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IN THIS ISSUE

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AHC Media

CMS pilots quality improvement, discharge planning surveys

New tools created to go with infection control survey

The Centers for Medicare & Medicaid Services (CMS) has started pilot testing of two more survey tools to go with the infection control pilot it began testing last year. The new tools are for hospital activities related to quality assessment and performance improvement (QAPI) and discharge planning and are already being used by state survey agencies, according to a CMS spokesperson who asked to remain anonymous.

The spokesperson says that they will be used separately during the pilot phase and that CMS is seeking feedback from surveyors and hospitals about the worksheets under consideration. Which hospitals are chosen for the pilot tests is, itself, being tested, says the spokesperson. CMS will look at readmissions data and use the knowledge of hospitals accrued by the state surveyors in past surveys. So a hospital that has higher risk-adjusted, all-cause readmission rates, or a hospital that a surveyor has found issues with previously is more likely to encounter the pilot test. Hospitals that don't meet the criteria of the tools won't be cited during the pilot phase.

Testing is due to be completed in a few months, and then revisions to the tools will be incorporated. The spokesperson says there is no word on when a final tool will be ready for surveyors. The infection control tool, in use for more than a year, has already had some tweaks due to comments from users, but there is no word on when it will be put into use officially, either. It has been praised by infection control professionals.

The new tools still need some work, though. "There is no instruction manual that goes with the tools," says **Patrice Spath**, RHIT, consulting editor for *HPR* and a quality consultant at Brown-Spath & Associates in Forest Grove, OR. "So a lot of the questions asked are very subjective. There is nothing here that defines the terms." For example, in the discharge planning tool, question 4.2 asks: Can hospital staff demonstrate that the hospital's criteria and screening process for a discharge planning evaluation were correctly applied? "But is that verbal demonstration?

Written in the record? They don't tell you, and your assumption of what qualifies as 'demonstrate' may be different from the surveyor's."

Another discharge planning question Spath thinks needs clarification is 4.6, related to evaluating the post-discharge needs of the patient in the environment from which the patient was admitted to the hospital. "Not all patients go from the hospital back to the place they came from," she says. "You might have a patient admitted from home, but going to a skilled nursing facility. Why would you need a home assessment then?"

In general, Spath says that many of the questions are similar to what you would expect from Joint Commission surveys, so incorporating these pilot tools into your current tracers could help you determine if you are meeting both Joint Commission and CMS requirements. But beware that things will change in the pilot tools. "Use this as a guidepost," she says. "It could be useful to understanding the CMS requirements and knowing what may be a focus in a survey. These are the things that will probably have a high priority when a surveyor comes."

In the QAPI survey, Spath says many of the questions have a "flavor" similar to Meaningful Use Stage 1 requirements, and she wonders if the Government Accountability Office will incorporate those questions into the audits they do for Meaningful Use. For example, question 3.1: Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital-specific evidence, peer-reviewed research, etc.). "I could say yes to that, but will anyone be showing up to check on that?"

She also thinks that some of the questions are difficult to interpret, and that some organizations could be cited, even accused of fraud, simply because the questions are difficult to understand. "I may think I'm doing something, I may think that I meet the requirements related to following specific data specifications, but am simply unclear on what the question really means." This is, of course, why a pilot survey is done, and Spath thinks that comments on confusing areas will be helpful to CMS.

At the very least, look at the surveys, she says. Follow the news as the pilot progresses and changes are made to the tools. They can be a useful way to know how you are doing and to ascertain the areas that are of interest to CMS and the state surveyors.

All three of the CMS surveys are available at: http://ow.ly/hJt1C.

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Alarm management gets renewed focus

NPSG for 2014; are you ready?

More than 1,000 alarms per patient per stay. That's what one unit at Johns Hopkins Hospital in Baltimore estimated nurses heard. It made for a noisy environment and one that was ripe for providers to become inured to the sound, potentially ignoring vital alarms because so many of them were false. Improving that kind of environment is exactly what The Joint Commission had in mind when the organization announced that alarm management would be a National Patient Safety Goal starting in January 2014.

Comments on proposed standards were still coming in at press time, and **Anita Guintoli**, RN, BSN, MJ, associate director of the office of quality monitoring at The Joint Commission says she can't quantify or qualify the comments received until they have been analyzed.

The rationale for making this a focus is the proliferation of equipment and monitors in the past decade or so, says **Patricia Adamski**, RN, MS, MBA, FACHE, TJC's director of standards interpretation for the division of healthcare improvement. "Vendors have added alarms to enhance value, but now there are so many that it's difficult to prioritize them or even determine which alarm goes to what," Adamski notes. "How do you know which to respond to first? Which is most critical and what is more of a nuisance that just needs to have a button pushed?"

A little under two years ago, TJC held a summit with the Association for the Advancement of Medical Instrumentation, the Food and Drug Administration (FDA) and ECRI. The group came up with a to-do list that was used in creating the proposed standards. *(See the proposal at http://www.jointcommission.org/assets/1/6/Field_Review_NPSG_Alarms_20130109.pdf and list of resources related to alarm management in the box on page 40.)*

Elements of the proposed standards include creating an inventory of alarms and their default settings, figuring out which ones are vital, which have parameters that can be changed, and which can be disabled completely. Hospitals will likely have to determine whether existing alarms are calibrated properly, who is allowed to change parameters, and whether the alarms can be heard and distinguished from the other ambient sound. They will have to educate staff about the policies and procedures related to alarms.

Quieting the noise

With the thousands of alarms that go off on a unit in a given day, it's no wonder that many front line staff start to ignore them. Indeed, some surveys have suggested that nurses believe the vast majority of alarms are nuisance alarms that don't require any attention other than to turn them off[1]. In 2006, **Maria Cvach**, MSN, CCRN, assistant director of nursing clinical standards at Johns Hopkins Hospital worked with an interdisciplinary team to address alarm fatigue. It included IT, nursing, physicians, and respiratory therapists. "Anyone with a vested interest in alarms had to be a part of it," she says.

The first couple years were spent quantifying the problem. "We had to analyze the data from a bunch of different devices that don't talk to each other, at least not yet." So the data related to alarm is something you have to create, she says. "You can get raw numbers that says how many of what kind of alarm per day. But we want to know how they are sorted. How many are related to high or low heart rate, how many are VTAC."

In the end, they had to get biomedical engineers to help retrieve and analyze the data they wanted and even installed a real-time surveillance system that integrated the data from all the devices at the bedside — cardiac, ventilator, and other monitors. Vendors were also helpful in retrieving data and understanding the alarm systems. Initially, there were more than two dozen data points Cvach looked at before cutting it down to six, including bed number, why the alarm sounded, its duration, and the kind of sound it made.

Cvach says they finally extracted data on alarms per bed day and how many of them were false. The numbers were staggering. One 12-day alarm system analysis registered 58,764 alarms, an average of 350 per patient per day. That rate was doubled on the noisiest unit. The pediatric intensive care unit (PICU) experienced 20,158 audible alarms in eight days for 17 beds, and analysis revealed a 90% false-positive rate among alarms for apnea in that unit.

Before making any changes, the team determined which were the most important alarms, and what proper parameters were for them going off. They made sure there were backup systems in place for the most critical alarms. Then they started doing rapid cycle testing of changes. Among the things they tried were sending pages and texts to provider cell phones when a critical alarm went off, changing electrodes for certain monitors daily, and altering default parameters. "None of the changes we made were earth-shattering," she says. "They were modest."

For instance, there were a lot of false alarms related to a VT greater than 2. "We had a VTAC alarm, so why did we even need two?" There are some 200 parameters for most cardiac alarms, and Cvach worked with the monitor company to make alterations. Some alarms were changed from audible to messages. Other non-critical alarms were altered so that they waited to sound for a minute to see if the condition persisted or if it was related to a patient moving — rolling over, getting up to brush her teeth. Staff were educated, and the committee found a champion on every unit who knew about the alarms, their purpose, and parameters and could act as a guide to other staff.

Reductions were 24%-75% depending on the unit. "If you start with 771 alarms per day and you cut that by half, staff will notice," she says. Along with the reduction in alarms, Cvach says there was a reduction in the duration of time they sounded because when they did, nurses knew it wasn't as likely to be false and so they acted quickly.

While they haven't researched the relationship between outcomes and alarm changes, it is something Cvach is interested in. "We are trying to get funding for a multi-site randomized controlled study on that," she says. Meanwhile, from a look at the cardiac arrest and rapid response team data, she doesn't think there has been any negative correlation between alarm changes and outcomes.

The dream of the future

Cvach says she dreams of a day when alarms don't sound because nurses and other frontline staff have information on trends for patient vitals that can predict future problems. While that may be a while away, there are trials under way to create devices that are better at talking to each other and can ascertain whether a particular metric points to a patient crisis or, when taken in conjunction with other metrics, is just a blip that doesn't merit attention.

Ross Koppel, PhD, FACMI, a professor at the University of Pennsylvania School of Medicine, is working on just such a project at the university's hospitals as part of a multi-hospital project funded by the National Science Foundation. They are two years into a four-year project that is supposed to create a smart alarm. "If a nurse on a typical shift hears up to 1,800 alarms, how many of them are real? If you have an upper limit parameter of 130 for blood pressure, someone in pain just after surgery may have 135, but that's not a problem. So the nurse just hits the three minute silence button over and over during a 12-hour shift."

Or the blood pressure could be fine, the oxygen saturation looks good, and respiration is great. But the patient rolled over and the cardiac lead fell off, so there is no heartbeat. "There's a good indication that the patient is fine, and a good, experienced nurse will realize that and give it lower priority. But the alarm will still ring. But if you had alarms that talked to each other, no alarm would sound," Koppel says. "We are trying to create that kind of intuitive alarm that looks at data in combination so that there are fewer alarms that are more meaningful when they sound."

Right now, creating that kind of system that talks to each other is a time-consuming feat for IT staff, who are creating dongles to link systems

Further resources on alarm management

- Association for the Advancement of Medical Technology: http://www.aami.org/meetings/summits/alarms.html
- ECRI top 10 Hazards: https://www.ecri.org/Forms/Pages/ECRI-Institute-2013-Top-10-Hazards.aspx
- The Johns Hopkins project: http://ajcc.aacnjournals.org/content/19/1/28.full.pdf+html?sid=353507c8-bbc5-418a-9a0a-35677c0b836a
- Johns Hopkins white paper: http://www.hopkinsmedicine.org/dev/_test_ben/The%20Johns%20Hopkins%20Hospital-Using%20Data%20to%20Drive%20Alarm%20Improvement%20Efforts%202012.pdf

together. "There is no coherent protocol that allows devices to talk to each other," he says. But they are working to create programs — some may even work on cell phones — that will process all the data. The key is to create something that isn't overly restricting the alarms. "You can't err on the side of a program not sending a critical alarm." The IT wizards are also working on a program to analyze the vast quantities of information that comes out of a neuro-ICU unit to predict cerebral events, and what combination of data could predict sepsis.

Like Cvach, the IT guys are realizing that there are a ton of monitors with a ton of information. "There are up to 117 devices in a typical ICU, and it's insane that they don't talk to each other," Koppel says. Further, vendors aren't always helpful in providing the proprietary code necessary to extract the data.

Getting to the part where they test some new alarm program will take more time, he adds. Meanwhile, there are steps you can take to reduce the burden. "Demand from your vendors that any device you use gives you data that is accessible not just through the vendor server. Ask for a common data protocol that will enable your own people to use data from devices connected to their patients. No one should have to spend time building dongles."

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10 steps to the ideal transition

No one does it all, but everyone should try

Everyone has a great idea for reducing readmissions and improving transitions of care. The literature is full of it. But just what would the dream discharge look like? How could you get a patient from the hospital to the next phase of care in the best way possible? **Robert Burke**, MD, a hospitalist at Denver VA Medical Center, and a group of his peers looked at the literature to see what the best possible transition would look like. They published their results in the February 2013 issue of the *Journal of Hospital Medicine*[1].

There are 10 domains that they found were part of the "bridge" between places of care. They are:

- discharge planning;
- complete communication of information;
- availability, timeliness, clarity and organization of information;
- medication safety;
- educating patients to promote self-management;
- enlisting the help of social and community supports;
- advance care planning;
- coordinating care among team members;
- monitoring and managing symptoms after discharge;
- outpatient follow up.

Most of these steps should take place while the patient is still in the hospital, and in places where they have, there is evidence they work. In his article, Burke has recommendations of where to start — such as with the Project RED program of re-engineered discharges that came out of Boston University Medical Center. His hope, though, is that someone will get a grant to do a trial of all of these things together.

"Everything here came from things that have worked in some way for others," he says. "But a lot of what has been written about hasn't worked to reduce readmissions in a meaningful way. I guess we really don't know why they are happening in many cases. I would hope that this would move the field forward."

No hospital has implemented more than seven of the domains — three hospitals reached

that level — and they are the most effective at reducing readmissions, says Burke. But there are issues which are unique to every hospital, and Burke wonders if there is really something called an ideal discharge that would work for every facility. "Some hospitals have more issues with primary care access — something that isn't an issue with the VA, where more than 80% of our patients have primary care providers. So one size won't fit all."

That said, this is a place to start, and each of these domains has proved effective — and cost effective — in a real world situation. "You can use this as a diagnostic tool and see which of these categories cause you the most trouble. Then you can work on them."

The best programs provide others with tools, information, and even training, Burke says. Project RED has a toolkit available (http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html), and Eric Coleman's Care Transitions Intervention provides a wealth of information on its website (http://www.caretransitions.org/), including free webinars.

Burke thinks that hospitalists in particular will play a big role in improving care transitions and discharges, possibly by working more outside the hospital in the post-discharge world. "Hospitalists often think their responsibility ends at discharge, but I think there is value in extending it a week or two beyond that," he says. "It's very valuable to have someone who knows about the inpatient experience be part of the outpatient care. It's better for continuity of care, and also for patient education. The hospital isn't a conducive environment to learning for a sick patient." Having hospitalists attend a post-discharge clinic and/or be at the first appointment with the primary care physician could be valuable, he says. "Patients can be confused about who their doctor is after they get out of the hospital. That joint appointment could help."

Granted, there are issues of payment and even the desire of inpatient specialists to move into the outpatient world, even temporarily. In a survey of hospitalists that Burke did on the topic, about half were willing to participate in an outpatient appointment, and most said they wanted to be paid for participation. But nearly all think that it would be a good thing for patients and have faith it would improve outcomes.

Beth Israel Deaconess in Boston has a program like this, Burke says. It's a money loser for the hospital, but it could be that when you take reduced readmissions into account, it has a positive financial impact. It will help that this fall the Centers for Medicare & Medicaid Services will start providing augmented reimbursement for the first post-discharge doctor visit. That might encourage more hospitals to create some sort of bridge program for patients.

None of the 10 domains is a panacea, particularly not individually. But Burke says they offer organizations a place to start.

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What makes a top hospital?

And why aren't there any from some states?

For the last three years, McKay-Dee Hospital — a 325-licensed-bed teaching hospital in Ogden, UT — has made the cut for *Modern Healthcare*'s 100 Top Hospitals. This year, they were named an Everest Award Winner, too, which is a status reserved for hospitals that have not only topped the metrics used for the list, but have had the fastest improvement. Seventeen of the hospitals were named Everest winners.

The 100 Top Hospitals list relies on metrics including mortality, 30-day readmission rates, complications, average length of stay, average cost per stay, and profit margins.

So what is it that makes a hospital that makes the list? Part of it is exceptional leadership, says **Scott Saxton**, the facility's continuous improvement director. "I've been here for just under a year and have worked for many

different industries, including mining and engineering. What I know is that companies that have the best leadership, who are passionate about driving the right things, are the ones that make these lists." At McKay-Dee, and its parent Intermountain Healthcare, those drivers are patient-centered everything. "From the first day anyone is hired, what you hear about is how everything we do is for the benefit of the patient."

Employees are schooled on the six dimensions of care: clinical excellence, service excellence, physician engagement, operational effectiveness, employee engagement, and community stewardship. And the excellent care? Well, the focus is on evidence-based practices, with a demand that everyone implements them the same way throughout the organization.

There is also a sense that every team member, from the custodial staff to the loftiest physician, has the potential to contribute a great idea that makes a difference to the patients and the organization. There are idea cards they can fill out, and last year, more than 4,000 were filled out. But more than just submitting an idea, employees know that the ideas will be considered. Each one is followed up on, and in a timely manner, Saxton says. "If you don't respond to ideas, why would anyone submit one?"

There are also team huddles every day. McKay-Dee uses these to give staff performance information that many hospitals opt not to share. But giving that data gives them a sense of ownership, Saxton says, which feeds the idea machine as they strive to do better. "Front-line staff always have the best ideas. And if they don't know where they are, continuously and in real time if possible, how do they know what they should be thinking about to improve?"

Not every hospital has the kind of high-level support for every-level inclusion, he says. In that case, start at the unit level where you have a charismatic champion who can inspire staff. Find a project that can prove this kind of engaged leadership can work. "Word travels and people get excited about success."

Next up at McKay-Dee is leadership training designed to improve employee engagement even further. Based on Lean management theory, Saxton says they are providing managers, directors, and other leaders with new tools to help them problem solve, determine bottlenecks and obstacles, and then how to clear them. The training talks a lot about the natural flows of a hospital — like patient flow, provider flow, medication and information flow. Each of them is independent, but also dependent on each other. Showing leaders how to figure out where there are blockages should improve efficiency, work environment, and quality of care alike. "We want to figure out where the waste is — motion, over-processing, over-inspection — and get rid of it."

Winning the Everest Award for rapid improvement this year was great, but Saxton says they still have more to do, and they don't do it to make a list, but rather to take better care of patients.

Why not your hospital?

There are some who criticize lists like the 100 Top Hospitals because they don't include some metrics and do include others. For example, looking for a profitable hospital might exclude one that has taken some write down for some obscure tax reason. The lack of profitable status keeps them from the list regardless of how well they do on metrics related to patient care.

There wasn't a single hospital from the Pacific Northwest on the list, despite the region having some pioneers of quality improvement like Virginia Mason in Seattle, which pioneered the Toyota Management model in healthcare. In Portland, Oregon Health Sciences University Hospital also didn't make the cut. But it's not something that bothers chief medical officer **Charles Kilo**, MD.

"The desire for transparency in healthcare is important," he says. "Consumers have the right to make informed choices and having access to reliable data is necessary to help them — we are very supportive of this with public reporting being an important component."

But there are problems with this kind of public reporting, he says. Several studies show that the data used for some of these lists can be unreliable or inaccurate. That's not to say that the data used for the 100 Top Hospitals list is inaccurate, but some data used for some reporting is. "There are no standards for the data that is publicly reported, and some of the reporting agencies won't reveal their methods."

That's why you sometimes get one organization touting a hospital that another organization ignores and why really great facilities with

stellar programs don't get this or that award.

Kilo continues: "In addition, the data used in many of the ratings is quite old, sometimes several years old and therefore may well not reflect the current performance of a physician, clinic or health system. While individuals deserve information for decision making, inaccurate data simply doesn't help — in fact, it can understandably build resistance among well-intended healthcare providers."

He wants data available, but he'd like to see some basis for understanding the age, provenance, and validity of the data. Right now, his organization is working with the American Academy of Medical Colleges (AAMC) on the standards for publicly reported data. "Our goal is to make healthcare more transparent while making sure the public receives data it can rely on. Building trust with both the public and with healthcare providers is essential as we move in this direction."

Modern Healthcare did not respond to a request for an interview about this year's list and its creation.

For more information on this topic, contact:

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Hitting the high (reliability) notes

Eisenberg winner goes for all or nothing

For the last 10 years, Memorial Hermann Hospital in Houston has been on a journey to make the only two scores that matter 100 and zero. They want 100% compliance on positive metrics and zero on things related to patient harm. They have aimed to become a high-reliability organization with the kind of safety profile usually related to nuclear power and airline operation.

The success of that journey won the hospital an Eisenberg Award from the National Quality Forum and The Joint Commission last month.

There was a blip in 2006, when a series of mismatched transfusions plagued the system's hospitals. Around that time, **M. Michael Shabot**, MD, was named system chief medical officer. He arrived just in time for a huge culture change signaled by high-reliability safety training for every single one of the systems' 20,000+ employees.

"The usual quality and safety initiatives weren't sufficient and weren't going to be," he says. "So we had a revolution."

Training for simple behaviors

The training was done by pilots from commercial and naval aviation, engineers from the nuclear industry, and other experts. It was done off site and no one was excluded. Even physicians are required to undergo a specialized form of the training at three of the campuses if they want membership in the medical staff. Interns, residents, and all medical school students are required to undergo it. Other campuses make it voluntary for their physicians, but the whole system will phase in, making it mandatory over time.

"We train for simple behaviors using the STAR system: stop, think, act, review," he says. Taking a one-second pause, even in an emergency, can make a huge difference. Indeed, they celebrate the hundreds of instances when that one-second stop has kept harm from a patient. One that they like to cite involves a neonatal nurse. She received an order through the computerized physician order entry system. The pharmacy checked it and dispensed it into the Pyxis unit. It was properly removed by the nurse. The drug has adult and neonatal concentrations, and while the proper prescription was made, and the drug was labeled as a neonatal dose, the nurse still took her one-second stop. She looked at the vial and noted that the neonatal package contained the adult strength drug. Her one-second stop certainly prevented harm to the baby, and possibly averted a tragic death.

"We love, we honor, we cherish near misses and the stories behind them," says Shabot. "And we teach employees to speak up. We call them the CUSS words." C stands for "I am concerned." U is "I am uncomfortable doing this, doctor." The first S is to stand up and the second is to stand together.

The words they teach employees are used only in those contexts and are so unusual that

they make people stand up and take note. In 2007, the system introduced new central line bundles. One physician in a hurry wanted to proceed without using the bundle. But the nurse said those words: "I am concerned" and refused to proceed. The physician was in a huff and demanded they go on. The nurse manager came in and said no. And then, eventually, the chief nursing officer came in and, standing together with the front-line staff, refused to continue unless the bundle was used. "That only happened once. Every single doc heard that story."

Another instance involved a sponge that a nurse was sure was still in the patient. A huffy surgeon insisted he never left sponges in patients, that the nurse must have miscounted, and he wanted to close the patient. Two nurses, both barely five feet tall, stood up to the surgeon and removed the instruments so that the patient couldn't be closed. They insisted on an X-ray, which discovered the sponge, still in the patient.

Spreading the word

The grapevine is one way to get the word out, but they also use internal messaging and newsletters to spread the word about events like that. The nurse who saved the baby? She went to Washington, DC, to help accept a safety award the system received. She was brought to a board meeting. She was celebrated.

Since the start of 2007, with more than 763,000 blood transfusions, there hasn't been a single mismatch. "We don't intend to ever have one again, either," says Shabot. There are still close calls, though, and the board has authorized a new barcoding procedure that will require patients to have separate wrist bands for blood products, with all type and cross happening at the bedside rather than the nurse's station. "It will augment a system that is already working, but where we still catch potential errors."

Shabot says any organization can change its goals so that they are zero for harm and 100% for the good stuff. "If you have a goal short of that, you are only going to achieve incremental improvement." To get to zero (or 100), you need to do things very differently, and having a goal of "better than 90%" won't encourage you to take the leap or consider drastic changes.

Memorial Hermann doesn't always achieve zero or 100, but it's always the goal. "Our most commonly reported number for every safety indicator, hospital-acquired infection and hospital-acquired condition is zero." They give internal recognition to hospitals that go 12 months or longer without a patient safety event, hospital infection or hospital condition. There are about two dozen such conditions — not including air emboli and transfusion reactions because they are viewed as extinct. "So far, we've given 91 of those awards."

For that goal, he admits he's looking to hit a number well beyond 100.

For more information on this topic, contact M. Michael Shabot, MD, System Chief Medical Officer, Memorial Hermann Hospital, Houston, TX. Telephone: (713) 242-2713. ■

TJC certifies primary care medical homes

Aim is to smooth transitions

Hospitals that have physician offices connected to and affiliated with them now have another option for getting certified for a Primary Care Medical Home. Along with programs run by the National Committee for Quality Assurance (NCQA), The Joint Commission started offering such certification in late February.

Based on the Agency for Healthcare Research and Quality model, the certification focuses on patient-centered care, care coordination, superb access to care, and a systems-based approach to quality and safety, says **Mark Pelletier**, RN, MS, interim chief operating officer and director of accreditation and certification services at TJC. "We built our standards on those definitions, and they require that an organization supply timely, evidence-based treatment. This will result in higher patient satisfaction, improved outcomes, and also reduced costs."

There are some additional standards included in the TJC program that others do not have, and Pelletier emphasizes that they require a site visit, not a desk review of policies and procedures. For hospitals getting such certification, it will add at least an extra day to the general survey process. "I think our scope of accountability is broader than what's out there, and we

add requirements for oral health and end-of-life care." The TJC model also includes standards related to health care literacy for patients, as well as proof of competency of the primary care clinician and care team. "It has to be an interdisciplinary team working in the primary care medical home," he explains.

While the physician offices will handle the bulk of the preparation for the primary care medical home survey, there will be some impact on hospital-based quality managers. "You won't be leading the charge, but you will probably be called on to assist with preparation."

Keeping patients in the community

Despite the fact it might cause you some extra work, Pelletier thinks this is something that all appropriate hospitals should consider. "This is what is expected from the government after healthcare reform. We have to improve outcomes and make healthcare more efficient. This will help with that. And the good thing is that when you do that, you will have fewer readmissions, which will be an increasing financial burden for hospitals that don't address them."

Take typical congestive heart failure patients, who are the most likely type of patient to come back to the hospital because they can't get in to see a primary care physician in a timely manner. Having that medical home connected to the hospital will help to smooth that transition and make it easier for patients leaving the hospital to see their doctors quickly.

Keeping patients out of the hospital and in the community is the idea behind medical homes, and while it might seem strange to think of a hospital trying to keep customers away, that's the right thing to do and increasingly, the thing that will help hospitals financially.

"I think this is the best thing for patients, and that should make it exciting. Look at the return on investment. If you invest in that primary care medical home model, you can accomplish savings to the organization as a whole."

The standards for certification as a primary care medical home are available at http://www.jointcommission.org/accreditation/primary_care_medical_home_certification_option_for_hospitals.aspx.

For more information, contact: Mark Pelletier, RN, MS, Chief Operating Officer, Joint Commission, Oakbrook Terrace, IL. Email: mpelletier@jointcommission.org ■

South Carolina hospitals collaborate on safety

Working with TJC to improve systems

The Joint Commission's Center for Transforming Healthcare has started working with 20 hospitals in South Carolina to improve their safety by examining systems, processes, and structures in an effort to minimize variability in practices.

Focusing on elements perfected by high-reliability industries, the hospitals will meet regularly to create projects, do survey assessments about their organizations, and come up with ways to improve what they do so that harm is reduced, quality is improved, and costs decrease. They will use a Web-based application to figure out which practices to focus on and assess how they are doing in those vital areas.

"Eventually, we hope this will include all the members of the South Carolina Hospital Association," says **Colleen Smith**, RN, MBA, CPHQ, director of high reliability initiatives at the Joint Commission Center for Transforming Healthcare. "The other hospitals will be pulled in as the work moves forward," she says.

What is different about this collaboration is that it isn't a single project. "There is no end point," says Smith. While the commission will stop working with the group in three years, the aim is for life as South Carolina hospitals know it to change forever with this collaboration. Once they start, they don't stop.

"The work of high reliability is forever," she says. The initiative came from South Carolina to The Joint Commission, in part because of personal relationships between leaders at TJC and the hospital association. It's possible that in the future, success in South Carolina might breed other such efforts in other states.

Over the summer, and regularly after that, the collaboration will update watchers with news of its efforts and the results they achieve. Tools they use may also be made available to the wider public.

For more information on this topic, contact Colleen Smith, RN, MBA, CPHQ, Director, High Reliability Initiatives, Joint Commission Center for Transforming Healthcare, Oakbrook Terrace, IL. Email: csmith@jointcommission.org ■

'Liking' you for the right reasons

Study shows link between social media, quality

Most hospitals probably have a Facebook page and Twitter feed by now. But does how many people "like" you or "follow" you matter? Maybe. According to a study published last month in the *American Journal of Medical Quality*, hospitals with better quality scores also have more "likes" on their Facebook pages.

Lead author **Alex Timian**, now an investigator with the Mintz Group in New York City, did the work with his colleagues last year at HITLAB, which does research related to health information technology. Timian says they wanted to see whether there was any correlation between a consumer's choice to "like" a page and more traditional metrics for that hospital's quality and patient satisfaction.

"Through our exploratory study we learned that Facebook 'likes' had a strong negative association with 30-day mortality rates," he says. For every 93 additional Facebook "likes," there is a corresponding 1 percentage point decrease in 30-day mortality. The number of "likes" was also positively associated with patient recommendation, although not as strongly as with 30-day mortality.

He says that with more research, you could get a sense from social media about quality and patient satisfaction. But for now, there is just a correlation evident. What it stems from and what it means isn't yet known.

Timian says his work, as well as other work including a paper published in March by Altman et al in the *Journal of the American Medical Informatics Association*, is a good starting point for people interested in the relationship between social media and healthcare. "Think about ways that your organizations can mine social media for feedback from their patients and community members, to help identify areas where they are doing well or that

COMING IN FUTURE MONTHS

- 10 best safety practices
- Accreditation field report
- Electronic health records and patient safety
- Preparing for caring in emergencies

CNE QUESTIONS

1. How will hospitals be chosen for testing the new CMS pilot surveys?
   a. By lottery
   b. CMS is asking for volunteers
   c. based on readmission rates
   d. Computerized random selection

2. The typical neuro ICU can have up to how many devices attached to the patient?
   a. 117
   b. 1800
   c. 771
   d. 75

3. How many hospitals have implemented seven of the 10 domains identified by Robert Burke, MD, and colleagues?
   a. none
   b. three
   c. seven
   d. ten

4. OHSU is working with what organization to create standards for publicly reported data?
   a. AMA
   b. AAMC
   c. AHA
   d. ANA

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.

they need to address," he says. "This study is just a first step in attempting to validate social media data so that we can better understand what it tells us about care delivery and patient experience. It would be ideal for quality and safety managers to build on this."

If you aren't involved in social media, get on that. It's here to stay, he says, and is an integral part of how patients seek information and communicate with others about their experiences. "We, as public health researchers, are embracing the exploration of these tools for research into care quality and patient satisfaction. In the same vein, we see significant momentum for hospitals and other facilities to embrace social media both for engaging with and listening to their patient communities."

REFERENCE

1. Timian A, Rupcic S, Kachnowski S, Luisi P. Do patients "like" good care? Measuring hospital quality via Facebook. *Am J Med Qual* 2013 Feb 1.

For more information about this topic, contact: Alex Timian, investigator, Mintz Group, New York, NY. Telephone: (212) 489-7100. ■

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. ■