professor, UC San Francisco School of Medicine. Telephone: (415) 476-6366. Email: bekmeziana@peds.ucsf.edu.*
- *Tania Lyon, Ph.D., Director, Organizational Performance Improvement, St. Clair Hospital, Pittsburgh, PA. Telephone: (412) 942-1149. Email: tania.lyon@stclair.org.*
- *Jeremiah Schuur, MD, MHS, FACEP,*

Director of Quality, Patient Safety, Performance Improvement, Dept. of Emergency Medicine, Brigham and Women's Hospital, Boston, MA. Telephone: (617) 732-5640. Email: jschuur@partners.org.

• *Elaine Rabin, MD, FACEP, Assistant Professor Emergency Medicine, Mt. Sinai School of Medicine, New York, NY. Telephone: (646) 522-3604. Email: elaine.rabin@mssm.edu.*

REFERENCES

1. Rabin E, Kocher K, McClelland M et al. Solutions To Emergency Department 'Boarding' And Crowding Are Underused And May Need To Be Legislated *Health Affairs*, 31, no.8 (2012):1757-1766.
2. Liu SW, Chang Y, Camargo CA et al. A Mixed-Methods Study of the Quality of Care Provided to Patients Boarding in the Emergency Department: Comparing Emergency Department and Inpatient Responsibility Models. *Med Care Res Rev*. 2012 Aug 23.
3. Bekmezian A, Chung PJ .Boarding admitted children in the emergency department impacts inpatient outcomes. *Pediatr Emerg Care*. 2012 Mar;28(3):236-42. ■

Seeing the forest and the trees

Transparency a key difference

If a health system wins a major national quality award, it must be doing something right, but also something different from other organizations, right? Ask one and likely at some point, a spokesperson will says something about focusing on the patient and striving to improve. But not everyone.

"What healthcare organization isn't patient centered?" asks, **Tamera A. Parsons,** the vice president of quality and patient safety for Mountain States Health Alliance, a Johnson City, TN-based system that includes 13 hospitals in Tennessee and Virginia that won the National Quality Forum National Quality Healthcare Award. "What organization hasn't shown improvement in quality and safety while the whole nation is watching?"

"I'm sure we did this because we have the right principles and processes. But I also think that we have found the value of integration. We have our guidelines and our processes and our people, but it is not about tasks, but about incorporating those values into everything at every level," says Parsons.

What does that look like? The organization has 10 patient-centered care guiding principles *(for a complete list, see box, below)*. Number eight is that transparency is the rule when caring for patients. "It makes a lot of sense that the patient has to be informed at every step of the way about what we are doing, why, and what we expect to happen. But we take it further. We include the patient's 'VIP — very important person' in that transparency. We extend it throughout the whole system so that the scorecard data that I see is given to every single person who has an email address ending in msha.com. We share patient data with accounting and accounting data with nurses. And we put it all up on our website so that anyone can see it."

MSHA is spread across 29 counties in Virginia and Tennessee. Much of the terrain is rural, some rugged. But Parsons says despite the size and complexity of the geography, they work hard to spread the projects and programs that work. Still, deployment is an issue that they continue to work on. "I think that using the Baldrige Criteria for Performance Excellence [http://www.nist.gov/baldrige/publications/hc_criteria.cfm] is helping us do better. If we were perfect, we wouldn't need the criteria, but we aren't, so we do," she says.

The organization uses the Baldrige criteria as its business model, something that makes her peers in other systems start asking questions. "It

10 principles of patient-centered care

From Mountain States Health Alliance

- Care is based on continuous healing relationships.
- The patient is the source of control for their care.
- Care is customized and reflects patient needs, values, and choices.
- Families and friends of the patient are considered an essential part of the care team.
- All team members are considered as caregivers.

Care is provided in a healing environment of comfort, peace, and support.

- Knowledge and information are freely shared between and among patients, care partners, physicians, and other caregivers.
- Transparency is the rule in the care of the patient.
- Patient safety is a visible priority.
- All caregivers cooperate with one another through a common focus on the best interests and personal goals of the patient.

is completely integrated into our organization. We start from the focus of the customer, not the focus of leadership."

Another thing the organization is doing that's different is focusing on population health management and accountable health. "We are making our focus managing the health of our population, not a single episode of care, and are creating a 10-year plan that focuses on that," Parsons says. "I don't know if it is unique, but there certainly aren't a lot of people doing that."

Parsons knows there is no destination when it comes to quality, but she feels that this has been a good year for Mountain States. Along with the NQF award, they were honored by Virginia's highest award for performance excellence, Senate Productivity and Quality Award Program for Virginia, an award that hadn't been given out to a healthcare organization since 2009.

For more information on this topic, contact Tamera A. Parsons, Vice President of Quality and Patient Safety, Mountain States Health Alliance, Johnson City, TN. Telephone: (423) 431-6111. ■

Where health care workers train matters

In-situ drills help make practice perfect

Some scenarios that cause nightmares for nurses and physicians are blessedly rare. But the problem with that is it's hard to practice so that if it does occur, you can feel confident in your actions. That's one reason why hospitals and medical and nursing schools have simulation labs and a variety of cutely named anatomically correct dummies: It's a place to practice on things that can't actually die.

The problem with this kind of training is that it isn't done in the same environment where those very physicians and nurses work. What you might reach for on the left in the lab is on your right in your own emergency room, for instance. But training on site can be difficult. It might interfere with your regular operations, and it can make patients and their families nervous. But you can make it work, says **Melissa Eichelberger**, MS, RNC, a patient safety nurse at Johns Hopkins Bayview Medical Center in Baltimore.

Identifying gaps

"Doing in-situ training is more natural and can help you identify system gaps that you just can't see in a simulation lab," she says. Usually, you have to wait until an event happens to identify such gaps.

Eichelberger says she started in the obstetrics unit, first coming up with scenarios that she thought might offer the opportunity to find safety issues. Then they were written out on cards, complete with objectives and schedules. Because the safety drills are held where there are patients actively being treated, staff had to let patients and family know that they were doing a drill. Otherwise, it could have been frightening for patients to see a simulated infant abduction.

Often, they had to cancel the drills — 68 were scheduled, but only 22 occurred, she says. "We wanted to do them, but not inhibit patient safety. If the unit is too busy, we can't do them."

When they did occur, they were taped, and then reviewed afterward by the participants. That allows the participants to see things from a different angle. "People don't always like that, though," she explains. "One simulation we had, a participant started crying because she couldn't get something right and thought she was going to be judged as being incompetent. But we were drilling on something I knew we had to work on. I decided to stop taping for a while after that, but when we got more comfortable, we videoed it again."

Doing the drills can help hone communication between team members, allow them to practice things that don't happen often, and also show up where some process needs to change. Or change back. One of the drills, says Eichelberger, brought to the attention of the nurses that a certain medication had been removed by pharmacists and was no longer kept on the unit. If they didn't do the drill and that same situation had occurred, it might have meant a dangerous delay in getting a necessary medication.

It's impossible to say if outcomes increase through the use of simulation drills, but she thinks they are more technically adept and pro-

vide better care because they practice. "Airlines practice all sorts of situations. Football teams practice. It makes sense that we should." She can tell from staff surveys that the safety culture has improved with the drills. That has meaning to her.

In-situ drilling doesn't have to be expensive, either. There are mannequins that cost tens of thousands of dollars that can code, cough, and even complain. But what has worked best in the OB unit at Bayview is a $700 apron simulator that is filled with fake blood and tied onto a real person. "If there is an open room and a slow day, I grab my cards and someone ties on the apron," she says. An upcoming study found that residents who used both the apron and the $30,000 dummy preferred the apron in every category measured and that it was a more effective method of testing skills.

More scenarios

While in-situ drills started on the OB unit, there are other units that have taken up simulation drills, some in situ, some in the Johns Hopkins simulation lab downtown, says Eichelberger. They do mock code drills, and when they redesigned the emergency department, they held a ramp drill. There is interest in expanding the repertoire to other units, too. With more safety nurses coming on board, it will be possible to write out more scenarios for the units that have an interest and see about

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
- ■ Tales from the survey trenches
- ■ Pressure ulcer reduction
- ■ Drug diversion prevention

CNE QUESTIONS

1. Ronald Wyatt, MD, the new medical director for quality improvement at The Joint Commission, says this is key to improving patient safety and quality:
   A. Data
   B. National Benchmarks
   C. Having an open door
   D. Collaboration

2. Comprehensive Stroke Center Accreditation requires that you have how many patients with subarachnoid hemorrhaging?
   A. 15
   B. 30
   C. 25
   D. 20

3. Among the issues that can result from ED boarding are:
   A. Increased length of stay
   B. Infection
   C. Staff injury
   D. Use of restraints

4. NQF Award winner Mountain States Health Alliance is working on this topic as part of it is 10-year plan:
   A. Population-based healthcare
   B. Baldrige criteria
   C. Transparency of data
   D. Patient-centered care

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.

scheduling in-situ drills, she says.

"This allows you to practice high-risk, low-occurrence situations in a safe environment without the possibility of harming patients and still learn," Eichelberger says. And the tapes can be saved and used as object lessons in training to improve communications or to show staff how much they have improved over time.

After she attended the International Healthcare Medical Simulation conference, Eichelberger was hooked. She has since been again, finding out key information such as how to make realistic fake blood for very little money. "You don't have to be technologically advanced to create things that will show you how your teams interact."

It doesn't take a lot of money to start a program, and there is a great deal of information and resources available from the Society for Simulation in Healthcare, http://www.ssih.org.

For more information on this topic, contact Melissa Eichelberger, MS, RNC, Patient Safety Nurse, Johns Hopkins Bayview Medical Center, Baltimore, MD. Telephone: (410) 550-9546. ■

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. ■