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The attraction of Magnet

Can Magnet, Joint Commission prep teams be of use to each other?

It is not surprising that in the competitive healthcare marketplace, for some facilities, getting the stamp of approval from The Joint Commission just isn't enough. So they seek other avenues to prove that the quality of care they deliver is stellar. For some, the nurse-centric Magnet journey is the obvious next choice. Nurses, after all, hold a special place in the hearts of just about everyone. Being able to say your hospital not only does well by its patients but does well by its nurses, who are responsible for the hospital being a great place to work and get well — it just makes sense.

It also seems to make sense that the folks who work on getting ready to pass a Joint Commission survey would be ideally placed to help a hospital prepare for the parts of the Magnet process related to quality. (*For more on the entire Magnet process, see page 3.*) But that is something that apparently rarely happens, says **Michelle Janney**, PhD, RN, NEA-BC, senior vice president and Wood-Prince Family Chief Nurse Executive at Northwestern Memorial Hospital, which has been a Magnet facility since 2006 and was reaccredited in 2010.

“The broad answer is that we all work together to advance quality, and that is the agenda of everyone every day,” says Janney. “When you get down into the weeds, though, it is a harder answer.”

Magnet and The Joint Commission measure quality differently, she says, so preparation is different. “There is overlap and integration, but the goals are not the same. The mechanism for The Joint Commission is compliance with a standard. Often a minimum standard that everyone has to meet.”

Magnet, however, is about excellence, surpassing the norm, and being better than almost everyone else. Not every hospital will be a Magnet facility because part of the deal is being exceptional, and being committed to excellence and innovation. “Both are critically important things,” Janney says of preparing for accreditation by the two organizations. “I’m not sure that you want to blend them, though.”

But the two entities themselves work together to some degree, and certainly they acknowledge each other’s importance in the quality improvement field, says **Linda Lewis**, MSA, RN, NEA-BC, FACHE, the director of the Magnet Recognition Program for the American Nurses Credentialing Center (ANCC) in Silver Spring, MD.

The two organizations have discussions regularly, with someone from Magnet involved in The Joint Commission's nursing advisory council. The Joint Commission has also held conference sessions on the benefits of seeking validation from Magnet or the Baldrige Performance Excellence Program. Last March the commission even created an entire report

comparing and contrasting Joint Commission, Magnet, and Baldrige principles and approaches. (The full report can be seen at http://www.jointcommission.org/assets/1/6/Comparison_Document2013.pdf.)

Leaving aside Baldrige, some of the standards for Magnet and The Joint Commission are similar enough that there is a crosswalk manual to show the parallels. For instance, one page in a crosswalk standard document includes this coupling of Joint Commission Standard number LD.02.01.01: "The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services." — with Magnet Recognition Program EP1: "The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals (See also NR.01.01.01, EP 2)." And EP2: "The hospital's mission, vision, and goals guide the actions of leaders."

"So there is synergy on the table," says Lewis.

But why isn't there any concerted effort to take what one group knows about Magnet accreditation and leverage it when The Joint Commission comes knocking? Why can't the stuff that the quality department works so hard on to be always ready for a survey be of use for Magnet recognition?

Working together

Lewis does not see any reason why the two groups can't work together. "In places where I have been chief nursing officer and the processes happen one after the other, having one be a success can give the other team a boost as they prepare. And while a Magnet application document may go many times more in depth than what you need for a typical Joint Commission survey, I think that the groups can certainly be of use to each other."

Both processes require the best of frontline staff, and many of the standards are the same, so getting both groups of people — those who focus on Magnet preparation and those who work on Joint Commission surveys — to sit around the table to talk about meeting standards and getting ready can only help. She mentioned that the people who work on Magnet applications "often know where the best stories in the house are, so be sure to ask them to share."

But be careful. Lewis says it would be a mistake

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to give anyone working on Magnet the idea that the program was getting a whiff of the regulatory about it. That it is voluntary and exclusive is part of what makes earning the achievement so special to those hospitals that make it — something only about 6% of U.S. healthcare organizations have achieved once, and half that number manage to repeat, according to Janney.

If nothing else, Lewis says, you'll get more people having conversations about quality, and that can't be a bad thing. And in a best-case scenario, you can have some cross-pollination on strategies to meet requirements, achieve new goals, or troubleshoot problems.

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The basics of Magnet recognition

Magnet hospitals are those that have demonstrated excellence in five areas, with 14 corresponding forces of magnetism:

1. Transformational Leadership. The ANCC website uses words like “vision, influence, clinical knowledge” in describing such leadership, as well as nursing practice expertise. The leadership sets the tone of the organization, creates the vision, and then preaches the gospel of necessary change in order to create systems that can innovate and problem-solve. The associated forces of magnetism are Quality of Nursing Leadership and Management Style.

2. Structural Empowerment. The leaders described above will create structures that encourage innovation and where the vision of the organization can flourish. Strong relationships between stakeholders within and outside of the organization will be demonstrated through policies, systems, and programs that the leadership develops, including for staff development as needed. The associated forces of magnetism are Organizational Structure, Personnel Policies and Programs, Community and Healthcare Organization, Image

of Nursing, Professional Development.

3. Exemplary Professional Practice. This is nursing-focused and relies on the organization to show how nurses interact with stakeholders throughout the hospital and the wider community and how they apply new knowledge. The associated forces of magnetism are Professional Models of Care, Consultation and Resources, Autonomy, and Nurses as Teachers.

4. New Knowledge, Innovation, & Improvements. This element is about improving healthcare, innovating, and expanding knowledge through the application of the science of nursing. The force of magnetism that goes with this element is Quality Improvement.

5. Empirical Quality Results. Outcomes matter. There isn't a lot of weight put on outcomes for Magnet, because there isn't anything measured to determine if a benchmark is met, but the ANCC acknowledges this needs to change. “There are no quantitative outcome requirements for Magnet Recognition,” the website notes. “This area is where the greatest changes need to occur.” Quality of Care is the force of magnetism that goes with this last element. Patient care is among the measures suggested on the ANCC website as a future empirical result. But the ANCC also mentions workforce and organizational data as appropriate for future benchmarking. ■

Is era of patient-reported outcomes at hand?

That's what one researcher hopes

The age of the process measure may be nearing its end, or at least the end of its heyday. But is it possible that the outcome measure as most people think of it is dead before it really gets off the ground? Not dead, but it may have to share the spotlight with another kind of outcome measure, says **Patricia Franklin, MD, MBA, MPH**, a professor and director of clinical and outcomes research at the University of Massachusetts Medical School in Worcester. She thinks the era of patient-reported outcome measures is at hand, and she has played a part in ushering it in.

As a medical director and a trained health services researcher, she thought that outcomes measures were the way to go in advancing

healthcare quality. She was gung-ho on the idea and was talking to a colleague — a high-volume orthopedic surgeon — about creating a database of outcome measures when he brought up not just using outcomes, but including patient-reported outcomes, and having the data available to physicians in real time, trended to help physicians better understand how to help patients.

This was back in 2007, and since then, she has seen that idea for a total joint replacement outcome registry go live at the University of Massachusetts, and then spread beyond to dozens of facilities across the country.

For some physicians, the idea of using something as subjective as how a patient feels as a measure of success, rather than what something objective like a blood test or X-ray says, is the antithesis of science. Maybe you include it, but do you give it weight? Yet adding patient-reported measures is not just something that a few researchers are thinking about. Entire countries are doing it — the UK, New Zealand, and Sweden now contact every orthopedic patient after surgery to ask about pain and function, says Franklin. The University of Massachusetts does so for every total joint replacement patient now, too.

Nationwide program

What started at the Worcester, MA, facility is now a nationwide program that 130 surgeons volunteered to be a part of, says Franklin.

The information comes from a validated survey computer program that patients complete at every physician appointment, before and after surgery. They answer questions about their pain and physical function and ability. The tests in the initial study at the University of Massachusetts were scored immediately and trended over time. Franklin says this enabled physicians to talk to a patient about how he or she was feeling on a given day compared to the previous appointment, or a month ago, and discuss options that might not include surgery based on that readily available information. The surgeon still makes the decision about whether the patient was a good candidate for surgery, but if the surgeon says yes, sometimes the patient will say no after seeing an improvement in function that might not have been evident without that data being available.

“In the traditional registries about total joint replacements, the information that was captured was about how long the joint replacement survived and if there was a need for a revision,” says Franklin. Pain was not a factor, nor was function.

Doctors can also benefit by being able to see which patient groups seem to benefit from which kinds of treatment. For example, if they have access to real-time data — or even relatively quick-time data like the current study, which gets data to the physicians every quarter — they might see that patients who have certain characteristics do better with a specific type of implant or procedure, or that others do best with a special post-surgical regimen. Maybe one would find a cluster of patients who aren’t doing well and discover they all have been in a particular unit on the same day of the week. A doctor could also provide statistics to a patient about others like him or her: In the 40 patients of his gender, age, weight and activity level that have had that implant this year, 35 of them have done well, and the five who did not weren’t compliant with the plan of care. It gives patients and physicians more and better information on which to act, says Franklin.

The doctors involved in the latest study had to be taught to use this kind of data, Franklin notes. “They did not know how to make use of information on pain and function, as opposed to information on complications and revisions,” she says. Those physicians were culled from a list of surgeons who were high-volume practitioners and were randomly called until they had enough willing participants to fill the study.

It didn’t take long: This kind of research is gaining attention, Franklin says. When the government was handing out stimulus money, she wrote a grant looking to see if she could create a new program to promote a vital sign for pain and functionality to use in primary care offices. The grant proposal got a lot of interest and attention from the National Institutes of Health, but it crossed so many different areas of interest that they did not know under which heading to fund it. So they opted not to. But it gave Franklin more of a push forward in this area.

So far, she hasn’t seen it expand much beyond orthopedics — a plastic surgeon, a couple of rheumatologists. “I do not think it has to be limited to perioperative assessment,” she says. “I

haven't seen it grow much other than doctor by doctor."

Which brings Franklin to her proselytizing moment — what she thinks every quality manager can and should be doing now that can be simple and make a difference to patients: If something is a high-volume, high-cost procedure, add a couple of questions to your patient satisfaction surveys about pain and functionality. The doctors probably ask these same patients about pain and function before they have surgery and have that recorded someplace. Include the responses post-surgery in the same place.

If you want to go a step further, make friends with the IT department and create a database of those patients who have that high-volume, high-cost procedure. Think hip replacement, or total knee. But it does not have to be about joints. It might be bariatric surgery at your facility. It might be something cosmetic. This data is useful now. Franklin says that even before they started their study, she put these questions on the total joint replacement post-surgery surveys, and they were able to use the data for other purposes — to find gaps in performance, or even areas of expertise you did not know you should be touting.

Someday, these questions will be important enough to enough stakeholders that they will be mandated, Franklin says, noting that the Centers for Medicare & Medicaid Services is already looking into her work as part of a review of patient-reported outcomes. That it isn't currently a requirement does not mean it is not important and can't have an impact now.

"Patients are not the barrier to this," she says. "They love to help, to be asked and to respond. And if you can help patients do better, well isn't that why we are here?"

She gives an example: Total hip replacement usually results in a dramatic decrease in pain for everyone. For most people, there is a similar dramatic functional increase. But not for all patients. "Being able to tease out the reason why some people do not do as well, which are related to comorbidities, which are related to things that the patient can control, and which you can counsel the patient to just expect to live with, well that would be a wonderful thing."

There are at least 10,000 patients in 22 states every year who get to report how they think they're doing, Franklin says. She'd be perfectly happy to see anyone add some more.

For more information on this topic, contact Patricia Franklin, MD, MPH, MBA, Professor, University of Massachusetts Medical School, Worcester, MA. Email: patricia.franklin@umassmed.edu. ■

Do you need to do an RCA on your RCA?

Make sure your analysis can fix a problem

Imagine a very busy hospital where there is a series of wrong-site surgeries. The hospital risk manager does a root-cause analysis (RCA) and figures the surgeons should implement a checklist. The quality director finds one online, gives the instructions to the chief nursing officer that all the surgical nurses should make sure to use it, and the hospital goes back about its business. But the problems persist. The newspapers get wind of it. The CEO isn't happy. The board is less happy. Don't even ask about the patients.

A consultant is brought in to unsnarl the problem and figure out what's wrong. In the eyes of the leadership, it's a matter of flushing out the bad actors, and fast, because time is money and this is just bad publicity that isn't good for business. In her interviews the consultant hears something that cements her feeling that the problem has nothing to do with the individuals in the operating room. Those checklists? The nurses were filling them out before the patient got into the theater because doing so saved time. And time was money. Just ask the CEO.

That fictional example might sound extreme, but it highlights issues than can exist in real-life hospitals.

"Doing a root-cause analysis is more than just finding a problem and creating a solution," says **Rhonda Filipp**, RN, MPA, director of quality and patient safety for the California Hospital Patient Safety Organization (CHPSO) in Sacramento. "You have to have some way to check if that corrective action plan was put in place and whether it addresses the problem."

A quality and scientific perspective

A checklist is a fine thing if it's used properly.

An interview of nurses, an audit of charts — those things could determine if a checklist in an operating room is being used, and being used at the right time, before wrong-site surgeries start piling up, she says.

Filipp notes that there has been a dramatic shift in the last two decades from adverse events being handled by the risk management team, to a patient safety focus, and now to events being viewed from a quality and scientific perspective. But those changes can be hard to digest — with a new lingo to learn, scientific principles to teach to people who didn't think they'd need them in their job — or to apply in a different manner — and a commitment to seeing changes over time, not necessarily today, or even tomorrow.

“If you have an event happen one day, and you start your root-cause analysis the next, a thorough process isn't going to be over quickly,” Philipp says. “You can do a causal analysis and a whole lot of work understanding what happened and developing a corrective action plan. But by the time you get there, it is three weeks later, and the emotional response you had right after an event from the people involved — well, that has shifted to the other things that are grabbing their attention.”

Addressing causal analysis

So what can you do? Philipp gives the following examples of how to successfully address causal analysis:

- First, she says, you can't stop at the first, obvious layers of causes. Keep working your way to the middle of the onion. The low-hanging fruit, the easy stuff? Sure, grab it. But don't assume that's all there is.
- Develop a corrective plan that includes a way to prove it was implemented. That might mean chart audits, or interviews, or observations. If you have a checklist, you can see if it is done. But if you want it done at a particular time, you either need to do it on a computer when it can be time-stamped, or you will have to rely on the trustworthiness and willingness of people to speak up and speak out. If you don't have a culture that encourages and embraces that, it might be difficult.
- Not all things are easily measurable. “What if one of the things you want to do is encourage better communication,” she asks. “How do you

measure that? It might mean creating surveys or walking through rounds and watching people and taking notes, and it might not be strictly scientific. That doesn't mean it's not valid.”

- Include a timeline for implementation and periodic status reporting periods.
- Have someone overseeing the efforts. One hospital where Philipp worked had a multidisciplinary committee in charge of doing root-cause analysis. They were in charge of determining if the causal analysis was complete and acceptable, they approved the proposed fixes, looked at the evidence that those fixes were being implemented, and eventually, would review the data to see if the solutions were working.

Committee members also determined how long to keep a pilot project going and were available resources if something needed tweaking. (This assumes that you have a quality and safety primed culture, where leadership encourages such activity.) When someone was late with a report, the committee was able to “hold their feet to the fire” and keep the team accountable for their role in improvement, Philipp says.

There are a lot of tools related to creating an effective analysis that is evidence-based which Philipp has developed and would love to share with anyone who has an interest. But many hospitals view them as proprietary. She is hopeful, however, that in the near future there will be a place where quality managers can go to find anything they need related to hospital quality.

“The California Hospital Association is launching the Hospital Quality Institute in January, and we are working to make a lot more of this kind of thing available,” she says. “We want the website to be the Google of hospital quality.”

Until then, she says your patient safety organization and state hospital association may have some tools — possibly some of the very ones she developed — that could assist you in ensuring you have created a causal analysis that has measurable, provable aims.

The Hospital Quality Institute website will be at hqi.org and goes live in late January.

For more information on this topic, contact Rhonda Philipp, RN, MPA, Director, Quality and Patient Safety, California Hospital Patient Safety Organization (CHPSO), Sacramento, CA. Email: rphilipp@chpso.org. ■

A little this and a little that equals success

Promise for reducing harm at handoff

Follow the logic: Communication errors are a leading cause of medical mistakes and are linked to two-thirds of all the sentinel events reported to The Joint Commission. Medical mistakes are a leading cause of mortality and morbidity in the United States — the third leading cause, according to some statistical sources. The number of handoffs in hospitals is growing as the number of hours worked by nurses and doctors declines. Each handoff is another chance for a communication mistake. This makes handoffs potentially a huge contributing factor to patient harm and also a great potential source for improving care, says **Amy Starmer, MD, MPH**, an associate scientific researcher at Boston Children's Hospital.

Starmer is lead author of a recent study published in the *Journal of the American Medical Association* (JAMA) that evaluated the use of multiple interventions bundled together to improve handoffs, and thus patient safety in a children's hospital.¹

The bundle was provided to interns and senior residents on two units. It included a training session that contained elements of a program developed by the Agency for Healthcare Research and Quality and the U.S. Department of Defense that focused on good written and verbal handoffs, a mnemonic (SIGNOUT) to standardize verbal exchanges — and restructuring participants' separate handoffs into a unified team handoff; moving handoffs to a quieter location; and having a chief resident or attending oversee handoffs for each resident at least once a month.

On one unit, there was also a computerized tool included as part of the electronic medical record that automatically imported demographic information, as well as data about allergies, medications, vital signs, and problem lists. The goal was to minimize inaccurate and out-of-date information included in handoffs. There were also fields on the computerized form for a patient summary, a to-do list, and contingency planning that could help make handoffs more complete.

The main measure was medical mistakes. Nurses reviewed all medical records and orders

from the study units looking for medical errors and adverse events. They also asked for error reports from providers and reviewed any formal incident reports. A physician reviewed every suspected incident, and they were classified as an adverse event, a non-intercepted near miss, an intercepted near miss, or a suspected incident that a research nurse reported but that the physicians didn't think met the status of medical error or adverse event. They were also rated as to how preventable they were, using an established four-point scale.

Researchers also assessed omissions from written handoffs, looking for any omissions or mistakes, and they evaluated workflow patterns and verbal handoffs.

The results were impressive. The bundle was associated with a reduction from 33.8% errors to 18.3% on the two involved units. Preventable adverse events were more than halved, from 3.3% to 1.5%, and intercepted near misses went from 15% to 8.3%. Those with little or no potential for harm declined from 8.3% to 5.2%.

The written handoff documentation improved markedly, too, with large reductions in the omission of key data, although the unit with the computerized tool saw a greater improvement than the other unit. And there was a significant increase in time the doctors spent with patients and families — from 8.3% to 10.6% of their total time, pre- and post-intervention, respectively.

“Physicians get a lot of training in managing disease, even in how to write a good progress note,” Starmer says. “But we don't learn how to do a handoff, and there has been shockingly little standardization of the process.”

One thing she thought might work was taking a little bit of a lot of things that seemed to have worked in other situations and mixing them up into a bundle. It's the kind of thing that worked for hard problems such as central-line infections. A single mnemonic might not work, but that combined with some training, mixed with changes in place, time, and means of communication? Put it together and maybe all the pieces would work better than any of them singly, Starmer says.

“Changing communication can be particularly difficult, because it tends to be culturally ingrained,” she says. “We knew that we were asking for something transformational. The literature review, some workshops, and our own brainstorming led to these ideas. And we didn't

know if they would work because the literature is on the fact that handoffs are a problem, not on how to fix it, and if there were two studies on mnemonics, you didn't know which would work better in your situation because no one compared the two."

Key to making that cultural change was having a large group of players from various departments involved. The residency program director, the chief medical information officer, nursing, researchers, residents — if someone might possibly have had an interest in the implementation or outcome, he or she was included, Starmer says.

That first pass at fixing handoffs was a success, which created a positive buzz for the participants, but that was just the start. Now there are nine sites participating in what is known as the IPASS study group, named after the mnemonic that superseded the unwieldy SIGNOUT. IPASS stands for

- Illness severity
- Patient summary
- Action list
- Situation awareness and contingency planning
- Synthesis by receiver.

Each of the new letters corresponds to something on the electronic record and related electronic handoff tool, too. The information comes up in the same order electronically as they are trained to bring it up in a verbal handoff — something that didn't happen in the original iteration. It's a much cleaner and easier-to-remember memory helper, says Starmer, who confides that not even the researchers always remembered all the words for SIGNOUT.

There is also new training available for faculty members to get them more engaged in observing the handoff process among the residents and interns, and in providing effective feedback. They have also been working on how to "sustain the brand," Starmer says, so that handoffs stay front of mind for the doctors, even though they may not be participating in a study any longer. "We don't want it to die out," she says. The study group is gathering data from those efforts now to see what will work to keep them thinking about IPASS long after they have left internships and residencies behind.

Data from the other nine sites is coming in, and while the scientist in Starmer won't let her say anything official, she thinks that the anecdotal evidence points to continued good news — that the bundle is working in the other places

where it is being used.

She's getting feedback from outside the study, too: The IPASS group has a website — www.ipasshandoffstudy.com — that is open for anyone to use. It includes links to resources, tools, the bundle, and literature. It's free, and so far, Starmer and her colleagues have processed more than 600 individual requests for the materials from 48 states and multiple countries. The people who have used it and have reported back on their experience have said it has been valuable.

"The first try on this was an intuitive guess, and we thought it would be successful, that we would see a reduction in errors," she says. "But I don't think any of us anticipated we would see a 50% decline in them. And when you are trying to change a system of communication, there is always going to be resistance. There will always be hesitation — especially about whether we would be taking time away from patient care. But we were able to prove to them that not only would they be giving safer care, they were able to spend more time with patients and their families. That was really good."

Nothing they did is specific to a children's hospital or a teaching hospital. Anyone can make use of the process, she says. "It is easily adaptable and anyone can figure out how it can help them."

The real lesson, though, might be to stop looking for a single solution to every problem. Maybe a bunch of little solutions will work together like something bigger.

Further information about the IPASS study group was published last year in *Pediatrics*.² A complete list of publications is available at the study website.

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Report: Cancer care could use a makeover

Hospital role is small but crucial

Most cancer care takes place in the community. Patients with cancer come into the hospital for surgery, for outpatient procedures, or sometimes, sadly, at the end of their life. But all of healthcare is changing, and who is responsible for patient care when isn't a matter of bright lines of demarcation any more. So when the Institute of Medicine released a report last fall saying that the cancer care system was in crisis, it was something that every part of the healthcare continuum ought to pay attention to. (The report can be seen at <http://iom.edu/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx>.)

Many hospitals are already working on one area of concern — to improve palliative care services and make sure they are available not just at the end of life, but whenever they are needed, says **Patricia Ganz, MD**, a professor at the UCLA Fielding School of Public Health and Geffen School of Medicine and the lead author of the report. “The palliative care world has been working very hard to disengage their work from the end of life world. It’s about more than that. It isn’t about dying, but about being comfortable from the time a patient is diagnosed,” she says.

Quality measures for cancer

An area that hospital quality managers have expertise in, and where they may be of service to others on the care continuum, is to help develop, collect, and analyze data related to quality care for cancer patients. “We don’t have good quality measures for cancer right now,” says Ganz. “The Commission on Cancer is working on accreditation standards for implementation in 2015, though, and about 90% of hospitals will be involved in that.”

If you aren’t looking at these kinds of measures yet, you might want to. The American College of Surgeons Commission on Cancer website, <http://inspiringquality.facs.org/about/commission-on-cancer/>, has links to information related to standards.

Ganz says that with the dearth of outcomes measures related to cancer — there is a call in the IOM paper for oncologists to suggest some — it might be worth your while to sit down with your affiliated oncologists and ask them what data they think it might be useful to collect. Even if you don’t start collecting it yet, having a list of the important bits could put you ahead of the game later on.

“Systems don’t exist for knowing how a particular kind of patient will do with a certain treatment,” she says. Eventually, registries akin to the tumor registry will be created, though, and that information will help physicians and patients make better decisions about their care. “I want to be able to tell a patient that this is how a patient like you will likely do on this treatment and have it be based in reality,” says Ganz. “That’s why this kind of outcome measurement is important.”

Patient access to data

As for whose responsibility it is to capture and manage the data, accountable care organizations may blur those lines so much that it doesn’t matter who does it as long as it gets done. What will matter is that you cooperate with the other players on the continuum to provide care that the IOM isn’t writing reports about that include the phrase “in crisis.”

Patients will have access to data in the future about which hospital has the best record with which cancer, which doctor does best with what surgery, so figuring out what data is important to collect related to cancer, collecting it, and then mining it for information is in your interest as much as the patient’s, notes Ganz. At the very least, put the people around the table and ask them what their data wish list is. It’s entirely possible you already collect it. And if you don’t, it’s entirely possible that come 2015, you’ll have to anyway.

For more information on this topic, please contact Patricia A. Ganz, MD, Distinguished University Professor, UCLA Fielding School of Public Health, David Geffen School of Medicine at UCLA, Director, Cancer Prevention & Control Research, Jonsson Comprehensive Cancer Center, Los Angeles, CA. Email: pganz@mednet.ucla.edu. ■

New CLABSI toolkit from The Joint Commission

Monograph expands on best practices

The Joint Commission has released a new toolkit related to preventing central line-associated bloodstream infections (CLABSI) designed to help healthcare organizations implement best practices.

Paired with a monograph published in 2012 on the subject, the organization says the most current guidance on practices, technology, tools and resources is at the fingertips of those trying to reduce their infection rate.

There are more than 23,000 CLABSI infections annually in the United States, costing more than \$1 billion, according to the Centers for Disease Control and Prevention.

The toolkit and monograph cover the types of central venous catheters used;

risk factors for CLABSI;

CLABSI pathogens;

information on best practices and common barriers to them;

clinical practice guidelines;

prevention strategies, techniques, and technologies;

information on surveillance, benchmarking, and reporting;

economic impact of CLABSI.

The toolkit is available at http://www.joint-commission.org/Topics/Clabsi_toolkit.aspx and the monograph can be found at http://www.jointcommission.org/preventing_clabsi/. ■

NQF endorses Medicare cost measure

Second try's a charm

After a negative vote in October that led to further discussions and input, the National Quality Forum (NQF) Board of Directors finally endorsed a measure related to assessing the total cost of services for hospitalized Medicare beneficiaries. The measure includes “costs incurred prior to, during, and following

a hospital stay” and is used in the Centers for Medicare & Medicaid Services’ (CMS) Hospital Inpatient Quality Reporting Program and its Hospital Value-based Purchasing Program, according to a news release from NQF.

At its first pass before the board, some stakeholders were concerned that there wasn’t enough risk adjustment for socioeconomic status, nor enough emphasis that the majority of cost drivers occur in post-acute settings. NQF sought more input before bringing it forward again in December.

In the news release, Christine K. Cassel, MD, president and CEO of NQF, said, “NQF works to foster constructive, collaborative discussions between knowledgeable stakeholders on the toughest issues affecting our healthcare system. The complex and controversial nature of this measure demanded further conversation, so NQF made sure members’ voices were effectively heard before any endorsement decision was made.”

The measure focuses on “how to hold hospitals accountable for providing high-quality, equitable care,” but still recognizing that some communities, like those who are economically disadvantaged, are more challenging to treat, according to the release. Hospitals also vary in how able they are to impact what happens after the patient leaves the hospital.

NQF is working to address these issues, including creating an expert panel that will zero in on risk adjustment and socioeconomic status. It will convene in early 2014. ■

Measurement practices under the microscope

White paper to explore patient experience

Just as *Hospital Peer Review* was going to press, the Beryl Institute issued a press release stating that it was publishing a white paper that brought together a group of traditional competitors to answer questions about how they measure patient experience.

“Voices of Measurement in Improving Patient Experience” shares the perspectives of seven healthcare survey organizations — Avatar International, Catalyst Healthcare Research, Gallup, Health Stream, National Research

Corporation, PressGaney, and Professional Research Consultants.

In a series of directed interviews, the companies' representatives answered questions about the rationale for effective measurement, including methods, effective collection, analysis, and actions. The questions included:

- Why is measurement important in addressing patient experience?
- What do you see as key measurement practice and what are the best methods for gathering and using data?
- Where should we be focusing to drive effective measurement in patient experience?
- What are the best and most effective modes of data collection?
- How should organizations be using measurement to support their experience efforts and drive their overall strategy?
- What is the best means to analyze and understand measurement data?
- What do you see as the impact of HCAHPS/CAHPS surveys and how has this common requirement influenced measurement strategy?
- What is the impact and potential outcome of effective measurement practice?

The white paper is available at <http://www.theberylinstitute.org/?page=PUBLICATIONS>. Next month, *Hospital Peer Review* will take a more in depth look at the paper. ■

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

- Improving care transitions
- Accreditation field reports
- Creating a search engine for hospital quality
- Quality winners from 2013

CNE QUESTIONS

1. According to Michelle Janney, what percentage of US hospitals achieve Magnet status on the first try?
 - a. 5%
 - b. 6%
 - c. 3%
 - d. 2%
2. How many doctors are in the second phase of Dr. Franklin's patient-reported outcome study?
 - a. 10,000
 - b. 22
 - c. 130
 - d. 322
3. According to Rhonda Filipp, doing a good root cause analysis is about more than finding a problem and creating a solution. It is about:
 - a. Finding the low hanging fruit
 - b. Checking that corrective action was put in place
 - c. Seeing if the checklist was used
 - d. Creating a positive leadership environment
4. How many sites are involved in the next iteration of IPASS?
 - a. 9
 - b. 22
 - c. 600
 - d. 48

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.

Clarification

The December 2013 issue mentioned a perinatal care measure from The Joint Commission concerning elective delivery.

According to The Joint Commission's Center for Performance Measurement, "PC-01: Elective Delivery evaluates patients delivering at 37 to 38 weeks of gestation completed. If a patient was induced during this gestational age range without a medical indication, the case will fail the measure. The measure does not evaluate inductions at 39 weeks; however, our Perinatal Care Technical Advisory Panel does feel strongly that inductions should still not occur at 39 weeks gestation unless there is a medical indication."

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.
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Dear *Hospital Peer Review* Subscriber:

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