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Putting pain on the front burner

What can you do to improve palliative care?

A recent survey of peer review studies related to palliative care by the Agency for Healthcare Research and Quality (AHRQ) found that only five of more than 90 studies targeted multiple outcomes measures and relayed data to providers. The literature, says the report — published in October 2012 — is too heterogeneous: “While a few high- and medium-quality, well-designed health care and palliative care interventions have been conducted to improve outcomes for patients with advanced and serious illness, this report highlights the continued presence of variable findings, quality deficiencies, vaguely defined interventions, and variable outcome measurement tools and reporting in much of this intervention literature.” There has to be more research, bigger samples, and standardization of outcomes measures, it says. *(To see the full report, go to http://effectivehealthcare.ahrq.gov/ehc/products/325/1303/EvidReport208_CQGPalliativeCare_FinalReport_20121024.pdf.)*

This isn't a surprise to people working in palliative care. It's often spoken of as a hospice go-with, as in “hospice and palliative care,” when those in the know will patiently explain that palliative care is symptom relief for anyone who is seriously ill, whether at the end of their life or not. They are gratified that the topic is on the radar of organizations like AHRQ and hopeful that more projects will be created to fill in the gaps the October report outlined.

The palliative care program at Gundersen Lutheran in LaCrosse, WI, is a long-established one that is so much part of its community that some 98% of LaCrosse County residents with chronic illnesses have completed advanced care planning, says Hilary Bingol, MD, one of seven providers associated with the service for the health system. It has a robust quality improvement program, and among its current projects is a four-year-long demonstration for the Centers for Medicare & Medicaid Services (CMS), currently halfway through its term, which aims to expose a wider group of patients to palliative care.

The Late Life Primary Care (LLPC) program targets patients with life expectancies of less than two years and focuses on issues such as continuity of care, quality of life, and respecting the wishes of the patient and family members. It is not limited to those with serious diseases that usually

end in death, but also for those with chronic illnesses or patients who are simply extremely frail. The organization estimates that some 7,300 eligible patients with diseases like Parkinson's, ALS, multiple sclerosis, and stroke will be exposed to the program during the demonstration period.

Bingol explains that Gundersen had a disease-specific advanced care planning process already

in place, which was leveraged into the LLPC project. It was designed to help patients make informed decisions on their care based on realistic goals and understanding of the particular disease they have.

Among the data being collected for analysis are length of stay, readmission rates, subspecialist physician visits, and medical testing. Bingol expects to see an increase in hospice admissions and length of stay, but a decrease in services of \$3,000 to \$6,000 compared to patients not in the program.

Another project involves getting more rural patients access to palliative care through a telemedicine program. That will enable patients who might be in a small hospital without subspecialty access to get the benefits of palliative care without being transferred to a bigger hospital away from family and the physicians who know them and their wishes.

An ongoing project, Respecting Choices, is an advanced care program that provides disease-specific planning for patients. That project has proved so well-respected and popular, Bingol says, that its leadership team travels across the country, and even as far away as Australia, to explain it to other organizations. (*More on the program is available at http://respectingchoices.org/about_us/history_overview.)*

Bingol says that of all the places she's worked in palliative care, Gundersen Lutheran has the most expansive and ingrained program. "Gundersen has pushed our community to where it is," she says. Still, she'd love to see the expansion of palliative care to all patients with chronic illnesses early in their disease process. "That way, when the disease advances, there is no panic about what to do. They have a plan in place."

There's great science to prove that what Bingol wants is a good idea, says **Cory Ingram, MD**, an assistant professor in family and palliative medicine at the Mayo College of Medicine in Minnesota and the medical director for Mayo's palliative medicine program in the Mankato area. "It's a lofty goal to design a way to ensure that all people who are cared for have access to palliative care," he says. "And I recognize that at a national level there will never be enough palliative care teams to see all the people who can benefit from our services. But it should be — and can be — something delivered by all people in healthcare to some degree."

A more reasonable goal might be to supply

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Editorial Questions

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subspecialist care to those who need it, and to raise the visibility and practice of palliative care principles and quality indicators to the health system as a whole, he says. “Palliative care has been shown to increase survival, improve the patient experience, decrease depression, and cut costs. If you could put this in a pill, it would be worth billions.”

More than end-of-life care

At Mayo, Ingram says he’s been thinking a lot about quality indicators and palliative care and linking it to the notion of value. That isn’t just a monetary term, he says. “Cost is just part of value. It’s not just about manipulating numbers, but also about patient wishes, and quality should include the notion of documenting those preferences. It’s not just about assessing pain and making sure it’s adequately treated, but about having conversations with the patient to make sure the care you give them is consistent with their preferences.”

And it’s not just about end-of-life care, either, Ingram says. “That’s like kicking a field goal to win a football game and assuming then that you don’t need to do more than be good at kicking field goals. That’s not how you have a winning season. In order to improve the care of seriously ill people, whether or not they are dying, you have to be involved from day one. They have needs from the start, and understanding them will also improve end-of-life care. What we have now isn’t even end-of-life care; it’s brink-of-death care.”

Why scramble to get it right at the end when studies show that if you start the palliative care process early in the disease process you can have positive outcome benefits for patient, provider, and payer? he asks.

If you look at how seriously ill physicians manage their own treatment, you get an idea of how palliative care can work for the wider patient population, Ingram says. “They avoid things that do not contribute to longevity or quality of life, and by the way, that leads to cheaper care. And docs do it differently because they are better informed.”

While Bingol says one impediment to spending the time required for that kind of patient education is the lack of reimbursement for it, Ingram says when we get to a place of population-based health management and wide expansion of

accountable care organizations (ACOs), it will shake out. “This will provide better outcomes for less money. For a hospital or ACO, doing it this way will become like oil in the engine. It will just run better.”

But even now, you should be investing in these programs because doing so provides value to the patients, and you can prove that by looking at the right quality indicators, Ingram says. “That is, having as an outcome that their particular goals and preferences are met by what the medical possibilities are, and that they are very well informed,” he says.

Mayo is working now to form a palliative care center of excellence. When launched later in the year, he hopes to prove its worth by making sure that the data they collect links not just outcomes and cost, but also his notion of value to the patients. “We will look at engagement, education, and efficiency, as well as dollars.”

The focus on palliative care is only going to increase as the population ages, he says. Best get on board now. As you develop programs, he suggests that you make sure you are doing the basics from the start. That includes assessing pain — something that most organizations already do pretty well — and treating it within 48 hours — something that is lacking throughout the country. “Get information on the quality of pain and the level of reduction.” But more than just pain, palliative care means dealing with the relief of other symptoms, including shortness of breath, loss of appetite, and fatigue. Document those items, and you can better see how your program is working for patients — or isn’t.

If you master those basics, you can think about projects related to well-documented discharge planning that includes palliative care. That can lead to reduced readmissions — something every hospital has a financial interest in limiting. “If you address issues like pain and fatigue, if you have great conversations that educate patients about realistic prognoses and setting attainable goals, you can keep them from bouncing back.”

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NY hospital achieves TJC wound care certification

20 hospitals so far have been certified

Just four months after deciding to apply, South Nassau Communities Hospital underwent and passed a survey by The Joint Commission for certification in wound care, making it the first hospital in New York to achieve that status, and just the 20th in the country.

Wound care isn't glamorous, but it is important to the overall well-being of patients and the bottom line of hospitals. And it's not just diabetic patients who need this kind of care. South Nassau wound care patients include those with pressure ulcers, venous or arterial insufficiencies, traumatic wounds, and radiation burns.

Laura Righter, RN, administrative director of the 15-year-old wound care center at the hospital, says that achieving the certification took a team effort, including nurses, physicians, and support personnel from nutrition, pharmacy, and physical therapy, among others. The journey began a year ago, when the organization received a scholarship for some of its nurses to become certified in wound care. By last summer, executives were impressed enough with the wound care rates — about 95%, which is above the national average — and patient satisfaction that they decided to go for the Joint Commission certification.

The site visit was in December, Righter says, so they had four months to go through the certification standards, page by page, and see what needed tweaking or improving. “We have just six providers, and a medical director who is really on board,” she says. “He's very into standardization, and although physicians have the freedom to deviate from standards with good reason, they have to justify it. And if after a month it's not working, it's back to the pathways we have established.”

That standardization probably made the certification process easier for South Nassau, she says. In addition, there is an existing collegial mentality strengthened by a decade of regular monthly team meetings where they talk about quality improvement opportunities and brainstorm ways to deal with difficult cases.

Given the maturity of the program, what is it that certification brought? Righter says it was a new focus on digging deeper into the data. “We looked at the broad brush data like healing rates,

but after the survey they told us we should delve more into them.” For example, they knew their healing rates, but what is it for each physician? For each wound type? And what is the cause of any deviations?

The surveyors also had suggestions for improving data collection, she says. “For instance, if we were monitoring the blood sugar of diabetic patients by having them self-report, and their A1C data didn't jibe with what they reported, we should look at why.” They now accept those self-reported blood sugar rates, same as before, but the wound care staff also do their own blood tests to see if there are any discrepancies that aren't the result of an intervening meal. “We picked up two people in the last month who were non-compliant and were not really doing their blood sugar readings. We sent them for endocrinology consults.”

Another example was doing monthly weight and BMI monitoring. That's fine, but you often miss the beginnings of nutrition problems with underweight and low-normal weight patients. Righter says they took on board a suggestion to look at that metric weekly so they can see potential problems earlier. Already one patient who was losing weight has been counseled and provided with protein supplements to keep her weight up and healing on track.

Righter says getting the certification shows the community that they have a commitment to providing the highest standard of evidence-based care. It also gave the staff of the center a sense of validation that what they were doing is great, as well as the impetus to keep reaching higher.

Another benefit of disease-specific certification is that it can galvanize other departments or units to seek their own certification and thus improve patient care, says **Jean E. Range**, MS, RN, CPHQ, executive director of disease-specific care certification at The Joint Commission. “Other departments take notice when you have a successful certification.” You might notice a sense of competition between units or departments as they vie to improve their own care processes. “Organizations tell us this over and over: When one group gets a certification, other service lines want to do it so they can get that acknowledgement.” That a certified service line may get more resources to help them with the increased data gathering and reporting requirements only increases that competitive desire.

Within the unit itself, Range says, it creates camaraderie and enthusiasm across the team as

they work toward a common goal. “That can translate to teams working better together for other projects.”

While wound care certification allows facilities to set their own goals for performance measures — versus a certification for something like stroke centers where there are standardized measures based on national norms that every applicant has to meet — Range says a facility that engages in certification will have little variation in care, and that alone will improve outcomes for patients. “This gives a facility the opportunity to really monitor the care you provide and align it with evidence-based guidelines related to it.”

The biggest hurdles for organizations seeking wound care certification seem to be getting all the stakeholders on board, from senior management down, Range says. “Physicians often have their own way of doing things and may interpret best practices differently. You have to get to some place of agreement, so that you are all implementing evidence-based practice the same way, and that it is baked into the process,” she says. “You all need to understand why you are doing what you are doing, and that it is implemented systematically across the entire patient population.”

Even if you don’t want to go through the entire certification process, Range says any organization can learn from the program. “Over and over we hear that facilities who think they have a great program obtain the manual and go through it line by line. When they do a gap analysis, they can see the things they are missing. You can learn to improve care.”

If you do decide to go for certification, don’t think that once you get it, your work is done. Although site visits are done every two years, Range says that in the off year they have extended conference calls during which a program must demonstrate that it is continually looking at its measures, discuss its data collection, and show its quality improvement activities. “We expect very active continuous involvement,” she says.

As the population ages, there will be more and more patients with the kinds of conditions that lead to intractable wounds, Range concludes. “This is a program where everyone can learn something.”

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NQF, TJC honor Kaiser implant project

Eisenbergs also go to two other winners

Choosing a pacemaker has its parallels to buying a car: There are different makes and models. You want one that’s safe and reliable and doesn’t break the bank. And every manufacturer says its version is the best. It was the lack of comparative knowledge that led a group of Kaiser cardiologists in the 1990s to suggest tracking patient outcomes with different units so they could see what worked best. That idea led to an implant registry that has tracked orthopedic, cardiology, and vascular devices in more than 300,000 patients and driven Kaiser Permanente to make system-wide decisions on which to use, leading to better outcomes and cost savings. The program won the organization the John M. Eisenberg Patient Safety and Quality Award from The Joint Commission and National Quality Forum.

“A successful project has many parents,” says **Jed Weissberg, MD**, senior vice president of hospitals, quality and care delivery for the Oakland, CA-based system. “The cardiologists may have come up with the idea, but the orthopedists drove the project and rallied colleagues.” They wanted to know how the various implants in knees, hips, and other joints were impacting their patients’ lives, he says. “The point is to reduce pain and improve function, but that’s not usually captured in EHRs.” Few organizations were collecting this information in any kind of systematic way.

In addition, manufacturers were marketing impressive features and charging more for them. But did they do anything more for patients? “We needed a way to follow these people, see how they did, and be able to give prospective patients a real idea of how they would do. We also wanted to be able to use the information to open a dialogue with manufacturers and get them to do the research that would prove the benefits of any new features they were trying to market for us.”

While the project certainly gave the operative team some additional work — forms to fill out, data to collect and track — the potential information boon to them made it an attractive prospect for them. “They had wanted to know about this for years,” Weissberg says. For the health system, they could also get information about the various practices of different providers, see what worked best and who had the better outcomes and then use that data to get physicians to reduce the variability in their approaches.

Initially, there were maybe a dozen vendors that orthopedists were using for implants, he explains. They were asked to whittle that down to two or three. Physicians could go outside those if there was a good reason. “It took a while for them to learn the new practices, but we now regularly use just two makers, with a third for some specialty implants. Less than 5% of our physicians go outside those three.”

He mentions the use of metal-on-metal Birmingham hip resurfacing. While some people thought it was a great idea, Kaiser wasn’t sure. They sent surgeons for the training at their expense. But the volumes weren’t huge, and they opted not to use it. Now, many with that procedure need revisions. For Kaiser, though, the fact that it wasn’t chosen as a treatment means they don’t have to absorb those revision costs.

The data have proved very useful for physicians and patients alike. A risk calculator based on what they collected allows physicians to input demographic, condition, comorbidity, and other data about a patient and the prospective procedure. The doctor can then tell a patient that based on experience with other patients like him or her, this outcome is expected. “It makes consent much more informed,” Weissberg says.

It has also pointed out problems for certain kinds of implants. “We found an increased revision risk with some ball socket sizes — larger sizes had fewer of them. We sent that data around, practices changed, and we have seen reduced numbers of revisions,” he says. The same thing happened with certain uncemented joints and mono-compartmental knee replacements. “For our patients, these techniques don’t work as well, so we encourage doctors to use alternatives.”

What started in orthopedics expanded to cardiology, where they found that batteries in pacemakers weren’t lasting as long as the manufacturers were saying. “That gave us leverage with them,” he says. They also found that leads were wearing

out prematurely. “We track how many are being explanted and when, and we can change practices based on that information.”

A study on implanted defibrillators showed that many in the United States weren’t adhering to best practices on when to use them. “But our data showed we were much more in concordance with when to use them, that we were being much more discriminant and sticking to the contraindications list better than others. These are very expensive devices, so it was good to know that we were using them appropriately. That’s what you can find out when you tie this data to the EHR.”

While the initial impetus was to get outcomes data, Weissberg says that increasingly they are using it to understand costs as well, and to use the information to drive down costs.

Even if you can’t create this kind of registry, he says that standardizing your implant inventories and reducing the number of vendors can help you improve quality. “You want to deal with a smaller universe of implants so that you know more easily that you have the right one. You want to make sure that what you do is benefiting the patient, so that all the pain and effort of something like a hip replacement doesn’t go for naught. And you need to make sure that the people doing this work get the information on how they impact patient lives. Collect this data. It pays off.”

A dedicated life

Dana Farber Cancer Institute’s **Saul Weingart**, MD, PhD, won the individual Eisenberg for his commitment and national contributions to patient safety through publication, education, research and leadership. Among his accomplishments are creating the Harvard Executive Sessions on Medical Error, one of which led to passage of the Minnesota Adverse Event Reporting Law of 2003; extensive research in understanding the role that patients and families can play in advancing patient safety; leading multiple operational improvement projects including implementation of medication best practices across a six-hospital network; development of one of the earliest medication reconciliation programs; development of a Web portal-based incident reporting system for patients; and development of novel curricula in patient safety and online patient safety courses.

He says that within a couple years of the 1999 Institute of Medicine *To Err is Human* report on medical errors, the medical community has been

galvanized to act on patient safety issues. “Before that, it was mostly research and risk managers who had worked in this area. But it became clear after the report that groups like The Joint Commission and the government were interested in addressing safety in a consistent way. There was an increasing alignment and momentum.”

There have been some great breakthroughs in the past decade as a result. The emphasis on infection control and realizing that hospital-acquired conditions are not just “a cost of doing business but can be prevented” is one, Weingart says. Meaningful Use and health IT is another thing that will have a lasting impact on safety and quality. Patient engagement is something he thinks will also make a difference.

“What I worry about, though, is that the next generation of improvements will have to come in the way we deal with routine operations of hospitals and clinics,” he says. “When I look at our organization, we have a robust patient safety program and committed culture, but you can overgrow your infrastructure. You have to reinvent yourself because the very burden and volume of clinical care, of regulation and oversight can have a paradoxical adverse impact on what you have to get done.”

He explains, “You have to figure out how to be both mass production and high touch at the same time. No one has cracked it yet.”

That said, he thinks there are things that every organization can do right now to be safer and to make quality improvement better. First, he says to invite patients to be a part of everything you do. “They understand how things can go right, how they can go wrong, and what your vulnerabilities are.” Of particular value are so-called expert patients. Often they are allied with the healthcare industry and have insiders’ knowledge. They often navigate the system better and have better outcomes.

Next, Weingart says to standardize everything you can as much as you can. Embrace technology, but cautiously. And lastly, set ambitious goals. “If there are best practices you want to implement, don’t do it piecemeal. Go for it. Do it all at once.”

Memorial Hermann Healthcare System of Houston is the other Eisenberg award winner, acknowledged for its High Reliability Journey from Board to Bedside initiative. The project focuses on providing compassionate and efficient care by using high-reliability behaviors, evidence-based care, and harm prevention across the sys-

tem’s 12 hospitals, 19 ambulatory surgery centers, clinics and other ambulatory care locations. Front line staff lead the quality improvement process, and data are collected and reported monthly. The system aims for 100% goals and zero incidence of harm.

While not available for interview by press time, look for an in depth story on this program in a future issue of *Hospital Peer Review*.

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Cutting the volume of data down to size

The beast should get smaller — eventually

Every hospital quality improvement manager hears complaints about all the data that has to be collected, how much of it is redundant, the different ways you have to report it, and the increasing number of organizations that want it. Why can’t they all get together and figure out a way to work together? they ask.

That’s one of the goals of the Measurement Applications Partnership (MAP), convened first in 2011 by the National Quality Forum at the request of the federal Department of Health and Human Services. The group just completed its second report, after asking for input regarding some 500 measures under consideration for use in federal programs.

The goal is to get private and public entities on the same page as far as data collection and reporting. Eventually, it is hoped that the vast number of program requirements will be streamlined, reducing the reporting burden for your average hospital.

This round, MAP supported the inclusion of 141 of the measures for some 20 programs, generally liked another 165, and recommended that 64 of the measures be removed over time. They

also added six measures that weren't on the list submitted to MAP and its panel of more than 100 experts. They acted after receiving some 400 comments from nearly 100 stakeholders. The complete report is available at http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx.

Along with the annual review of the list of measures, MAP members also identified gaps in the measures and proposed solutions. Most of the kinds of gaps had been previously mentioned in MAP reports — creating more outcome, versus process, measures; that children and other special populations needed more measures; using patient experience measures in settings other than inpatient; using fewer checkbox-type measures; too few composite measures for multifaceted topics; and a dearth of measures for specialties like behavioral health.

The next generation

The report notes that comments largely supported MAP members' opinions on the measurement gaps, and some suggested other areas of lack as well, such as palliative care, functional status, and disease-specific measures for conditions like osteoporosis.

Members of the MAP team recommend ramping up efforts to create a “next generation” measure set. It would include things like resource use and composite measures. NQF plans to work on this during the coming year. And the report notes that there must be better collaboration, both to close the identified gaps, but also to reduce duplication and harmonization. “The resources available to fund measure development, testing, and endorsement are finite,” notes the report, “so stakeholders need to establish agreement on the highest priority measurement issues and how to overcome barriers to address them.” NQF hopes to act as a coach and coordinator of efforts, as well as a measure incubator.

The work for the coming year for MAP includes working on new measure families. Thus far, they have created families for safety, care coordination, cardiovascular disease, diabetes, cancer, hospice, and dual eligible beneficiaries. The team wants to add families for affordability, population health, patient and family engagement, and behavioral/mental health.

MAP will also work to create feedback loops

to get ongoing information about existing measures, gaps that may not yet be on the radar, and unintended consequences of new measures.

One of the key findings of this report was the need for more “rigorous” performance measurement, says Tom Valuck, MD, JD, senior vice president for strategic partnerships at NQF. “As we evolve from pay for reporting to pay for performance, we have to have measures that are more meaningful to providers, purchasers, payers and patients alike,” he says. “What that means depends on the audience involved. Outcome measures may be more meaningful to patients — such as functional status. But providers are interested in measures that are fair, valid, reliable, and appropriately adjusted. That might mean more rigorous reporting of socioeconomic data to help account for readmissions. Purchasers, though, may be more interested in ensuring we don't adjust away meaningful differences, and that we have measures that look at both quality and cost of care.”

The goal is to tie measures more closely to outcomes, Valuck says. “Having a checkbox measure that asks if you have an electronic medical record doesn't provide any information on whether you have coordination of care or effective transfer of patient information between providers. That is what we want to move toward.”

Linking cost and quality

Valuck says MAP also intends to move toward a more overt linkage of cost and quality in its measures. What that looks like will depend on what level of data you examine — patient, provider, hospital or system level data. Good cost measures for each are still being developed, he says.

There is total cost of care for a procedure, but does that give you all the information you need if the cost is solely based on what happens in the inpatient setting? How does that help complete payer understanding if the costs associated with rehabilitation aren't included? And if information on a hip replacement doesn't include information on whether the patient has a better quality of life, does it have any meaning for the patient?

It could be that there will end up being some kind of index related to a particular kind of care. Under hip replacement will be data look-

ing at the cost of implant, surgery, recovery, rehabilitation, nursing, home care, and on down the line, Valuck says. That kind of thing takes time, though.

For now, quality managers can assist in making sure that the burden isn't high but the payoff in data is by communicating with the NQF and MAP. "We want to engage you and find out what you have difficulty with. Where are you finding unintended consequences? What data do you wish you had more of?" he says. "We are committed to streamlining data collection and reporting and decreasing the administrative burdens you face. So tell us what is redundant. Tell us if you have ideas for making it more efficient."

Nothing MAP suggests is set in stone. HHS takes the suggestions under advisement and may or may not adjust its proposed rules. But Valuck says he thinks they understand the value of the knowledgeable group of stakeholders involved in MAP. Late this year, they will start the process again, looking at what rules and measures came to fruition and whether they are helping the healthcare system as a whole better meet its quality, safety, outcome, and cost goals.

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Ensuring hand-washing when no one's watching

Tips for encouraging staff compliance

It is this dirty little secret: Everyone thinks health care providers of all people wash their hands all the time. But it is not so. Indeed, if you are counting "washing" as "washing correctly when you should for the right length of time," then the numbers shrink to sometimes embarrassing levels.

At Northshore Hospital in Manhasset, NY, the vice president of infection prevention, **Donna Armellino**, RN, DNP, CIC, says hand-washing is a challenge — not just to make sure it is done, but to measure how often it is actually happening.

"You can do human observation, but the subjects can see you observing and it modifies their behavior," she says. "Once the observer leaves, that person's hand-washing may return to what it was before anyone was watching."

During observational studies, hand-washing frequency was near 100%. But what was it really? There was a way to find out: to use cameras to capture what happened and when after a provider entered a patient's room.

Using a video monitoring program, Northshore put the cameras in the medical intensive care unit rooms. They were motion-activated to turn on whenever someone walked in the door, and were pointed so as to avoid catching patients.

Remote auditors looked at the video feeds, noting whether a clinical staff member washed his or her hands upon entrance and before exit.

Implementing the program took about a year from the idea to actual filming — there were privacy considerations to think about related to HIPAA compliance, as well as research into the only other facility to make use of the remote auditing program: a surgi-center in Macon, GA, which saw hand-washing rates rise from a dismal 30% to 90% in three weeks.

Once they started the project, they audited 100-150 instances per day. The data are tabulated and sent to a scoreboard in the unit, which includes data from the last 5-30 minutes. If rates fall below a certain level, Armellino gets an email alert. She can check on the per room, per provider, and per unit rates. There are also daily and weekly summary reports.

Staff had some initial concerns, such as whether the information would be used to discuss personal behaviors, or just the aggregate behavior on the unit. "They were worried about being disciplined, but our plan was just to use this for positive reinforcement and aggregate numbers. And once we alleviated their fears about the potential for discipline, they were okay," Armellino says.

Expanding the program

The cameras ran with no feedback for a couple months in June 2008. The rates were less than 15% — largely because the rule was that once providers entered the room, they had to wash their hands within 10 seconds.

Feedback began in October, and when staff understood the 10-second rule, rates climbed.

They have been over 85% since October 2008. When a particular room hits 90% or above, there is a messaging system to give positive reinforcement.

The hospital expanded the taping to the surgical ICU in 2010, with baseline readings at about 30% initially. Rates quickly rose to the 90s and have stayed there since.

Armellino says there are 20 cameras in the medical ICU, and 18 in the surgical unit. They cost about \$50,000 to buy and install. The hospital pays a monthly monitoring fee of “less than \$4,000” per month. “It is worth it because hand hygiene is up and maintained, and if we can’t relate that directly to a reduction in hospital-acquired infection because our cohort is so small, I can say we have seen a decrease in *C. difficile* and MRSA. It is hard to say if it is related, though, or significant since our rates are low to begin with.”

Other uses for cameras

The hospital thinks there are other potential uses for the cameras, but there will never be one for each of the 800 or so beds. That would be intrusive to many and probably just too expensive. Among the issues that might benefit from monitoring are using bedrails and turning and positioning patients — although that would require patient permission. More likely to happen first is a protocol in the operating rooms for end of day and cleaning between cases.

The hospital’s experience was documented in a study published in 2012¹. That led to other hospitals opting into the video system, including the University of California San Francisco Medical Center, which is doing its own study on hand-washing. Other facilities are working on projects that use videotaping to see how providers comply with protective clothing and hand-washing requirements with patients in isolation units.

For more information on this topic contact Donna Armellino, RN, DNP, CIC, Vice President, Infection Prevention, North Shore Health System, Manhasset, NY. Email: dar-melli@nshs.edu.

REFERENCE

1. Amellino D, Hussain E, Schilling ME et al. Using high-technology to enforce low-technology safety measures: the use of third-party remote video auditing and real-time feedback in healthcare. *Clin Infect Dis*. 2012 Jan 1;54(1):1-7 ■

New faces at Joint Commission, NPP

The Joint Commission has hired a former emergency physician to be the medical director for its division of Healthcare Quality Evaluation. In his role, Daniel J. Castillo, MD, MBA, will be the physician voice in the development of standards, survey processes, and performance measures for TJC accreditation and certification programs. He will also liaise with external stakeholders, such as fellow physicians and national organizations.

Most recently an emergency physician at NorthShore University HealthSystem in Evanston, IL, Castillo led physicians in training, nurses and staff in direct patient care activities.

Meanwhile, a former Joint Commission face has been named co-chair for the National Priorities Partnership (NPP) of the National Quality Forum (NQF). Susan Frampton, PhD, president of Planetree, was a member of a Joint Commission expert panel on culturally appropriate care. She has been part of the NPP — a partnership of 52 major national organizations with a shared vision to achieve better health, and a safe, equitable, and value-driven healthcare system — since 2009. She has done committee work for the group on issues of readmissions and patient-centered approaches to care.

She will serve a three-year term. ■

CMS readmission measures stand

The National Quality Forum (NQF) Board of Directors upheld endorsement of three measures addressing planned readmissions, reviewing them after the Centers for Medicare & Medicaid Services (CMS) made changes that impacted the scientific acceptability of the measures. Following further review, the Board of Directors concluded that the measures should remain endorsed.

The measures are:

- 0330: Hospital 30-day all-cause risk-standardized readmission rate following heart failure hospitalization for patients 18 and older (Centers for Medicare & Medicaid Services);
- 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

(Centers for Medicare & Medicaid Services);

- 1551: Hospital-level 30-day all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA) (Centers for Medicare & Medicaid Services). ■

New children's EHR format from AHRQ

Now data from pediatric patients will be more easily mined after the Agency for Healthcare Quality and Research (AHRQ) and Centers for Medicare & Medicaid Services (CMS) announced a new electronic health record (EHR) format specifically for children's health.

Existing EHR systems aren't tailored to capture pediatric-specific information such as whether a child has received specific childhood vaccinations and information about functionality that relates specifically to young patients. The new formatting will let vendors and developers create appropriate modules for pediatrics.

The format includes a minimum set of data elements and applicable data standards that can be used as a blueprint. The elements are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for

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

- Fighting alarm fatigue
- Accreditation field report
- Electronic health records and patient safety
- Hospital readiness for EHR data reporting
- More top safety worries of 2013

CNE QUESTIONS

1. Palliative care doesn't usually address which of these symptoms?
 - A. nausea
 - B. depression
 - C. loss of appetite
 - D. fatigue
2. Which of these isn't mentioned as a kind of wound treated by South Nassau Communities Hospital?
 - A. arterial insufficiency
 - B. radiation burns
 - C. surgical burns
 - D. pressure wounds
3. Kaiser prefers to use which of these orthopedic procedures?
 - A. uncemented joints
 - B. large-size ball and socket joints
 - C. Birmingham resurfacing
 - D. mono-compartmental knee replacements
4. Which of the following isn't currently on the families of measures list for MAP?
 - A. safety
 - B. hospice
 - C. behavioral health
 - D. diabetes

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.

children with special health care needs, and child abuse reporting. The format also includes guidance on structures that permit interoperable exchange of data, including data collected in school-based, primary and inpatient care settings. AHRQ says the format is compatible with other EHR standards and “facilitates quality measurement and improvement through the collection of clinical quality data.”

AHRQ and CMS worked with the American Academy of Pediatrics and the American Academy of Family Physicians to create the format, which is built on specifications from sources that include the Health Level Seven International EHR-S Functional Model, the HL7 Child Health Work Group’s Child Health Functional Profile, and the HHS Health Resources and Services Administration’s Health IT for Children Toolbox.

Next steps include testing by two CHIPRA quality demonstration grantees, the Commonwealth of Pennsylvania and the State of North Carolina. CMS will also work toward integration of the format into future editions of the Office of the National Coordinator for Health Information Technology’s EHR Standards and Certification Criteria.

Further information is available at <http://healthit.ahrq.gov/childehrformat>. ■

CNE INSTRUCTIONS

CNE INSTRUCTIONS

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

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

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