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AHC Media

Alarms #1 tech risk despite focus, according to ECRI

Annual list also highlights dangers to peds patients

Last year, when alarm fatigue appeared on the ECRI Institute technology hazards list, it seemed to coincide with a push from a lot of organizations to deal with the issue. Indeed, within months of the ECRI report coming out, there was a Joint Commission sentinel event alert and 2014 National Patient Safety goal related to alarm management. But all that attention hasn't made it any less of a hazard in the eyes of the experts who craft the annual list. This year, it's number one.

"It is really validating to have what we find an issue and push for to be on the radar is also important to others," says **Rob Schluth**, senior project officer of the ECRI Institute, who works on the annual list. "We try to highlight what we think people need to pay attention to in the coming year, what is high profile. If it's something that might land you on the front page of the paper, well, that's what makes it important to deal with."

The alarm management issue could be one of those front-page issues: In three years prior to the sentinel even alert, The Joint Commission had 98 reports of alarm-related events, 80 of which resulted in death and 13 in permanent loss of function. It's not just about diminishing noise on a unit.

Schluth says there are "hundreds of places" to look for potential errors, competing priorities, and finite money and time. Creating a list is a practical way to give health care organizations a way to find high-impact gains that can improve patient safety.

Top technology hazards

A group of experts looks at problem report databases, internal evaluations of technology from the internal testing lab at ECRI. They solicit ideas from contacts in hospitals about what they are seeing as potential problem areas and look in the literature to see what people are publishing. After the group creates a master list, it researches the topics and then goes through a voting process to come up with the top 10.

The top technology hazards for 2014 are:

1. alarm hazards;
2. infusion pump medication errors;

3. CT radiation exposure in pediatric patients;

4. data integrity failures in EHRs and other health IT systems;

5. occupational radiation hazards in hybrid ORs;

6. inadequate reprocessing of endoscopes and surgical instruments;

7. neglecting change management for networked devices and systems;

8. risks to pediatric patients from "adult" technologies;

9. robotic surgery complications due to insufficient training;

10. retained devices and unretrieved fragments.

Several of these are new to this year; some are very new. Number 5, related to hybrid operating rooms, is probably something that only the largest and newest of facilities will have to deal with, but the risks are new, unknown, and given the expansion of this technology, potentially growing.

A hybrid operating room is one that has high-end imaging equipment built into the OR setting. "The idea is that you can have a full-scale angiography system to do minimally invasive surgery," says Schluth. "But then if you need to convert to full-scale open surgery in an emergent situation, what happens? What are the risks? And imaging technology has traditionally been used in a separate department. Now you are using it in an environment with staff that may not be as familiar with the risks as the imaging staff. Will they be unnecessarily exposed to radiation?"

Another OR-related item on the list is number 9, related to the training of those who use robotic surgery tools. Most physicians go through training with manufacturers for specific procedures, says Schluth.

But will they then use it for other procedures? Will the person who teaches you a particular procedure have done it before with that particular robot? What does a surgeon have to do to prove he or she can do this particular surgery effectively? Will there be proctoring? Will the whole surgical team have to have experience with the technology, or just the surgeon? Schluth says there are no hard rules for this, which means there is the potential for harm.

Retained objects

Still on a surgical theme is the last item on the list, retained objects. This made the cut in 2009 and 2010 and is back again — at the same time that The Joint Commission has issued a sentinel event alert on the topic. *(For more on the Joint Commission Sentinel Event Alert on retained objects, see page 138.)* Schluth says that for a couple years, "it didn't rise to the

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level to supplant one of the other areas. But now it's back. It seemed a good idea to put it back on the radar."

While there are recommendations around the issue, and procedures to follow, the passage of time can lead to reduced vigilance, he says. "It's not news to people, but there are some who may not be aware of the danger. We have an accident and investigation group, and since we last included the topic on the list, we have been contacted for nine investigations of retained objects. Digging around in the data, we found that if you look at the top three reasons for malpractice cases, retained objects are implicated in half of them." Add in the sentinel event alert, and Schluth says it's obvious that this should be back in the spotlight.

The other new items on the list — numbers three and eight — relate to pediatric patients, and emphasize the notion that you can't just treat children as small adults, he says. Their growing bodies require special care and consideration, and if your facility isn't a pediatric one and you have pediatric patients, you should pay special attention to those issues. Consult with specialists on those areas to make sure you are treating children like children.

The order of the list is based on ECRI's "internal judgment," he says. It won't apply to every facility, but Schluth says it can be a starting point for discussion. There are others that didn't make the list that might be more important for your facility. There is a self-assessment tool online for each of the 10 topics that you can send out to departments. It has 10 to 15 questions that will show the risk of each of these for your facility, whether one is particularly high or not, and that can be a starting point.

While those tools are generally for members of ECRI only, Schluth says anyone can call and see if "we can work something out."

If you aren't a member and don't want to make that call, look at whether you had events in these areas; ask staff in the relevant departments where they think the gaps in safety are, what worries them. "I think that people in most hospitals will find most of these items resonate," he says.

For more information on this topic, contact Rob Schluth, Senior Project Officer, ECRI Institute, Plymouth Meeting, PA. Telephone: (610) 825-6000. ■

Are we there yet? Quality quest continues

Report highlights areas for improvement

There are two ways to look at the top-line piece of information in The Joint Commission's annual quality report for 2013: Either a third of the hospitals it surveys achieved top performer status, or two-thirds of them didn't. Given that the achievers — 1,099 — were joined by a large number — 673 — who missed top performing status by a single measure, the news is pretty good. "We are very pleased at the progress," says **Margaret Van Amringe**, MHS, executive vice president for public policy and government relations at The Joint Commission. "We had a significant increase in the number who made it this time, and there was another large number just a measure away. There is a lot of attention being paid to the core measures; the practices around them are being embedded so that they are a part of daily practice and routine. You can see that in these numbers."

Top performers have to achieve cumulative performance of 95% or above across all reported accountability measures; reach 95% or above on each and every measure with at least 30 cases; and have at least one core measure set with a composite rate of 95% or above and, within that measure set, all individual measures have a performance rate of 95% or above. And they have to do that on four different measure sets. Most of the top performers chose heart attack, heart failure, pneumonia, and surgical care. Other options include children's asthma, venous thromboembolism (VTE), stroke, immunization, and hospital-based inpatient psychiatric care.

For 424 of the hospitals, this was the second time they achieved top-performer status; for 182, it was the third year in a row. Of those that missed by one measure last year (583), 253 made it this year.

It's not easy to make the list — and perhaps there is a good argument for it being hard to be a top performer — but Van Amringe says that if hospitals take these measures seriously, "there is no reason why they shouldn't make the list."

Here's where The Joint Commission says it can see room for improvement. There is a composite result score it calculates by combining all the individual accountability measures. Last

year, accredited hospitals achieved a 97.6% composite accountability measure on 18.3 million opportunities to perform care. As a comparison, a decade earlier, the score would have been 81.8% on 957,000 opportunities.

But while there was a 95% or better score on most measures, the report noted that providing care plans and discharge instructions for asthma patients (86.7%), continuing care plans for psychiatric patients (86.1%), and providing discharge instructions for VTE patients taking warfarin (82.2%) are among individual results that need to improve.

Van Amringe says that the top performers program is a "great equalizer" because you "don't have to be a great center of one thing or another to do well, or not do well. With a lot of the other report cards out there, they are based on reputational data, like what doctors think about other doctors or where they would go for care. That's not to say they don't have a place. But this is based on data. We are not looking at overall hospital performance on everything — just narrowly focused points where science has proved that it is justifiable to say 'these things must be done by everyone, no matter what size your organization.'"

She was pleased to note that the Healthcare Association of New York State's rating of report cards (http://www.hanys.org/quality/data/report_cards/2013/docs/2013_hanys_report_card_book.pdf) ranks Joint Commission methods higher than any other — because of its use of data.

Most of the top hospitals haven't chosen to use VTE and stroke as measure sets, something Van Amringe says might be because they are newer measures. However, starting next year, to be a Top Performer, hospitals will have to excel in six measure sets, including stroke and VTE. *(For a list of measure sets, see box, page 137.)* In addition, hospitals with more than 1,100 births will have to add perinatal care measure sets. "It takes a couple years to get Top Performer status on new measures. You have to learn to embed those practices in your daily routine," she says.

Urban and rural make the grade

Among the Top Performers are more than a dozen Kaiser Permanente hospitals, about 18 of them in California alone. **Patti Harvey**, senior vice president for Patient Safety and Quality, says that being a connected system helps make consistent care possible, thus giving Kaiser hospitals a bit of a leg up on providing the best care every time. Every part of the system is designed to foster doing the right thing the right way every time, she says.

Still, most of those hospitals that hit Top Performer for Kaiser focused on those first four measures, not stretching to stroke or VTE or immunizations yet. That will change next year, Harvey says. "We are looking to become stroke certified in our California hospitals, so you will see that, and we are already above 90% in the majority of our Southern California hospitals for VTE." A couple of years ago, that would have earned Top Performer status for hospitals who included VTE in their measure sets, but the requirements were increased to 95% this year to reflect the higher performance most Joint Commission-accredited hospitals were achieving.

The hospitals are measuring and collecting data on issues such as perinatal care, VTE and stroke; they just haven't started reporting it yet, Harvey says. "That does take resources," she says. "For now, we are spending those resources on other things."

In Northern California, Kaiser is actively reporting on some measures that Southern California isn't. And across other states, there are different priorities at other hospitals. Happily, the regions cooperate, communicate, and coordinate, she says. "We learn and share across those regions, whether we are top hospitals or not."

And that learning is vital. Being a Top Performer isn't something that allows you to sit back and relax, Harvey says. "We have systems, but they are not always 100% reliable," she says. "You can have a 95% reliability in a report to the commission, but if you are one of the five patients out a hundred that doesn't get that care and is harmed, what do you care? Ninety-five percent isn't good enough; 98% isn't good enough. As complex as this system is, with competing and compelling priorities, the focus has to be on taking care of this patient here today. Translating that across a whole system is an art. We are trying to make it a science, but it is still an art."

So when something bad happens, they review — in every region, not just in the one where the bad thing happened — to see if something needs changing. That keeps the fire burning, Harvey

says. It's great to be a Top Performer, but there is no destination in quality. It's all a journey.

In Wyoming, the quality concerns often revolve around how to provide timely care for folks who are coming from vast distances, says **Carol Solie**, MD, chief medical officer of Wyoming Medical Center in Casper, another Top Performer.

Next year, the 200-bed facility will have to start reporting perinatal data, and she wonders if distances will keep her off the list. One of the measures is about not inducing labor before the 38th week. But imagine this scenario, not uncommon in rural Wyoming: A woman lives far away, and a blizzard is forecast for tomorrow. She is 37 weeks, 5 days pregnant. The best option is to get her to Casper before the storm. The ideal, according to the folks who make the rules, would be to have the patient pop herself into a hotel or with a friend and hole up until she hits that magic 38-week mark. Then you could induce. Or maybe the storm would pass and she'd go into labor naturally. But for many patients, says Solie, that's not an option. They don't have the money for a hotel, they don't have friends in town, and you can't admit her and have her hang out in a hospital bed. So the best alternative has been to induce at 37 weeks, six days.

Solie says the realities of rural life — the isolation preferred by many, the extreme difficulty some providers have getting people to agree to follow a plan of care — don't always match what "measures" say you have to do. Still, thus far, the hospital has been able to be a paragon of quality and safety. It is a "Gold Plus" stroke achiever. It has gone as many as 400 days without any safety event — "it's just devastating to go back to zero on the board after that long," she says — and while they don't report on stroke and VTE to The Joint Commission (as a way to save money), they have been collecting and reporting that data as part of Meaningful Use, and of course, using it for the benefit of quality improvement projects.

"The challenge for leadership in any industry that engages in quality improvement is sustaining the game," Solie says. "It's easy to slip into complacency. You build a wall. You stand on it. You say it's there. But quality is a wall you have to build every single day with every patient."

She says that getting behaviors hard-wired into staff is great, as long as you continue to have those people doing those things continually. If someone moves onto something else — another project focusing on another task to be hard-wired, or another job that doesn't use that skill — then eventually, the "hard wiring" will be more like that French class you took in college 20 years ago that left you feeling sure you were fluent.

Solie says it wouldn't surprise her to see fewer top hospitals next year — six measures is a lot, and there are hospitals like hers in rural areas that will have a hard time figuring out how to meet the requirements of some measures and still meet the needs of patients. But she knows that hospitals will still reach for that level of achievement and feel good if they meet it. She hopes Wyoming Medical Center is one of them.

The complete annual report is available online at http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2013.pdf. It contains the list of the 1,099 Top Performer hospitals by state.

For more information on this topic contact:

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2014 Top Performer Hospital Measure Sets

- Heart Attack Care
- Heart Failure Care
- Pneumonia Care
- Surgical Care
- Children's Asthma Care
- Inpatient Psychiatric Services
- VTE (venous thromboembolism) Care
- Stroke Care

Sentinel event alert on retained surgical objects

Counting on you counting right

It's the kind of thing that ends up on the front page of a paper, or on the evening news with a graphic that shows an X-ray of a scalpel in an abdomen. Unfortunately, unintended retention of foreign objects (URFOs) happens more frequently than anyone would like; it even made the annual list of ECRI hazards again this year. *(See story page 133.)* Sponges, towels, small pieces of devices, those scalpels and scissors you see on TV graphics — in the last seven years, The Joint Commission received 772 voluntary reports of URFOs, 16 resulting in death. Almost all of these led to additional care, extended hospitals stays, and as much as $200,000 per case in additional costs, both medical and liability.

Those are the reasons behind the October release of a Sentinel Event Alert on URFOs. The alert makes several suggestions for avoiding unintended retained objects, including:

- creating a highly reliable and standardized counting system;
- developing an evidence-based policy, using a collaborative approach, that is used throughout the organization;
- researching assistive technologies to supplement manual counting and wound exploration;
- creating the opportunity for any team member to speak up about concerns he or she may have related to retained objects;
- appropriate documentation, including the results of counts of surgical items, including those left in the patient because they were thought safer being left in than removed, and what the team did if there were any discrepancies.

The alert also notes some of the risk factors that make URFOs more likely. They are nine times more likely to happen when an operation is an emergency, and four times more likely to happen if something in a procedure changes unexpectedly. Overweight patients are a risk, as are patients whose surgeries involve more than one surgical team or multiple surgical staffs. And while those hard objects in X-rays are what come to mind when you mention retained objects to the public, the biggest risk is sponges and towels, as well as needles and other sharps.

If you look at the root cause of these incidents, most often The Joint Commission found there was a lack of policies and procedures or failure to comply with them. When they do exist, there is often a culture of fear that intimidates team members from speaking up and saying they think something was left in the body.

There has been an uptick in reports on retained objects, says **Ron Wyatt,** MD, MPH, the chief medical officer for the division of healthcare improvement at the commission. That's great. But "there has been weak action around it, and we want people to pay closer attention to this. We don't want you to wait until someone is killed or otherwise harmed physically or psychologically, or had their trust in medicine diminished. We want you to pay attention to this now."

These things used to be called "never events," he says, but the rate of them has not declined. "We have to look for the systemic problems that contribute, not to a person to blame when it happens," Wyatt notes. "Part of this is to expect the unexpected and have some sort of standardized process for what to do when something unexpected happens. What do you do when you bring in another surgeon? How do you prepare for a patient who is morbidly obese? More and more of them are. This will help you develop the policies of vigilance."

The complete alert is available at http://www.pwrnewmedia.com/2013/joint_commission/urfo/downloads/SEA_51_URFOs.pdf.

For more information on this topic, contact Ron Wyatt, MD, MHA, Medical Director, Division of Healthcare Improvement, Joint Commission, Oakbrook Terrace, IL. Email: rwyatt@jointcommission.org. ■

Stopping workarounds means changing culture

Open culture will let you measure the problem

What do you think are the top medication administration workarounds in your hospital? Can you guess? Have you tried to figure it out? Maybe you think you don't have that problem. You're probably wrong, says **Beth Boynton**, RN, MS, a nurse and consultant who works in New England to help hospitals and their staff change bad habits and embed new ones. Here is her list of some of the top work-

arounds she has seen in her years as a nurse.

- relying on memory from earlier in the day or previous shift for some steps;
- stopping in the middle of the process to answer an alarm and then, rather than restarting the process, picking up where you thought you left off;
- trusting that the pharmacy sent the right dose or medication and not checking yourself;
- gauging timing as "close enough" or "maybe the only opportunity";
- the patient is sleeping and the nurse doesn't want to wake him or her;
- there is dried-up pasta sauce on the bracelet bar code or the scanner isn't working, or someone else has it.

Most of these, Boynton says, don't lead to problems for patients. But they are, in and of themselves, errors.

While a lot of what is done related to medication administration is governed by checklists and automation and barcodes, there is plenty of room for workarounds and mistakes, she says. "People will always find a way to do something wrong. If you think about using a scanner and you scan the patient and med, it takes a couple seconds. But if you are interrupted, and you have to stop and attend to someone else, do you come back and do it again, or do you save those couple seconds and just give them the medication? And if you want to give it later, what if you forget?"

One nurse in the neonatal intensive care unit told her a story once about using scanners that were "temperamental." So they developed a workaround. Well, what if the workaround became so convenient that you found a way to make that scanner permanently temperamental? "We, as nurses, are always struggling to get through our shift. We have 100 things to do but can only manage to get 80 done if we do it right, but 90 if we use workarounds, what do you think we'll be inclined to do?"

If you want to find out what your workaround issues are — and you should — you have to start by asking questions. But there's a chicken-and-egg problem here. Because Boynton says if you don't have a just culture that is warm and open to anyone speaking up and speaking out, you aren't going to get the information you need to identify problem areas and then solve them.

She tells the story of one organization that knew it had some problems with medication administration workarounds. It sent out a survey asking nurses what the problems were. The response rate was abysmal because nurses felt one of two things would happen — they would be punished for being honest or, nearly as bad, the hospital would take the information and do nothing.

"The first issue is getting to the truth. Once you have a culture where you can do that, then you have to determine the magnitude of the problem." While she thinks a just culture would probably have less of a problem with workarounds — people would speak up and say there was a problem, call others they see using workarounds on their behavior, and work together to find solutions — they undoubtedly still exist. "They aren't always bad; because we are by nature in a state of nearly constant crisis, a shortcut can be a lifesaving thing sometimes. But for the most part, they are bad habits, and it's a good idea to minimize them as much as you can," Boynton says.

Some may be a matter of muscle memory that comes from 30 years of doing something one way before someone instituted a change. Some may be a faster, better way of doing something that deserves a hearing. Some might be laziness.

"Sit down and ask people," Boynton says. Use informal discussions, or if you are looking to measure problems, create a survey. You need to ask them about the areas of concern, the places where they are using shortcuts or have seen others use them or wish they had them. You should ask about areas that are pitfalls and persistent problems. But don't ask them, "Why don't you do this?" Boynton suggests that you instead ask, "What do you need to do it right?"

Some solutions are going to be easy, she says. Think of the hand-washing problems that are solved by having more paper towel dispensers, for example. But some will be harder. A lot of what is wrong with nursing care, says Boynton, relates to staffing levels. More staff — whether it is administrative to reduce interruptions or clinical so that there those 100 necessary things can get done on a given shift — takes money that a lot of organizations will say they don't have.

Make part of your process understanding what kind of resources it takes to do things the right way every time. Not just in terms of people, but time. Figure out how long it really

takes to do things in a real-world environment — like on a busy Saturday night in the ED or Tuesday afternoon on the med/surg unit. Test out education materials on real patients — including the ones who are hard of hearing and left their hearing aid at home. Have this kind of data available, along with the information on workarounds, and you should be able to come up with some workable solutions.

And if you have a truly just culture, with a leadership that is willing to hear hard messages, a solution to medication workarounds that requires more staff is something that will be heard with respect.

For more information on this topic, contact Beth Boynton, RN, MS, Portsmouth, NH. Telephone: (603) 319-8293. ■

It's not always what you say that counts

Non-verbal communication makes a difference

Two new studies are highlighting the importance of non-verbal communication and the ways in which appropriate use of a gesture or a note can help improve a patient's perception of his or her care. And since perception of care can translate into how that patient rates your hospital and even how that patient feels physically, improving those perceptions matters.

The first study, published in the *Journal of Participatory Medicine*[1], looked at the use of eye contact and other social niceties. Enid Montague, MD, and her team looked at eye contact, pats on the back, and handshakes, and compared the number of social touches to empathy scores the physicians received. The interesting news is that doctors who used more than three such niceties had their scores decrease. But a pat, good eye contact, and a handshake goodbye? The trifecta.

Jie Xu, one of the coauthors and an engineering professor at the University of Wisconsin in Madison who worked on the project with Montague, says they were trying to figure out what kind of training would influence the perception and trust of providers. "There are a lot of things that are not in the control of the clinical world — insurance, family. What can they influence? What can they change?"

Paying attention to the patient is one thing, and it's something that is increasingly hard to do, given the short time spent with patients and the diversion that smartphones, tablets, and computers can have on a provider's attention when he or she is in a room with a patient.

But these things make a difference, he says. The first thing it changes is how patients think of the physician, the clinic, and the hospital, which can impact patient satisfaction scores. But that's not the end. It can also potentially affect whether a person trusts the doctor and what he or she is telling the patient to do, Xu says. So if eye contact and a simple touch are things that make the patient more likely to comply with a medication regimen post-discharge, why not?

The group based its work on a study from the 1980s, which found that how a patient and physician talked to each other affected how the patient acted after that and whether he or she followed the treatment plan. Xu says times have changed so much, they wanted to see what would have that impact now. The answer is a look and a touch. Words are less important.

The group will continue to work on this project to see if outcomes are better or worse with patients whose providers engage in these social niceties. Meanwhile, Xu says that providers should be coached in making good eye contact, even when other things are tempting them to look away. If they are having to look at a laptop or tablet device because they are unfamiliar with it, they should be given remedial help until they can use it accurately with just a glance. "Patients need to feel attended to."

Pads of paper

The second study, in the October issue of the *Journal of Hospital Medicine*[2], looked at the impact a pad of paper can have on how a patient feels about his or her care. **Aaron Farberg**, MD, now a plastic surgery resident at the University of Michigan in Ann Arbor, thought of the project while he was a medical student. Assigned to follow around a chronically ill patient to see how they experienced the medical system, he wondered why he saw pads of paper everywhere, but not at the patients' bedside. He and one of his classmates started using their printing allocation to create pads of

paper for patients to leave questions and comments on.

That led to a project that provided notepads modeled after prescription pads with three prompts on each page for questions about diagnosis and treatment; tests and procedures; and medications. There was a prompt at the bottom to ask other questions on the back, with a box to check if there was further reading on the back.

The pads were left with patients on one unit over three months, and surveys were matched with those in a control group who didn't get the pads. Most of those who got notepads used them — nearly 80%. Of those who got the notepads, almost two-thirds said they used them to take notes on their hospital stay, while just over a fifth of the control group took notes. And patients who used the notepads all felt that it enhanced their communication with their providers.

Farberg says they didn't have enough of a group to determine if they could move an actual patient satisfaction number up with their results. But the implication is that this works to make patients feel better about their communication with their doctor. That it also helps them keep track of their hospitalization is even better, since there is plenty of data that show people aren't usually at their mental best when they are hospitalized.

"This is one more thing that we can do to show we care for our patients," he says. "When you pick an airline, you assume they won't crash. So you choose based on other things. The same with a hospital. You have to move them based on other things. And if one of those things is that their doctors communicate better with patients, I think that's an important point to put across."

While a quick focus group of patients, family and friends helped them determine what questions to put on the note, others in the hospital are now using their own — a cardiology unit has different questions, and a children's ward has a blank pad.

"The coolest thing about this is that it's easy, it's cheap, and it's very effective. We had to limit what we could extrapolate in print because this is a peer-reviewed article. But there is an obvious link you can make that having your questions answered and improved communications will improve the way you feel about a hospital in general."

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A new estimate of patient harm

People were horrified when the Institute of Medicine released a report estimating that 98,000 people died each year due to harm cause by healthcare. But the real truth may be much worse. That number was based on data from 1984, and a new study in the September issue of the *Journal of Patient Safety*[1] used new data to determine a more accurate number: 400,000 people likely die prematurely in this country every year because of harm caused by healthcare, and serious harm is likely 10 to 20 times more common than lethal harm.

The research was based on four studies deemed appropriate to determine preventable adverse events and had a lower limit estimate of 210,000 deaths associated with healthcare mistakes. The authors note that in the end, the number, whether 98,000 or 400,000 or something in between doesn't matter. It demands attention.

The full study can be seen at http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx.

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Patient safety summit in January

The Joint Commission Center for Transforming Healthcare and the Patient Safety Movement Foundation are sponsoring a summit in January whose focus is to approach zero preventable deaths in U.S. hospitals by 2020.

The Patient Safety, Science & Technology Summit, scheduled Jan. 11-13, 2014, is for industry leaders and will focus on three areas that continue to be an issue for healthcare as a whole in this country:

- improving handoff communications;
- reducing hospital-acquired conditions;
- creating a culture of safety.

The summit's new focus areas are in addition to those considered in the 2013 summit: failure to rescue, medication errors, blood transfusion overuse, intravascular catheter-related infections, sub-optimal neonatal oxygen targeting, and failure to detect critical congenital heart disease. ■

Telemedicine brings more risk with more use

Use likely to increase in coming years

Telemedicine has been the new frontier of caregiving for years, but it finally is becoming a reality at many healthcare facilities. That change means that the liability risks discussed in theory up to this point are becoming real, and risk managers must act quickly to address them.

Whereas the use of telemedicine in the early years was mainly the purview of leading-edge physicians who either devised their own long-distance connections or worked with academic researchers, hospitals are now being approached by companies offering to provide telemedicine capabilities. That change magnifies some of the potential liability risk, says **Mark Kadzielski**, JD, an attorney with the law firm of Pepper Hamilton in Los Angeles.

"A risk manager should be very, very aware of the issues when someone at your facility says they are going to contract for telemedicine services," he says. "There will need to be a written agreement for telemedicine services, which needs to be looked at carefully because of the myriad legal issues involved."

Telemedicine is defined by the Centers for Medicare & Medicaid Services (CMS) as "the provision of clinical services to patients by practitioners from a distance via electronic communications," and by the American Telemedicine Association (ATA) as "the delivery of any healthcare service or transmission of wellness information using telecommunications technology."

The technology will be employed more in coming years as a way to compensate for the increased patient load and the lack of physicians, Kadzielski predicts. "Given the expansion of access under Obamacare, telemedicine is a natural fit so that people in remote areas and busy urban areas without enough doctors can be seen," he says. "It can be a wonderful component of care if used properly."

Unaddressed issues

There are many significant unaddressed legal issues that risk managers must face to ensure that their telemedicine services are compliant with federal and state requirements. One of the first concerns is reimbursement. Medicare reimbursement for telemedicine services is limited, but CMS has indicated that it might expand the payment possibilities. Medicaid reimbursement varies from state to state, though at least some type of reimbursement is offered in the majority of states, Kadzielski explains.

Due to the varied reimbursement climate, hospitals, healthcare organizations, and healthcare systems should do the following:

- Be aware of the federal and state reimbursement laws and restrictions that might affect their billing practices.
- Know what telemedicine services will and will not be reimbursed.
- Know how to bill for certain telemedicine services.
- Only submit compliant claims to avoid liability for fraud and abuse and false claims.

"When you're offered a contract and people say don't worry because you'll split the money, that raises all sorts of concerns about fraud and abuse," Kadzielski says. "And of course, if what you're splitting turns out to be zero, that's

going to cause a contractual dispute faster than you can imagine."

There is very little case law regarding telemedicine, and most of what exists involves criminal charges related to prescribing medicine across state lines, says **Paul Hildebrand**, MD, associate director of the patient safety organization TeamHealth in Knoxville, TN, and regional director of quality with the San Franciscan Health System in Tacoma, WA. Though he agrees there are many potential risks, he sees the possibility of telemedicine actually reducing liability in some ways.

Prepare now, experts recommend

"The overall risk could be diminished by telemedicine because you're able to provide a service that you might not otherwise have been able to provide," Hildebrand says. "If the patient can get the care they need, regardless of where they are located, that can be a positive aspect in terms of patient care and liability."

Hildebrand recalls one physician who was making use of email and electronic health records to communicate with patients, to the extent that his malpractice insurer decided to audit him, because staff there feared that the remote consultations were jeopardizing patient care and creating liability risks. After looking

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

- ICD-10 and the quality manager
- Accreditation field reports
- What Magnet and Joint Commission accreditation have in common
- Achieving total flu vaccine compliance

CNE QUESTIONS

1. How many years in a row has alarm management been the number one hazard on ECRI's list?
   a. 2
   b. 4
   c. 3
   d. 5

2. To meet perinatal core measures, labor can't be induced before when?
   a. 38 weeks
   b. 39 weeks
   c. 37 weeks
   d. 37 weeks 6 days

3. How much does the average retained object cost a hospital in health and legal costs?
   a. $2.2 million
   b. $1 million
   c. $500,000
   d. $200,000

4. According to Beth Boynton, RN, MS, the first step to figuring out if you have a problem with medication administration workarounds is:
   a. having a just culture
   b. asking nurses why they do things a certain way
   c. asking nurses what they need to do things right
   d. figuring out how much time it takes to do certain tasks

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.

at his email use, the malpractice insurer reduced his premium.

"They found that his use of telemedicine improved his relationship with patients, rather than leaving them to grow angry over long waits for an appointment," he says.

Hildebrand and Kadzielski urge risk managers to address the risk management issues related to telemedicine immediately, even if the technology is not yet employed widely. If it is not yet a significant part of your organization's caregiving, it soon will be, they say.

"You have to worry about the risk now. You can't kick the can down the road," Kadzielski says. "Given the exponential expansion of telemedicine services, the time to be concerned about the risk is now, not tomorrow." ■

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. ■

Hospital Peer Review
2013 Index

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AHC Media

Coordinate care for physical, mental health issues

Each condition can affect the other

Healthcare organizations are recognizing that medical problems and mental health conditions often are intertwined and that each condition exacerbates the other. Organizations are taking steps to improve communication between mental health and physical health providers.

A tremendous body of research shows the connection between physical and mental health. For instance, in the *Preventing Chronic Disease* journal published by the Centers for Disease Control and Prevention (CDC), **Daniel P. Chapman**, PhD, and colleagues wrote that a review of published materials showed that mental illnesses were associated with increased prevalence of chronic diseases and that the association "appears attributable to depressive disorders precipitating chronic disease and to chronic disease exacerbating symptoms of depression."[1]

Their review of articles showed that nearly 50% of asthma patients may have significant depressive symptoms and that 87.5% of people who have frequent asthma attacks manifest psychopathology compared

EXECUTIVE SUMMARY

Researchers and healthcare organizations alike recognize the connection between physical conditions and behavioral health conditions and are working to coordinate care between the providers.

- Many people with chronic diseases also suffer from depression and other behavioral health issues.
- People with mental health problems die earlier than the general population because they smoke, are overweight, and have chronic illnesses.
- Behavioral and physical healthcare providers often operate in silos and lack coordination, which can result in a negative impact on individuals.

with 25% of persons with less frequent attacks. They wrote that research shows that people who are depressed are more likely to develop coronary artery disease and that people with significant depression are twice as likely to have a stroke as people with fewer symptoms and more than four times as likely to have a myocardial infarction as people with no history of depression.

The National Center for Disease Prevention and Health Promotion at the CDC calls for including mental health promotion as part of its efforts to prevent chronic disease in the report, "The Public Health Action Plan to Integrate Mental Health and Promotion and Mental Illness Prevention with Chronic Disease Prevention 2011-2015."

"The interconnections between chronic disease, injury, and mental illness are striking," the report says.[2]

People with behavioral health conditions die on average 25 years earlier than the general population because they tend to smoke more, be more overweight, and suffer from chronic obstructive pulmonary disease, according to **Sue Bergeson**, vice president of consumer affairs for Optum, a health services company based in Eden Prairie, MN.

"They spend so much time with psychiatrists and other behavioral health professionals that they don't see their primary care provider and deal with their physical conditions, such as diabetes and chronic obstructive pulmonary disease," she says. People with behavioral health conditions smoke 44% of all cigarettes and may be taking medications that make them gain as much as 30 pounds a year, she adds.

"Many people who have behavioral health issues don't adhere to their treatment plan because, like other people with chronic illnesses, they don't like to admit that they have a condition they have to treat for the rest of their lives. In addition to coping with their condition, they have to cope with the stigma of mental illness and don't take their medication because they feel ashamed to have the condition. Sometimes they stop taking their medication because they feel better or don't like the side effects of their medication and suffer a relapse," she says.

To help people who have been hospitalized for a psychological condition remain out of the hospital, Optum's Field Care Advocates — licensed, community-based clinicians — work with people who are at risk for rehospitalization for behavioral health issues to ensure that they receive adequate therapeutic support and that they are receiving care for their medical comorbidities. They support the individuals on following their treatment plans and promote communication between the patients' medical and behavioral health providers. Patients who need extra help are paired with a peer specialist, who assists the patients in making lifestyle changes. *(For more on Optum's program, see related article on page 89.)*

Recognizing that behavioral and physical healthcare systems often lack coordination which can result in a negative impact on individuals, UPMC Insurance Division developed Connected Care, a program that links behavioral health providers and medical providers, says **James Schuster**, MD, chief medical officer for Community

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EDITORIAL QUESTIONS

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Care Behavioral Health Organization. The program provides coordination of mental health and physical health benefits for members of UPMC for You, a Medicaid managed care plan, as well as Community Care Behavioral Health for its behavioral health services. Case managers from both organizations have access to a shared database with information on all the care patients receive, and they meet regularly to brainstorm on difficult cases. *(For details, see article on page 90.)*

"People with serious mental illness have significantly shorter life expectancies than the rest of the population. Many are impoverished, and their illness often prevents them from taking medication as directed and making the lifestyle changes that would improve their physical health. Coordination of the mental and physical health services is a key to helping them improve their health," he says.

Licensed behavioral health clinicians in the behavioral health unit of Aetna's Disability and Absence Management Services coordinate behavioral health interventions for employees with a primary or secondary diagnosis of a mental health issue that may impact the member's return-to-work.

"We look at the person holistically and deal with more than just the primary medical condition. When the medical disability management unit uncovers a psychiatric issue, the claims are referred to a behavioral health clinician for review and consultation to identify any psychosocial issues that can impede treatment and lengthen the time it takes for the employee to return to work," says **Adele Spallone**, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services.

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Mental health care gets employees back to work

Care coordination for mental and physical issues

Aetna's disability behavioral health clinicians educate primary care physicians on the employees' disability plans and requirements, along with stressing the importance of a referral. Employees who were on short-term disability because of a behavioral health condition averaged 11 fewer days out of work than an industry benchmark when their claims were managed by Aetna's disability behavioral health unit, a study by Aetna's Disability and Absence Management Services determined.

The results translate into a savings for employers of $1,177 per employee when compared to the benchmark, according to **Adele Spallone**, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services.

The behavioral health unit is staffed by licensed behavioral health clinicians who work with employees, employers, and physical and behavioral health care providers by telephone to coordinate care and see that employees receive the care they need for a safe and successful return to work.

Most of the claims referred to the unit are for employees who see multiple providers, have complex return-to-work issues, and need frequent interventions and assistance with medication management.

"When employees have a primary or secondary diagnosis of mental health issues, it may impact their health recovery or return to work. We take a holistic approach to managing return-to-work and help our members deal with both physical and emotional health issues and return to work sooner," Spallone says.

When employees file claims for disability because of behavioral health issues, the claims automatically are referred to the disability behavioral health unit for assessment and management. If they file medical claims and the

EXECUTIVE SUMMARY

A study by Aetna shows that employees with a behavioral health condition return to work sooner if their claims are managed by a behavioral health clinician.

- Employees with a primary or secondary diagnosis of a behavioral health issue are referred to the disability behavioral health unit.
- The disability behavioral health clinicians identify all the physicians treating the employee and contact each of them, becoming their partner in coordinating care and getting the employee back to work.
- When employees with a behavioral health issue are seeing only a primary care physician, the disability behavioral health clinicians encourage them to refer patients for specialty behavioral health treatment.

medical disability management unit uncovers a psychiatric issue, the claims are referred to a behavioral health clinician for review and consultation.

In some cases, employees call in to the disability management unit to file a claim because of a medical event and speak only about the medical condition, but they may also have behavioral health comorbidity, Spallone says. "Often there are also psychosocial issues, such as financial problems or childcare issues that go along with the medical event," she says.

For instance, if an employee calls in about a back problem, the claims processor asks the employee about other problems that may be going on that could exacerbate his or her physical condition and prevent a return to work, such as if the employee feels anxious about returning to work or is concerned about loss of income if he or she doesn't recover sufficiently to return to work. People with long-term back problems tend to suffer from depression, she points out.

"We look at the person holistically and deal with more than just the primary medical condition. We identify the non-medical drivers upfront that can impede treatment and return to work. For example, we go beyond making sure the employee has an MRI and takes his medication but look at all the other factors that could make the duration of the claim longer," she says.

When disability claims analysts don't identify non-medical issues, employees may improve medically but say they still aren't ready for work. The disability claims analyst may uncover depression or fears of returning to the job and will have to help the employee overcome the psychosocial issues, which sometimes lengthen the time out of work, she says.

Many times employees who are out of work with a psychiatric issue don't have a relationship with a behavioral health physician and see a primary care physician. "When patients are treated for behavioral issues by a primary care physician, they often don't get the follow up they need. Some doctors just write medication prescriptions to address the psychological symptoms. But when people are dealing with depression and are out of work for any reason, they need to see a behavioral health professional regularly who will assess the patient's coping skills and their ability to function and help the individual work on things that affect their lives," Spallone says.

Aetna's disability behavioral health clinicians educate primary care physicians on the employees' disability plans and requirements, along with stressing the importance of a referral for specialty behavioral health treatment, she says. Many times primary care physicians don't realize that patients have behavioral health benefits and don't consider making a referral for that reason, she adds.

Some disability claims are subjective in nature and driven by the patient, Spallone points out. "Patients will go to their physician with whom they have a long-standing relationship and say they don't feel like they can work and the physician will concur. The physicians are not trained in disability benefits and often don't know what the patient's responsibilities are at work or what their job entails. Our clinicians educate physicians on the employee's job description and the national benchmarking tool used to determine how long people with a specific diagnosis are typically out of work," she says.

If patients stay out of work longer than the norm, it's usually because of other factors. "Some employees go out of work because of a non-physical problem such as getting a bad performance evaluation or if they don't like their work shift. We'll have a conversation with the physician to find out why patients can't work and don't feel they are ready to return to work and work with them on a return-to-work plan," she says.

When a claim is referred to Aetna's disability behavioral health unit, a clinician immediately makes contact with the employee and the primary care physician as well as all of the other providers who are treating the employee.

"We believe it's important to get the right clinical resources and right clinical interventions in place up front," she says.

When they talk to employees, the clinicians conduct a functional assessment and ask a series of questions, including how long the employees have had the condition, what happened to exacerbate it, who their treating physician or physicians are, when the employees last saw their doctors and the date of their next office visits, and what the employees think are the barriers to going back to work.

The clinician also asks questions about the employee's ability to perform activities of daily living. When an employee is out of work due to chronic or major depression, the clinician looks for any potential suicidal ideation. "If the employee voices a threat to themselves or others, the clinicians have a threat protocol to follow," Spallone says.

The disability behavioral health clinicians identify all the physicians treating the employee and contact each of them. "We want to gather information from everyone to get a holistic view of what's going on," she says. The team created a behavioral health questionnaire that asks each treating physician to assess the patients in three areas: cognitive, emotional, and behavioral impairment.

"When we talk to the treating physicians, we want to go beyond the diagnosis and make sure that the employee meets the requirements of their disability contract and is not able to perform core elements of their job. We talk to the physician about the employee's job description and educate them about duration guidelines. We become their partners in determining the best approach for the patient getting back to work," she says. ■

Readmissions reduced with psychiatric care

Patients stay out of hospital longer

Optum's Field Care Advocacy program, which provides comprehensive services to people who are being discharged from a psychiatric hospital, has resulted in fewer hospital readmissions and longer periods of time between admissions.

Patients admitted to the hospital due to a behavioral health condition are often at high risk of being rehospitalized within 30 days after discharge because of a variety of factors, including the need for better coordination between medical and behavioral health providers and inadequate links to community-based resources and support, says **Margaret Brennecke**, PhD, national president for outpatient programs for Optum's behavioral health business.

"To address this problem and promote the goal of recovery, the Field Care Advocacy program targets people who have recently been discharged from inpatient and residential settings who have been identified as being at highest risk for readmission. Our data analysis shows that the program helps decrease hospital rates and extends the time that people spend in the community between hospital visits," Brennecke says.

Based in Eden Prairie, MN, Optum contracts with employers, health plans, public sector programs and health care providers to support the needs of people with behavioral health problems.

Care for people in the program is coordinated by Field Care Advocates, who are independent licensed behavioral health clinicians who work with patients in person and over the telephone. Because they live in the communities in which they work, they understand the residents of the community and the services that are available. The Field Care Advocates have received extensive training from Optum Behavioral Health on engaging patients and tools and techniques that patients can use to manage their own mental and physical health.

Whenever possible, the Care Advocates make initial contact with patients while they are still in the hospital to introduce the program. Otherwise, they contact the patient immediately after discharge.

"When people are hospitalized for a behavioral health condition, it's usually a traumatic and frightening experience. Nobody wants to feel that ill, and they don't want it to happen again. At this point, they are open to making changes in their lives so this is often the best opportunity for the Field Care Advocate to go in and engage them in a plan of care," says **Sue Bergeson**, vice president of consumer affairs for Optum's behavioral health business.

When patients have complex physical and mental health conditions, have experienced multiple hospitalizations and have had difficulty coping with their illness, they also may be assigned to a peer specialist who works as a health coach. They help the patients set goals and work with them on making lifestyle changes such as getting regular exercise or eating a healthy diet. The

EXECUTIVE SUMMARY

Optum's Field Care Advocacy program that provides services for people at risk for rehospitalization for a behavioral health condition helps decrease readmissions and extend the time that patients are able to live in the community.

- Field Care Advocates, who are licensed behavioral health clinicians, work with patients in person and over the phone, help them follow their treatment plan and access needed services, and coordinate care with their providers.
- They typically work with the patient and providers for 90 days.
- People with complex needs who have problems following their treatment plan are paired with peer specialists who act as health coaches and work with them for about six months.

peer specialists are people who are in recovery from behavioral health conditions and who go through extensive training on engaging patients in managing their physical and mental health.

Optum's Field Care Advocates work with people with behavioral health issues to ensure that they receive adequate therapeutic support and that the medical comorbidities are addressed. "We bring the concepts of recovery and resilience to the table and provide support so participants can learn to manage their own health," Brennecke says.

When patients are identified for the program, the Field Care Advocate conducts an assessment in four areas—therapeutic support, community and family support, medical comorbidities, and recovery and resilience. "We look at whether therapeutic services are available and if the patient has made appointments. If the services are in place, we make sure that all providers are aware of what others are doing, and that the patient is receiving effective, evidence-based care," Brennecke says.

The Field Care Advocates also assess whether the patient and/or family members need education and support and refer them to support groups, online sources, and other support systems.

When they conduct the initial assessment, the Field Care Advocates also assess the need for interventions for physical conditions. When there are medical comorbidities, the Field Care Advocate contacts the treating physicians and works to ensure appropriate communication between the patient's medical and behavioral health providers. "Many times we find that physical illnesses are being under-treated because the patients are so focused on the demands of their behavioral health condition. To address that gap the Field Care Advocates coordinate with the behavioral health practitioners and physical health providers to make sure they are communicating with each other to meet all the patient's needs," Brennecke says.

Often behavioral health providers and physical health providers work in silos and don't know what the other providers are doing, she adds. "Our ultimate goal is to get patients aligned with services that meet their needs and get all providers communicating with each other," Brennecke says.

Bergeson adds, "The fourth pillar of the program, recovery and resilience, assesses whether, from the patient's perspective, they are living a quality life and working toward goals that are important to them and whether they need support to enhance that," she says.

Typically, the Care Advocate works with the patient for 90 days but can extend the program if the patient needs it.

"The Care Advocate's goal is to engage individuals, help them put a recovery plan in place, and step away. We don't keep a member chained to our engagement because our goal is to help. We want them to take charge of managing their own conditions," Bergeson adds.

People who are paired with a peer specialist are identified when they come into the program. Typically, they have experienced multiple hospitalizations and have difficulty in coping with their illness and becoming engaged in adhering to their treatment plan.

Because the peer specialists have experienced hospitalization and treatment for behavioral health problems themselves, they have a good understanding of how these conditions can affect the physical and psychological wellbeing of the patients with whom they work. They often share stories of their own illness and recovery as they help patients identify their challenges and work through them. They typically work with patients for about six months, helping them develop recovery goals and support them in following the wellness and treatment plan the patient has developed with his or her providers.

"The peer specialists demonstrate the power of peer support in helping people improve their overall health and wellbeing. They work along with the rest of the team to ensure that the patients' needs are met and that they continue to be able to stay in the community rather than being hospitalized," Bergeson says. ■

Program joins physical, behavioral healthcare

Initiative focuses on mentally ill patients

UPMC Insurance Division's Connected Care, a program that links behavioral health providers and medical providers, has reduced the use of behavioral and physical health services by participants in the program.

"We've seen a significant reduction in hospital admissions and emergency department visits among members in Connected Care," says **James Schuster**, MD, chief medical officer for Community Care Behavioral Health Organization,

which partnered in this effort with UPMC Health Plan and the Allegheny County Office of Mental Health.

The program provides coordination of mental health and physical health benefits for members of UPMC for You, a Medicaid managed care plan as well as Community Care Behavioral Health for its behavioral health services. Community Care manages behavioral health services for recipients of Pennsylvania's Medical Assistance program in 39 counties.

Connected Care is an effort to better coordinate care for individuals with serious mental illness by linking health plans, personal care physicians, and behavioral health providers in outpatient, inpatient, and emergency department settings, Schuster says. The program aims to improve the health of people with serious mental illness and enhance the patient experience of care by coordinating both physical and mental health services as well as minimizing the cost of care for the population.

"Many individuals with mental illness have wellness and physical health issues as well," Schuster says. The majority of people with serious mental illness smoke or are significantly overweight, and many have chronic conditions such as diabetes, heart disease, and respiratory problems. Even without health problems, their behavior often places them at risk," Schuster says.

When it created Connected Care, UPMC merged data from care management systems at UPMC for You and Community Care Behavioral Health to create a database that both physical health and behavioral health care managers use to share information about patients. The database helps staff identify what providers each member is seeing, what case manager from each component is coordinating care, and any barriers to receiving care that have been identified. A multidisciplinary team from both Community Care and UPMC for You worked together to design the program.

"Connected Care allows us to share information about acute services with providers. If members have a hospital admission, we notify behavioral health providers who use the information as an opportunity to reconnect with the patient," Schuster says.

The care managers from both organizations were trained to function as wellness and health coaches as well as learning how care coordination works in both organizations.

The program has developed patient registries that list members with gaps in care for preventive services or chronic conditions, cuing the case managers to intervene. The care managers notify primary care and behavioral health providers, including community-based case managers, when patients are admitted to the hospital or visit the emergency department and when there are gaps in refilling antipsychotics and receiving recommended lab tests and other care.

As members are identified, a multidisciplinary team from both organizations discusses the case and chooses a lead case manager, based on the member's needs and existing relationships. The multidisciplinary team works together to develop individual integrated care plans for each member in the program and meets periodically to discuss specific patients with complex needs and brainstorm on ways to help them follow their treatment plan. The lead care managers contact patients by telephone and make sure they understand their medication regimen and work with them on following their treatment plans. The team contacts each individual's mental health and physical health provider, informs the provider of the treatment plan, and talks with a therapist or a nurse about concerns for each individual patient.

When patients are admitted to the hospital, the program care manager assists with developing the discharge plan and follows up to ensure that patients receive a post-discharge visit with an appropriate physician and understand their discharge plan and how to take their medication. In addition, the care coordinators share

EXECUTIVE SUMMARY

By coordinating care between behavioral health and medical health providers, Connected Care, part of UPMC Insurance Division, has reduced hospital admissions and emergency department visits for members of UPMC for You, a Medicaid managed care plan as well as Community Care Behavioral Health which manages services for recipients of Pennsylvania's medical assistance program.

- Case managers at both organizations share a database that shows physical health and mental health interventions for patients in the program.
- When patients receive services from a mental health or physical health provider or are hospitalized, the care managers make sure all of the patient's providers are aware of what has happened.
- A multidisciplinary team from both organizations develops a plan of care for individuals and assigns a lead case manager who coordinates care with the patients' providers.

information with primary care providers about the patients' behavioral health interventions and alert mental health providers when patients have a medical intervention.

"The care managers do a lot of work and ongoing communication to engage community-based mental health providers and care managers as well as working to support the primary care physicians in managing the physical health of the patients. In the past, communication between providers was not as predictable or regular. We created a structured process to make sure that physicians and behavioral health providers are aware of what's going on with patients in regards to both their physical and behavioral health issues," Schuster says. ■

Team reduces ED wait times, improves safety

Collaboration nurtures quality improvement

The fast pace of a busy ED can make it difficult to focus in on processes that could be improved, but leadership and commitment can move the needle in the right direction as long as emergency personnel understand why change is important. That, at least, is what **Erin Muck**, RN, the ED manager and trauma coordinator at Avera Marshall Regional Medical Center, a 25-bed hospital in Marshall, MN, has discovered. The ED treats about 7,200 patients annually, and 100 patients per month are admitted to the hospital from the ED.

When the ED at Avera Marshall began participating in a project aimed at improving throughput times toward the end of 2011, Muck utilized a collaborative process to identify steps that could be improved. Muck asked one of the ED's four physicians to participate in the effort by attending a monthly meeting in which ideas would be solicited and discussed. She also invited nurses to participate, and she brought in representatives from the lab and radiology departments as needed. Two representatives from the hospital's quality department participated in the meetings as well.

To make it convenient for the physician to participate, Muck says she always scheduled the meetings during the morning hours when the ED is typically not as busy, generally around 9 a.m. The discussions typically lasted for 30-60 minutes, she explains.

Use data to drive improvement

Over a period of several months, the so-called "quick-hits" meetings produced a number of ideas to shorten wait times for patients while also improving safety. One of the biggest improvements that resulted from the process was a reduction of 12 minutes in the ED's average decision-to-admit time, bringing this metric from 44 minutes down to 32 minutes. "It was hard to address the decision-to-admit times because a lot of people don't document them," says Muck. "It took us a good six months just to get that piece of it done."

The "quick hits" team theorized that the admission process could be expedited if the charge nurses were notified earlier on that a patient was likely to be admitted. "That way they could be thinking about who they are going to assign the patient to, what room they are going to open up, and those kinds of things," says Muck. Under this type of arrangement, charge nurses would be able to give the nurses on the inpatient floors a heads-up when they are likely to receive a patient. "It would just give them the time to wrap up whatever they are doing so that they are prepared for an admission," says Muck. Also, the charge nurses would be mentally prepared for a phone call when the decision to admit is made by the physician, she says.

One other reason why Muck felt the approach would work well is because she has a very experienced group of nurses manning the ED. "The nursing staff here average about 24 years of service, so they are very well versed in working the ED and estimating [which patients are likely to be admitted]," she explains. "They do a pretty nice job."

However, when the approach was first implemented, there was snag. "Most of the charge nurses were awesome about this," says Muck, but there was one charge nurse who was not acting on the early information. Consequently, Muck shared a report with the charge nurses showing the decision-to-admit times per charge nurse. "Then she stepped up her game," says Muck.

To sustain the improvement in decision-to-admit times, Muck acknowledges that she needs to keep her eye on it. "If I am not watching that

constantly and putting the data out there for [the staff to see], then it is out of sight, out of mind, so then they aren't doing quite as well," she says.

A similar approach worked well in getting the physicians to pay attention to their throughput times. "Every month I would have a printout of our general throughput times, and then I would have it per physician," says Muck. "Occasionally, I still run those reports. We have some locum physicians [who work in the ED now], so I want to keep track of them and how their throughput times compare with our own physicians. It is a little friendly competition."

Get buy-in

Other ideas that came out of the "quick hits" process include the establishment of a goal for completing the triage process by the time a patient has been in the ED for 10 minutes. Also, blood is now routinely drawn during triage for patients who present with an issue that will likely require blood work, such as patients presenting with abdominal pain, explains Muck. "We figured out how to do triage quicker and better, and these were ideas that we got from the nursing staff, physicians, and sometimes lab or X-ray," she says.

While some organizations might struggle to prevent this type of team-driven process from turning into a blame game, Muck says hospital administrators have nurtured a culture in which it is not OK to get defensive or angry when discussing problems. "We don't have that problem here. It is always good to get advice," she says. "The managers work well together and we are always open for suggestions. If my suggestion doesn't work, then they will suggest something different that does."

Muck acknowledges that it can be more difficult to get physicians on board with any type of change. The key, she says, is making sure they understand what the benefits will be of a change in process. She adds that a team-driven approach can facilitate this type of exchange. "In order to problem solve, it is good to have the people involved because you can have better buy-in regarding how to fix things," she says.

While the formal monthly "quick hits" meetings no longer take place, Muck explains that she regularly uses the approach for quality improvement. For example, she is now engaged in an effort to identify ways to improve trauma care. "We have a trauma surgeon involved, trauma physicians, and sometimes orthopedics as well," she says. "Who we invite to the meetings just depends on what issue we are addressing."

SOURCE

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What makes for good care coordination?

Start by asking your patients

Ask a doctor if she thinks her hospital does a good job at care coordination — or an administrator or board member — and she'd probably say yes. She might admit to room for improvement, but in all likelihood, she would think she and her peers do a good job taking care of patients in and out of the acute care setting. But the reality is different, says quality guru and Harvard professor **Lucian Leape**, MD, chairman of an eponymous institute at the National Patient Safety Foundation.

"I teach a course on quality and safety in health care, and the first day, I ask the students to find a patient — any patient — with a serious medical problem who will talk to them about it, and interview them about their experience," he says. "It's very worthwhile for the students. I read the essays and this year, three quarters of them had patients that reported serious care coordination problems. These are people with complex problems. And my take away is that this is endemic. These are patients from all over the country. It's a huge problem, and yet most places think they coordinate care well."

A starting point

Leape says one of his colleagues has decided that talking to patients about their perception of care coordination is so vital, that she has developed a survey tool just for that.[1] It's currently being piloted. He says that hospitals can get a sense of patient views from other patient experience surveys, but those other surveys are not focused on how well patients think providers care for them across the continuum. Consider developing questions that would help you determine how your organization does in the eyes of patients.

There are some existing tools that offer a starting point, such as one created in Australia in 2003 (available at http://intqhc.oxfordjournals.org/content/15/4/309/T5.expansion.html).

Part of the problem is that the consequences of doing a bad job seem to fall on the patients, not providers. "Who sees it when you do not do a good job? And for the poorest or those in the worst health? Well they're not really a vocal bunch are they?"

Another issue is that the position of "care coordinator" is not dignified by payers financially. "If you have a patient with more than two diagnoses, we need payers to pay for someone to actively coordinate their care," Leape says. "There is a ton of data that shows asthma patients, for example, have fewer emergency room visits and fewer hospitalizations when they have highly coordinated care. What we need is a certified care coordinator position whose time is billable and paid for by insurers."

Some organizations seem to do it well — Group Health in Seattle, for instance, and Cambridge Health Alliance. The latter provides safety net services for a "difficult" population of poorer, less healthy people in Massachusetts, Leape says. "But they have put a big emphasis on coordinating care for a long time."

Cambridge Health Alliance has certified five outpatient sites as patient-centered medical homes in the last 18 months, says **David Osler**, MD, MPH, senior vice president of ambulatory services for the organization in Somerville, MA. Most of the ambulatory sites for the organization are staffed with care coordinators, too. They have achieved some cost savings and some improved outcomes as a result, he says.

What he thinks would help would be a unified electronic medical record that both inpatient and outpatient providers can readily access. They have also had success by putting some patients on risk-based contracts. Perhaps the best thing a hospital can do is work with area providers to ensure every patient has ready access to outside primary care providers.

The playbook

"The hospital is like the quarterback in the football team," says **Angel McGarrity-Davis**, RN, a healthcare consultant based in Clearwater, FL. "The hospital must lead the other members on the team to perform their duties," she says. "They have to know what every person's job is in the post-acute care arena. They must be able to relay to the various players what their responsibilities and accountabilities are. And they need to have input into the playbook."

That book would be the various clinical pathways and processes they use, as well as the evidence on which they are based.

Share that playbook throughout the healthcare community, she continues. Get out of the silos that isolate the various parts of the continuum — have joint training, for instance. Gather the team members to discuss what works and what doesn't. "Working together is key," McGarrity-Davis says. "Get together with the skilled nursing facilities, long-term acute care hospitals, and home health agencies. Everyone should be on the same page for discharge planning, and the entire multidisciplinary team should be involved to follow up."

Most organizations will admit that such collaboration sounds like a great idea. Many may already do it.

But McGarrity-Davis adds another layer in that echoes a suggestion Leape makes: Get patients and their caregivers and/or families involved in the process, too. Have them work with the rest of the team to create forms that work, information that is understandable, and procedures that take the patient into account in the process.

Payers introduced penalties for unplanned readmissions for a reason, she says. "It's not because hospitals are responsible for or the cause of the readmissions all by themselves. But they are the industry leader. So if the hospital seeks solutions, creates a plan, and says it should be done, then the rest of the continuum will follow suit."

REFERENCE

1. Singer SJ, Friedberg MW, Kiang MV, Dunn T, and Kuhn DM. Development and Preliminary Validation of the Patient Perceptions of Integrated Care Survey Med Care Res Rev April 2013 70: 143-164

SOURCES

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System said to reduce falls, transfers in elderly

Also helps reduce other adverse events

A fall reduction system that encourages caregivers to respond early to warning signs has been proven to significantly reduce falls, according to the manufacturer.

EarlySense, based in Waltham, MA, announced the results of a multi-center clinical study demonstrating that the system helps medical teams at rehabilitation centers to reduce patient falls as well as the number of patients transferred back to the hospital.

The technology involves continuous patient monitoring in hospitals and rehabilitation homes by monitoring patients' heart rate, respiration, and movement without touching the patients. Eight hundred and thirty-three patient records at The Dorot Geriatric Center, a 374-bed facility in Netanya, Israel, and 773 records at the Hebrew Home at Riverdale, an 870-bed skilled nursing facility in Riverdale, NY, were collected and reviewed over six months. The transfer rate to the hospital decreased by 21% at Dorot, and the falls rate decreased by 38.5% at the Hebrew Home.

The contact-free sensing capabilities and immediate data transfer enable nurses to proactively provide personalized patient care and potentially prevent adverse events, the company says. Through continuous patient supervision, the system can help staff reduce the risk of patient falls and effectively work toward decreasing other adverse events, such as pressure ulcers.

The data was presented recently at the 2013 Annual Scientific Meeting of the American Geriatrics Society (AGS) by Hebrew Home medical director and study principal investigator **Zachary J. Palace**, MD.

"The system also alerted regarding early warning signs of patient deterioration, which enabled our medical team to proactively respond and literally save four lives," Palace adds. ■

COMING IN FUTURE MONTHS

- How your peers are working to reduce readmissions
- Why culturally competent care is so important
- How to promote patient-centered care in your organization
- Coordinating care across the continuum

CNE QUESTIONS

1. According to Adele Spallone, LMHC, LMFT, clinical services head for Aetna Disability and Absence Management services, employees who are out of work for a physical issue may have psychosocial issues that could exacerbate their physical condition and prevent a return to work.
   A. True
   B. False

2. When do Optum's Field Care Advocates aim to contact patients who are hospitalized with behavioral health condition?
   A. While they are still in the hospital
   B. Within 24 hours after discharge
   C. When they have their first follow-up visit
   D. Within 48 hours after discharge

3. How long do Optum's Peer Specialists work with patients on average?
   A. Six weeks
   B. 90 days
   C. 120 days
   D. Six months

4. According to James Schuster, MD, chief medical officer for Community Care Behavioral Health Organization, what wellness and physical health issues do people with serious mental illnesses tend to have?
   A. Smoking
   B. Being overweight
   C. Chronic diseases
   D. All of the above

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

CNE INSTRUCTIONS

Nurses participate in this continuing education 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. ■