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AHC Media

What do you do when evidence changes?

Process measures may provide better proof of VTE care

There has been a lot of talk about the importance of shifting away from process measures to determine quality of care and making more use of outcomes measures. The argument goes like this: Ticking a box to indicate you did something is all well and good, but whether the patient does better because you have done whatever that checklist asked you to do could be a better determinant of quality care.

That premise may not always hold up. A recent study strongly indicates that the commonly used measures for determining if a hospital is providing good care for surgical patients to prevent venous thromboembolism (VTE) may not show that at all. Indeed, the measure in question may not only give a false sense of quality, but as value-based purchasing (VBP) becomes a reality, it could financially hurt the hospitals that are providing better care.

The study[1] examined whether reporting of VTE rates is really a good way of showing which hospitals are doing the best to prevent it. Data from nearly 3,000 hospitals and close to a million surgical patients was used. The researchers looked at VTE event rates, VTE prophylaxis rates, whether a hospital was considered a quality facility (based on accreditations, size, and quality initiatives undertaken), and the relationships between these metrics.

Not surprisingly, providers who did more imaging studies on patients to find VTE found more events, and the hospitals that did more imaging and found more events scored higher on the quality metrics used by the study authors. Paradoxically, the increased number of events makes them look worse than other providers and hospitals that don't look as often for such events. More surprising was a correlation between increased use of VTE prophylaxis and increased VTE rates. One might expect that trying to prevent VTE would result in a decline in events. And it wasn't hospitals that might have quality problems that had this strange correlation evident: Researchers found a positive correlation between hospitals that had higher quality scores and higher prophylaxis rates with higher VTE rates.

The authors note that this isn't the first time a study has found that there isn't a relationship between more prophylaxis and surveillance and lower reported VTE rates. They note that this evident surveillance bias calls into question the use of VTE event rates as a way of measuring quality — something currently done by several organizations that create lists of top hospitals, such as the University Health Consortium (UHC) and the American

College of Surgeons (ACS). VBP will make use of VTE rates to determine cuts in reimbursement from the Centers for Medicare & Medicaid Services (for low performers) beginning January 2015. Currently, CMS collects that data for the Hospital Compare program, but it is only reported in supplementary material.

Beyond the potential loss of reimbursement, hospitals that are doing exactly the right thing may see the public avoid those facilities because the VTE rates look bad compared to other hospitals. The authors also worry that providers may shift their behavior — do fewer studies, use chemoprophylaxis on patients who aren't at high risk for VTE and thus increase the potential for dangerous bleeding, or using inferior vena cava (IVC) filters when they aren't needed.

Back to the drawing board?

"Clearly VTE is important," says lead author **Karl Bilimoria**, MD, MS, a surgeon at Northwestern Hospital in Chicago and assistant professor in surgery at the Center for Healthcare Studies in the Feinberg School of Medicine at Northwestern University. "But the outcome measure may not indicate quality of care. It might indicate the inverse — that those who look more because they are vigilant find more events and may then be penalized" because more VTE means lower quality of care, according to some organizations.

Bilimoria says that if you can't get an outcome measure to adequately and validly determine quality, then it's probably best to take another look at process measures. "The problem with that is that what we do currently in process measures around VTE is also inadequate," he says. "We only look at the 24 hours around a surgery, for instance. The process measures we have, though, could be expanded to be more comprehensive and thus give us a more accurate measure of quality of care related to VTEs."

The authors thought there might be some surveillance bias, but Bilimoria says the magnitude of it wasn't anticipated. The variations in use of imaging among hospitals were also a bit of a shock.

Bilimoria may be sure that this is the wrong way to measure VTE care, but he is also adamant that you can't stop caring about it or looking at metrics that can help get a handle on it. He suggests expanding the time you look at these issues from the 24 hours around surgery to the entire post-operative period. Whether the patient gets up and starts walking, and mechanical and chemo-prophylaxis used — even into the discharge period for the latter — may give you a better sense of if you are doing the right thing.

For now, the measure is something required by many parties, so collecting that data will continue, but consider the findings of this study when you look at them, Bilimoria says, and be aware of the

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potential for unintended consequences, particularly those that might cause harm, such as chemo-prophylaxis on patients that don't really need it.

The authors of the study are working to build a "more robust" process measure that will tell stakeholders more about the quality of care a provider or facility gives around VTE. "Some people will probably think we should use an outcome measure, but for now, we don't have one that works."

Next steps

Elements of VTE care have been on the radar of the National Quality Forum (NQF) since 2006. (See a report on measures included at http://www.qualityforum.org/Publications/2008/10/National_Voluntary_Consensus_Standards_for_Prevention_and_Care_of_Venous_Thromboembolism__Additional_Performance_Measures.aspx.)

NQF endorsed three of the related measures in 2012 as patient safety measures related to reducing complications — 0372: Intensive Care Unit Venous Thromboembolism Prophylaxis (Joint Commission), 0373: Venous Thromboembolism Patients with Anticoagulant Overlap Therapy (Joint Commission), 0450: Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12) (AHRQ).

Now that there is some evidence that they may not be appropriate, what happens? **Erin Reese**, the public outreach coordinator at NQF, says that there is an established ad hoc review process through which any party can request that a measure be reviewed, as long as there is "adequate evidence" to justify it. To meet those criteria, the evidence supporting the measure has to have changed, its implementation has to have led to unintended consequences, or there have to have been material changes made to the measure.

Reese says "very few measures undergo the ad hoc process. That said, the [VTE rate measure] seems to fit the criteria."

The Joint Commission's measures related to VTE are more process related — whether a patient has had prophylactic treatment for VTE — says **Daniel Castillo**, MD, MBA, medical director at the division of healthcare quality evaluation at the commission.

"Outcomes measures is a young science," he says, while process measures used by The Joint Commission for its reporting requirements are all based on science and results that have stood the test of time.

"This is a really strong, very good study," Castillo says of Bilimoria's findings. "It's interesting given the push for more outcomes measures, but we really should be careful to make sure that we limit the possibility of unintended consequences."

Castillo's advice to an organization is to make sure you aren't encouraging providers to "practice to a measure." Don't change what you do now — a requirement is still a requirement, even if new information makes it look of dubious use. Instead, look to other measures to determine if you are providing quality care, says Castillo. Ask your providers what they think makes a difference, and make sure you are looking at those metrics.

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What does the 2014 IPPS have in store for you?

Two-midnight rule stirs controversy

Have you read the final rule for the Centers for Medicare & Medicaid Services (CMS) 2014 Inpatient Prospective Payment System (IPPS) yet? Even if the thought of plowing through 2,200 pages of *Federal Register* documents makes you queasy, it's something quality managers must do, according to **Deborah K. Hale**, CCS, CCDS, president and CEO of Shawnee, OK-based healthcare consulting firm Administrative Consultant Services.

Within the pages is what Hale calls "a paradigm

shift" in rules related to admission that will require providers to think very differently from how they have in the past. "CMS talks about how the decision to admit is a very complex medical judgment that only a doctor can make, but in the next breath, they talk about the need for a case manager to be available for consultation at all times," she says.

The first thing is for you to read and understand the rule, says Hale, and then to open up a line of communication with physicians to help them understand it. "If you are not clear on this stuff, it's like playing a game of telephone when you are a kid: You might think you're giving them the right information, but if you haven't thoroughly understood it, then you can't be sure that what you tell them is correct."

The biggest change relates to the new "two midnight" rule, which requires that a patient stay 24 hours that encompass two midnights to be considered for inpatient care. Hale explains the genesis of the rule. "Medicare has always defined an inpatient as someone who has a severity of illness and plan of care that warrant inpatient status. They took into account not just the existing illness, but also comorbidities." The benchmark for inpatient status versus observation or outpatient care was, up until now, 24 hours. If the care required more than 24 hours, then the patient was an inpatient. If less, then the patient was classified as outpatient, and some of that outpatient group was classified as observation patients.

When the Recovery Audit Contractors (RAC) looked at cases, they denied many where the patient stayed only one day because he or she was not expected to need 24 hours of care and the physician should have known that. Hospitals have appealed many of those decisions and have won some 70% of them, Hale says. Hospitals also got very conservative as a result, putting a lot of patients they would in the past have admitted into observation status.

The rule was designed to help decrease the number of long observation stays, as well as very short inpatient stays, according to Hale.

When the two-midnight rule was unveiled in the proposed IPPS, comments quickly accumulated that it's hard for even a very good physician to estimate a patient's length of stay. But CMS held its ground and stated that doctors have been required to do this for Medicare patients for some time. The back and forth of comment and response is readily evident in the *Federal Register*. If a physician can't estimate the length of stay, then CMS says he or she should continue to treat the patient as an outpatient until there is enough information to determine whether the patient should be admitted. That means that while a patient has to stay two midnights to qualify for inpatient status, a patient could — conceivably — stay longer than two midnights and still be considered an observation or outpatient. However, CMS says the goal is to reduce very long observation stays to near zero.

Hale says many have expressed worries that the change in rules will lead RAC auditors to disallow inpatient payments in an inconsistent way. Some commenters noted that there are other guidelines available for inpatient care from medical societies, healthcare organizations, and commercial entities like Milliman and McKesson. Can providers use those non-CMS manuals to aid their decision making? The final rule notes that they can be used, but not instead of the CMS manual, rather in conjunction with it. In the end, the auditors will come down on the side of that, not InterQual or Milliman Care Guidelines.

While the tenor of information coming from CMS supports the theory that hospitals and providers will gain financially from this — there won't be any more of the lesser-paying long observation stays; those patients will move to inpatient status, which has higher reimbursement — Hale says it's hard to believe that will pan out. "Observation status has been overused, and CMS rightly wants to reduce it. But I think they have been too conservative. They say the decision to admit will be easier as the second midnight approaches. And it sounds simple. But knowing how they interpret guidelines, and based on what's being said in the forums they have held, they are saying that if you admit before that second midnight, you have to meet medical necessity only. You can't do this because you are waiting for a discharge plan or you have to wait for Monday for a stress test. That's for the convenience of the patient or hospitals, not medical necessity."

The big problem with that is that it leaves some patients in observation for potentially longer times. "I can't help but think this will explode," says Hale. "I have taught seminars with a variety of hospitals, and I always poll the audience and ask if this is better or worse or unchanged. So far, they seem evenly split between good and bad. But it will be months before we know how bad."

Hale notes that CMS says that these cases will, in the beginning, be exempt from RAC and MAC audits. Instead, 10 to 25 records from each hospital

will be audited between now and the end of this year. That and the fact that there is litigation pending against these changes make her think there will, inevitably, be changes to the two-midnight rule. "To me, this seems like a showdown," she says. "Everyone expected CMS to back down because their own forums showed they didn't have a lot of answers and said they'd be providing guidance after the rule was put into effect. Everyone is frustrated, and CMS, even though they are unprepared, appears to have dug their heels in."

Your to-do list

As the issue winds through courts and bureaucracy, Hale says there are things to know and do. First, be prepared that the shift in inpatient admissions may affect data. Coders may see that while before, admission indicators kick off with the admission order, now the time and date of admission orders may differ by two days from the time the patient entered the hospital.

Imagine a patient who comes to the ED with dizziness. In observation, that patient falls and breaks a hip. But the patient isn't admitted yet, so that second condition is present on admission. "You might need a mechanism to better find hospital-acquired conditions."

Hale figures that if a physician could have admitted before the second midnight in the past, he would have, so she is unsure how much will change. That said, hospitals often overuse observation status and something had to give. "The battles between RACs and hospitals can drag on for two to three years. The hope is that this will reduce the number of denials and appeals."

IPPS is just one of a number of huge changes in healthcare — ICD-10 coding comes in next year, there are changes in VBP, and huge efforts to reduce mortality and readmission rates. Hale says hospitals are stretched very thin already. Your best bet to say on top of everything is to be as informed as you can. "Read the rule," Hale says. "Really. Read it all. If you don't understand something you have read, ask questions at seminars or of peers or experts," she says. "Then talk to the docs where you are and make sure they understand it."

For the full IPPS rule, complete with comments and responses, see the *Federal Register* at https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-18956.pdf. The explanation of and comments on the two-midnight rule, and responses to those comments begin on page 1,807. The CMS page related to the final rule can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.

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Hospitals slow to join PSOs; deadline looms

Thirteen-month countdown

State insurance exchanges and the federal marketplace got off to a rough start at the beginning of October. But there is no reason to believe that the exchanges won't have smoothed out many of the glitches in the next year. And it's doubtful that the requirements of the Affordable Care Act (ACA) will change dramatically in that time. Given those realities, what explains why hospitals with more than 50 beds haven't joined patient safety organizations (PSOs) in larger numbers, given that if they want to participate in state exchanges after Jan. 1, 2015, they will have to be part of one?

"I think there is still a lot of confusion among hospitals," says **Nancy Schanz**, RN, MA, MBA, MHA, director of the patient safety organization at the (Cary) North Carolina Quality Center. "I think that it seemed like people could wait since it was going to happen way off in 2015. And the rules that initially came out said that we have to have a patient safety evaluation system, but no one knew that what meant. The language on that has not been clear, even when it has been forthcoming."

Schanz says it seems pretty clear that hospitals over 50 beds will have to belong to a PSO, and that a lot of PSOs have been working hard at recruiting those hospitals — including organizations that are not federally certified patient safety organizations, but which think they still could qualify as a patient safety evaluation system, and that hospitals will be able to use membership to participate in a health exchange. She gives an example of the Pennsylvania Patient Safety Authority (PPSA), which isn't certified as a PSO, but does a lot of great quality and safety work. Schanz says the government may develop a way for organizations like PPSA to apply for an exception based on the work it has done in the past.

If there was some impetus to act gathering steam as the year progressed, it ground to a halt during the summer, when the American Hospital Association sent members an advisory that indicated they might be able to participate in exchanges even if they aren't part of a PSO. "My understanding is that there will be some clarification forthcoming," Schanz says.

That means there is still some breathing room for hospitals that haven't climbed aboard the PSO train, she says. "I think it's safe to wait for clarification, but you have to use the time to educate yourselves about what patient safety organizations do."

Look at the PSOs that are out there — Schanz says there are specific PSOs that cover just one thing, such as surgery or emergency services, as well as more generalized PSOs that are better for facilities that are not operating in a specific niche. Check out the costs, which vary. Some are supported by state hospital associations, and provision of services is free. Ask questions and seek opinions, says Schanz. "I think that when we get whatever clarification comes — probably by the end of the year — you will see a strong support from the AHA to belong to a PSO and the pace will pick up again."

Whatever enthusiasm there is for PSOs is predicated on the potential benefits of collecting data and sharing it with others so everyone can learn from it. "PSOs can pick up patterns and trends you can't see with small numbers, and help you come up with ways to mitigate harm and share best practices," says Schanz.

Small and medium-sized hospitals have a lot to gain from participation in a PSO, partly because they don't have the resources and quality infrastructure of large or academic institutions, says **Bethany A. Walmsley**, CPHQ, CPPS, executive director of the Oregon Patient Safety Commission in Portland.

PSOs were created to collect and aggregate data "in a protected environment for the purpose of accelerating learning among organizations," Schanz says. "This protected environment allows providers to discuss and share information within a culture of safety and thus improve the quality and safety of patient care without fear of reprisal." The act that created them also provided for common formats for reporting, which will aid aggregation and comparison of information and hopefully eliminate the data silos that have limited the usefulness of information in the past. "If hospitals are not collecting the same data with the same definitions, the usefulness of the data is certainly diminished," says Schanz.

"Requiring a hospital to have a patient safety evaluation system makes sense," Schanz notes, "and PSOs are designed just for that purpose. PSOs can provide valuable support and benefits to organizations."

"Familiarize yourself with what is available to you in the PSO market and contact them to find out what joining can offer you," says Walmsley.

A current list of approved PSOs is available on the website of the Agency for Healthcare Research (AHRQ) at http://www.pso.ahrq.gov/listing/psolist.htm. AHRQ is responsible for certifying PSOs and managing the process for becoming one.

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Grooming the next QI physician champion

Let them learn by doing

It can be very hard to find a physician champion for quality improvement projects. Docs are busy — there are more responsibilities, patients are sicker, days are longer, and resources are tight. But there is a way to make sure that you have a constant stream of physicians, not just to take a grudging lead on projects, but to be willing leaders of the quality brigade.

Increasingly, medical education includes some elements of quality education. However, what students learn and the quantity of time they spend on quality improvement education varies. But some of the best programs have good ideas on how to engage students at teaching hospitals in quality improvement in general.

Hiloni Bhavsar, MD, is proof of that. Currently a senior instructor in internal medicine at Case Western Reserve University's Medical School in Cleveland and the university hospital quality institute liaison, Bhavsar started out as a resident in search of a specialty like so many others.

"I did my residency and chief residency here, and until my third year was prepared to go into some

sub-specialty fellowship. But as a second- and third-year student, I got involved in our quality improvement program. It got me interested."

In the end, she couldn't let go of it, and with the help of her advisor, who worked in the quality institute, she developed a hybrid position that is 40% clinical, 40% in the quality institute, and 20% working as department liaison for the electronic medical record program.

Case's quality education is in-depth. There is a four-week quality rotation for residents and medical students, as well as didactic instruction on quality improvement theory, metrics, measurement, and reporting.

Residents have to pick a quality improvement project, which they have to present to the appropriate committee just like any other project. For example, if it is a QI project related to medication errors, it would go to the patient safety committee.

That hands-on approach is why Bhavsar says she thinks so many of the students who have gone through quality education since it started in 2009 have stuck with quality after their rotations, after their projects, after they were done with school. "It isn't just a lecture. That's the least part of it," she says.

If you have a quality center or institute, it should be fairly easy to leverage students and residents into the quality infrastructure, she says. "Give them a chance to learn by doing. Let them sit in on meetings where QI projects are reported. Put them in the review meetings for morbidity and mortality so they can see how the system works and where there might be problems."

At Case, the students and residents do just that, and they are responsible for presenting cases before the quality assurance committee in the department of medicine during their course of study, and for answering quality-related questions in those meetings. If a problem is discovered, they are part of the process of determining if it was a system failure or something that relates to communication or education.

Once you get residents interested and working through the system by being a hands-on part of the QI process, you will find it's easier and easier to recruit new students and residents to the process. Bhavsar says that because she is so close in age to the students, they are willing to listen to her wisdom, come to her for help, and let her brainstorm with them for project ideas, ways forward when there is a problem, or proper design of a project. If possible, create a hybrid position for one of those freshly minted quality gurus. "I help create new converts," she says, so it's worth it.

You may have to argue for resident time to participate in quality projects and education, but there is increasing pressure to include this in education for all medical students and residents. If you start now, you can be on the leading edge and thus attract the best students and residents.

Getting buy-in from the leadership helps. You can educate them by pointing them to some of the training programs that make a big deal about quality — like Case (http://medicine.case.edu/residency-program/residents/education/quality-improvement), but also others, such as Stanford University (http://medicine.stanford.edu/education/quality_improvement.html).

Having a full-time quality guru isn't important, she says. You just need someone on the floor who they see working both with patients and with students. Just having that presence can help win over naysayers who don't think it's a good use of resident time to have them working on some quality project that a nurse or someone else could do. "The ones who express the most frustration with what you're doing are the least likely to step up and help you," Bhavsar notes. That makes creating your own team of go-to champions even more important in the future.

While it's true that quality improvement education done right can change the way a physician thinks for the better, Bhavsar says that having resident quality education has changed the culture of the institution as well. "Our residents can and do speak the language of quality — even more than some of the attendings," she says. "All of the didactic material is from presentations that are done for faculty and departments anyway — although possibly with less technical information. We are using the existing infrastructure and parlayed the resources we already have in nursing, risk management, and infection control to make this happen. These people give an hour of their time a month towards this."

It's paid off, too. "You have to expose students to this and increase their understanding of it in this healthcare world as it is now. You can't succeed with complete novices who don't understand this."

The program has gained such renown that other residency programs at Case are looking to adopt it. Neurology is particularly interested, says Bhavsar. "This is beyond just one sub-specialty. It can span them all."

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Cutting into *C. diff* rates

Consider the lipstick test in your hospital

Clostridium difficile (C. diff) should sound a lot scarier for what it is: the second most common nosocomial infection in hospitals, with an average cost of $5,000 for each patient episode and an extra week in the hospital.

At WellStar Windy Hill Hospital in Marietta, GA, a program to reduce incidence of the bug led to good results in six months — a 15% reduction — and amazing ones — a decline of more than 44% — by the end of two years.

Windy Hill is a 50-bed long-term acute care center where patients had been bringing *C. diff* in when admitted and transferring it patient to patient. "The patients are here about 25 days on average and usually on a lot of antibiotics," says **Betsy Brakavich**, MSN, RN, the vice president and chief nursing officer at the facility. "They are immuno-compromised and old — the poster children for *C. diff*."

Between 2010 and 2011, there were 50 cases, says **Renee Miller**, RN, MSN, CPHRM, CIC, infection prevention officer. "It was a large bioburden, and we figured most of the transmission was hand to hand, patient to patient."

They worked with environmental services to find out where the problem areas were in patient rooms by putting 21 lipstick dots in high-touch areas. Staff members were then instructed to clean the room as if it was a terminal clean. Then they looked to see what was left. There were some consistent areas that were missed — like under the bed rails.

Every environmental services employee participated in the test. On average, they found 18 of 21 dots, says Brakavich.

The cleaning crew changed from string to microfiber mops, and started using bleach for cleaning, which at the time wasn't recommended but now is, Brakavich says. Bleach wipes are used on all equipment in the rooms.

Windy Hill also started a new isolation process. Now, if staff or family members are going into a room for a casual connection that does not include touching or doing a procedure, visitors are asked to put on gloves. For the higher-risk times, gown and gloves are required. "It results in better compliance, because people will walk in with nothing at all," says Brakavich. The signage for the new rules wasn't initially noticed, so Milller says they changed it recently to a shocking pink color that's hard to miss.

While a lot of emphasis has been put on having alcohol sanitizing stations in hospital rooms, Brakavich and her team went back to a soap and water mandate for team and family members, which is better at physically scrubbing *C. diff* from hands and washing it down the sink.

Patients were getting their own blood pressure cuffs, but oral thermometers were kept on the blood pressure machine that went from room to room, so Brakavich wondered if that was potentially another mode of transmission. "We now give everyone a digital thermometer of their own for the length of their stay," she says.

As many items as possible were changed from reusable to disposable, such as basins and slings for Hoyer lifts. Brakavich says that any additional costs are more than made up for by the reduction in infection and its associated costs.

Sister hospitals and community liaisons were educated to look for signs and symptoms of the infection, and education on the new procedures was spread through in-services and daily huddles. Everyone from nurses and patient techs to dietary staff and environmental services received the same education and messages. The project was written about in newsletters and was the subject of puzzles and prizes. "We wanted to keep it front of mind for everyone," Brakavich says.

The changes led to a decline in the number of cases to 29 in a fairly stable population by 2012. In the last four months, there have been just two cases. The goal is zero, Brakavich says.

Miller says they keep track of infections on a big board that includes rates for other hospital-acquired conditions such as falls and other infections. If there is an infection with *C. diff*, the chart notes the room number, along with the number of days since the last infection, and how many cases in the month before and the year to date.

That doesn't happen very often. Instead, there are a lot of celebrations for "100 days since" some infection or another. The latest was related to central line-associated bloodstream infections, and it's been almost a year since the last case of ventilator-associated pneumonia.

The lipstick comes out periodically, still, and occasionally, someone misses something — a light switch, the bedside table edge, or the TV remote.

"You can't fix this completely because patients will come in with this, and when they do, it's a time bomb," Brakavich says. "Transmission can happen before you know it, and then the patient down the hall has it. You have to be relentless."

For more information on this topic, contact Betsy Brakavich DNP, RN, MPA, NEA- BC, Vice President and Chief Nursing Officer, or Renee Miller, RN, MSH, CPHRM, CIC, Infection Prevent and Employee Health, WellStar Windy Hill Hospital, Marietta, GA. Telephone: (770) 644-1079. ■

How do your transitions of care rate?

A look from the other side

In the brave new world of healthcare, what goes right and wrong in patient care can't be blamed on someone else along the continuum of care. Rather, with the advent of Accountable Care Organizations, everyone has a part to play, and learning to play it well may make the difference not just in the quality of care provided to patients, but in whether an organization survives financially.

It was with that background that Ning Tang, MD, an internist at UC San Francisco, wrote a piece in the August issue of the *Journal of Hospital Medicine*[1] outlining what she, as a primary care physician, sees as imperatives for hospitals in creating an ideal transition of care.

She outlines seven things that need to happen during the hospitalization: communicating with the primary care physician on admission, involving that doctor in discharge planning early, letting the doctor know when his or her patient is discharged, completing discharge summary at discharge, scheduling follow-up appointments by the time the patient is discharged, making sure the patient has or can get needed medications at the pharmacy, and educating the patient about managing his or her condition.

Tang outlines another seven items that are the purview of the primary care physician and his or her clinic staff within the first three days after discharge: ensure follow up appointments with the primary care physician are made, coordinate care, get the patient to medical stability, make sure patients with new symptoms have access to the physician, track readmission rates, and track and review frequent flyers.

What she notes in her article are all things seconded by other primary care physicians. What they say could be the inspiration of quality improvement projects that could transform transitions of care and make them better for everyone on the continuum. Below are five that could bring their wish list to fruition.

Ulfat Shaikh, MD, MPH, MS, associate professor of pediatrics and director of healthcare quality at UC Davis School of Medicine, is working on a project with clinicians and residents in pediatrics to improve transitions of care by getting the parties involved to communicate better.

Among the communication elements they are working on in her project are improving the timeliness and quality of discharge communications. "The Joint Commission has mandated what a discharge summary should include, and while most have the essential elements, they don't come in a form that the outpatient provider can make easy use of."

For example, Shaikh notes that if medications were changed while the patient was in the hospital, there needs to be a way to flag that in the summary, and include an explanation about why the medications were changed and how long they should be continued, or continued at that particular dose. "You rarely see something where the medications piece is completely missing, but you'll often get this long list of meds and no indication of why they were changed. I want to see that reason and for how long the change should last."

1. Consider a chart audit that looks at unplanned readmissions and how many of them had changes in medications or dosages during the first hospitalization with notations on the rationale for the changes.

Shaikh agrees with Tang that timely delivery of discharge summaries is vital for a good transition. "Most outpatients who are readmitted go back to the hospital in the first few days or first week. If the discharge summary isn't sent to the primary care physician immediately on discharge, then I have to recreate the hospitalization from the patient's perspective alone, which is hard and may not be completely accurate." Those missing pieces are often enough to tilt a patient into a situation where a return to the inpatient setting is required. If you can't get it to the primary care doc the day of discharge, then make sure it's there within 24 hours. That gives the doctor time to look through it before the patient comes in, usually on day three or four.

And make that summary succinct — about a page is usually enough. It needs to include all the pertinent information, but it shouldn't go on for pages. "I need to be able to absorb the information in a short patient encounter," Shaikh notes.

2. Educate physicians on ideal length of discharge summaries. What is the existing average length? Keep track of that number and post a trend

chart. Reward those who have the best succinct summaries.

The way discharges are communicated is crying out for some standardization, Shaikh says. "If there is a discharge coordinator who can bring order to that process — make sure that there is a one-page discharge summary faxed or emailed within 24 hours, that it includes a list of pending labs, that everyone uses the same templates and language — that would go a long way to improving things." Shaikh is clear that a bunch of lone wolves doing things their own way won't play in the new healthcare world order. Everyone will have to quickly come to an agreement on the information included and the way to present it.

One thing she thinks would help make up for any lapses: Make sure a discharge summary leaves with the patient, too. That way, if something goes wrong in the process of faxing or emailing a copy to the primary care physician, the patient has one she can bring with her to the follow-up appointment, says Shaikh.

3. Consider a QI project that tracks readmission rates for patients who get a copy of their discharge summary compared to patients who don't.

One of Tang's colleagues at UC San Francisco, **Molly Cooke**, MD, says that what happens in transitions can range from the ideal described in literature to nothing. "Getting nothing still happens," she says. "Can you believe it?" Cooke, who is president of the American College of Physicians and the director of education for Global Health Services at UC San Francisco, has a fairly sick patient panel — she has specialized in the care of patients with HIV, among others — and they are often in the ED. "The most common thing I get is an electronic communication that my patient has discharged from the hospital and told he needs to make an appointment with me in three days. I may get nothing more than that."

The university's health system has a shared electronic health record, so sometimes there is a way to find out more, says Cooke. "But the ED may use a template that says the following: that my patient was seen for chest pain and that certain tests were done but nothing alarming was found. It will note that my patient needs to see me in three days. But that third day may be a Saturday and I can't do that suggested interval."

She says it's even more frustrating that it's often not clear to her why the patient, having just been cleared by ED docs, needs to see a primary care physician in such a short period of time. "If he isn't having acute coronary syndrome, but they fear that, it could be a reason to be seen quickly. But it doesn't say that. I need clear information about why they want me to see him in a particular interval. Without it, the patient has expectations that something is going to happen or be done, or there is something to worry about. If it's a 72-year-old who just wasn't feeling well generally, there is more reason to get a quick appointment than if it was a 20-year-old with anxiety and a tight chest."

A template that includes clear spots for information on pending tests, when to see the patient next, and why would be much more helpful, Cooke notes. "And include a list of red flags that, if we see them, mean we should call the hospital provider."

Good transitions of care require more than just checking off a list of to-do items, Cooke says. Those check boxes are great for internal and external quality metrics. But they say nothing about high-quality communication, which doesn't always happen. Many physicians use templates of admission notes, or copy and paste notes from one part of a record to another. Those copied bits can include statements that the inpatient doctor has contacted the primary care physician to notify her of the patient's admission when that didn't happen this time. Or last time. It happened three or four times ago, and the inpatient doctor is simply copying the admission notes over and over.

4. How many charts of readmitted patients and frequent flyers have cut and pasted portions of charts from one place to another with no changes at all?

5. Facilitate a meeting between primary care and inpatient physicians about what data needs to be transmitted when. Compare it to what you are already doing.

If you find gaps between what is needed and what is done, Shaikh says, that's fodder for a great QI project that could pay dividends — not just in quality of care, but in actual financial benefit.

REFERENCE

1. Tang, N. (2013), A primary care physician's ideal transitions of care—where's the evidence?. *J Hosp Med*, 8: 472–47

For more information on this topic contact:

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CNE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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

- What's with ICD-10?
- Accreditation field reports
- New tools to promote patient engagement
- Achieving total flu vaccine compliance

CNE QUESTIONS

1. VTE study author Karl Bilimoria says which of these is one of the weaknesses of current DVT measures:
   a. that it doesn't include ambulation
   b. that it only looks at the 24 hours surrounding surgery
   c. that it doesn't look at processes, but outcomes
   d. that outcomes measures don't have enough science behind them

2. The new rule on inpatient admissions for the IPPS requires that inpatients stay in the hospital for:
   a. Any time longer than 24 hours
   b. Two days
   c. At least 24 hours encompassing two midnights
   d. As long as the physician deems necessary

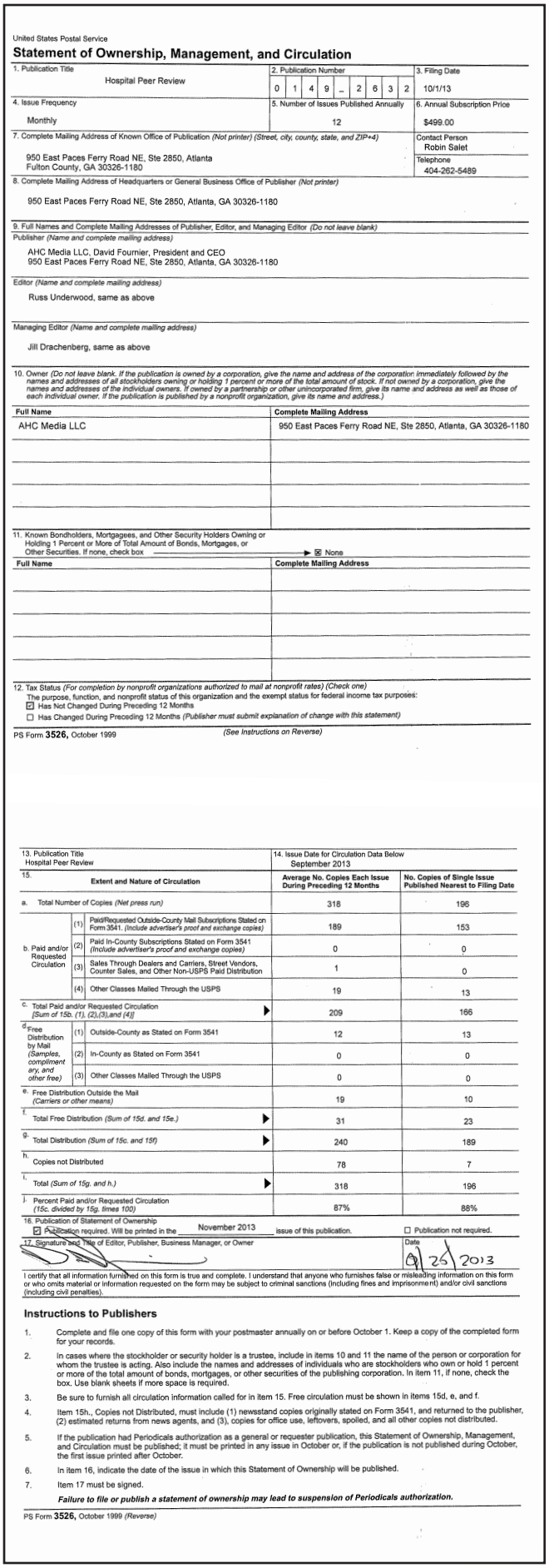
3. If hospitals don't join PSOs by 2015, what happens?
   a. They can't share data
   b. They can't participate in the insurance exchanges
   c. They can't be part of single issue PSOs, like those for emergency medicine
   d. They will get lower payments from CMS

4. The material used to teach residents at Case about quality improvement theory and practice comes from:
   a. Stanford
   b. the neurology department
   c. existing committee presentations
   d. quality gurus

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.



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