YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

February 2014: Vol. 39, No. 2
Pages 13-24

IN THIS ISSUE

Follow us on Twitter
@HospitalQI

Financial Disclosure:
Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

Big and small, Baldrige winners say it's about the journey

Feedback and site visits provide "addiction" to improvement

It's doubtful that anyone goes into the Baldrige process looking for a site visit the first year. For most organizations, it can take three, four, or more years of applications before you get called and told you are one of a handful of organizations around the country that is lucky enough to be granted that honor. But those who go through that process seem to view it as valuable, not tedious, and 2013's healthcare winners — Baylor Regional Medical Center at Plano (TX) and Sutter Davis Hospital in California — are no different.

Those who orchestrated the efforts uniformly describe a process that they look forward to engaging in and describe staff asking about the arrival of feedback reports like kids wondering how long until Christmas. As winners, they are barred from applying again for five years, and **Janet Wagner**, RN, Chief Administrative Officer of Sutter Davis, a 48-bed facility that serves the university town a few miles west of Sacramento, wonders what they'll do in the interim to keep them on their quality toes.

"After the last site visit, we sat right down and were already planning our strategy for our 2014 application, what we were going to focus on, what our theme was going to be, where we felt we needed to improve," she says. The call that they won was a huge surprise, but one she thinks they deserve.

In its award notification, the National Institute of Standards and Technology (NIST), the division of the U.S. Department of Commerce that hands out the recognition, outlined more than a dozen reasons why it chose the hospital as a recipient. Among them:

- High performance on key national quality metrics, including ranking in the top 10% of core measure scores for the Centers for Medicare & Medicaid Services (CMS) since 2010.
- Better than benchmark performance for length of stay and readmission rates for pneumonia, heart failure, and heart attack, as well as for general length of stay for Medicare and the overall patient population.
- Low levels of hospital infection rates that beat national benchmarks and the competition. It is in the top 10% for post-operative orthopedic surgical infections — there were none between 2008 and 2012. There have been no CAUTI situations since 2008, and no CLABSI events since 2010.
- The birthing center, which delivers 1,300 babies a year and is an area

of focus for the hospital, has a lower than average C-section rate, lower than average elective deliveries at less than 39 weeks, and higher than average use of breast milk only for feeding. It has been the focus of national interest for its collaborative care model, and Wagner says it has even been the subject of a documentary due to its family-centered approach and openness to alternative birthing methods.

Hospital Peer Review® (ISSN# 0149-2632) is published monthly by AHC Media LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 550669, Atlanta, GA 30355.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

Editor: Lisa Hubbell

Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Associate Managing Editor: Jill Drachenberg, (404) 262-5508 (jill.drachenberg@ahcmedia.com).

AHC Media

Editorial Questions

For questions or comments, call Russ Underwood at (404) 262-5521.

• Fiscal health data that includes margins over 25% while maintaining a commitment to affordability.

• Door-to-doctor time in the ED decreased from 45 minutes in 2008 to 22 minutes in 2012, well below the California average, which is nearly an hour.

• Employee and physician satisfaction scores in the top 10%.

Wagner knew that many would think her facility was too small to consider competing for Baldrige, but it has been a progressive organization for some time, with a short average length of stay and strong alignment with physicians. In 2007, it was named to one of the consumer top hospitals lists, and that, she says, got them looking for specific management frameworks with which they could achieve greater success. One was Baldrige, and the team started applying.

They got their first state visit a couple years in, but did not get a site visit from the national organization until 2012. "It was so energizing," she says. "You never know if you'll write an application worthy of a site visit, but we did. Twice! It was a great honor." And they really saw no difference between the two site visits that would lead them to think they could have been a winner in 2013 when they weren't in 2012. That was why they started planning for the next application right away, just as buzzed by the experience as they were the year before.

"We were going to focus on a new category, we had ideas for improvement, we were just set to go, and then we got the call," Wagner says.

When Sutter first started the application process seven years ago, the first question Wagner and her team tried to answer was about core competency. Sutter Davis listed three. "We did not know to narrow it down to that one thing we do best, to refine and refine," she says. "You get smarter with every application and feedback report. You start to see things differently."

By the third or fourth year, they had figured out what they were best at, that what underpinned everything they do was a culture of caring. That was the core competency. "I would say that before, our care was compassionate, good. But not as refined. Now we have developed a very deep understanding of what is important to patients and what drives their loyalty."

There were always pretty good patient satisfaction scores, she explains. But with the advent of the Baldrige application and feedback experience,

they learned to use those surveys to identify behaviors that each member of the workforce does that drives those scores and the experience that patients and their families have when they are at Sutter Davis.

Based on some Baldrige feedback, they opted to look outside healthcare to improve workforce behavior in key areas. Disney came in to help them learn to "create experiences that touch your heart and soul," she says. Ritz-Carlton, which prides itself on anticipating customer needs, helped staff, including physicians, learn to anticipate when patients might be experiencing something troubling, like anxiety, and what might alleviate it. "That helped us learn to train our physicians differently," she says.

There was no real imperative to do this, Wagner says. "We could have been good enough without it, but we want to be the best. I'm a nurse. Patient care delivery is important to me. When I cared for patients at the bedside, I wanted to give the best care, a standard of care that I could be proud of. Now, I manage a hospital where everyone here is passionate about this and doing their very best to provide the best care there is. My team believed we could do this — we think big and act big, even if we are a small hospital. And look! Now we are a role model."

There is more than just pride in it, though. There are metrics that prove this journey was worth it, and they were pointed out by NIST when it announced the award. The facility is on strong financial footing, infection free, has short lengths of stay, and has growing lines of business, particularly in the emergency and oncology departments. "A lot of that increase is happening by word of mouth, too, which is the best marketing you can get," she says.

The hospital's birthing unit is an object of curiosity — for good reasons — to people who've probably never heard of Davis, California. The ED has wait times that are nearly a third of the California benchmark. All this, Wagner says, comes part and parcel with deciding to take this journey and make Baldrige the modus operandi for the hospital.

And the cost? Nothing. Not a single FTE was added to the payroll to make Baldrige happen, Wagner says. "I don't know who said it, but someone told me when I was thinking about doing this that Baldrige would be the least expensive management consulting I could ever get. And it's the truth. All we did was incorporate this framework into what we do every day."

Her only worry now is how to keep her team excited until they can start work on the next application. According to her math, after all the speaking engagements related to this award are done, that leaves about three and a half years to fill up with other things before they can get excited for the 2018 application. "I think I'd like us to start publishing some of what we have done. We've developed some great leaders through this process. They can share what they've learned with others."

Big state ambitions, small-town hospitality

Baylor Plano, a 160-bed hospital in North Texas, was also recognized for several of its quality metrics by NIST. Among them:

- an increasing share of "all-or-nothing" bundled CMS measurement standards;
- a low rate of ventilator-associated pneumonia that puts it in the top 10% of providers nationally;
- a consistent presence in the top 10% for key measures include pressure ulcers, blood clot prevention, and OR turnaround time. The facility is also extremely efficient at getting patients out of the hospital at discharge.
- exceptional patient satisfaction scores;
- an orientation process for new employees that extends 18 months, which helps keep the retention rate for first-year employees above 90%. For employees regardless of duration, retention now stands at 94%, a point lower than first-year retention, which is currently 95%.
- administrative efficiencies including increased use of preadmission surgical testing and reduced ordering of unneeded services for treating heart failure, sepsis, and pneumonia.

As with Sutter Davis, the journey started several years ago for Baylor Plano, says **Pat Cooper**, MSQA, RHIA, director of Healthcare Improvement at the hospital. They had been working for the state quality award, the Texas Award for Performance Excellence, and in 2010, when they won, they turned around and submitted that application to Baldrige. With the subsequent feedback report, Cooper and her team made some changes to the way they did things and submitted again twice more before getting a site visit in 2012, and then another in 2013.

Cooper says that there were some consistent themes in the feedback through the years. "It took us a while to understand more about listening to the voice of the customer," she says. "Sometimes

in healthcare, we think we know what's best. But there is real value in listening to them, in having them help you to identify the services we need to provide, how we should measure them, and how we should evaluate our processes," she says. "Which is not to say at all that now we have it all figured out, but we have come a long way since 2009."

Another issue that was brought out through the feedback reports and site visits was the need to prioritize work. "There is a lot on everyone's plate, and we are all very busy doing a whole lot of things. So how do you decide to figure out what to do first to get the best result? How do you make sure that what you think is the right thing to do doesn't take people away from the bedside?"

New quality initiatives may seem important — even vital, she says, but if it ends up taking nurses away from patients, it might not be the best thing to do right now. Now, they have a process of looking to see what is already ongoing, where the manpower is already deployed, and whether a particular project can be done without exceeding existing staff capacity. If it is something that aligns with the mission and there is still a capacity problem, then it can be discussed. "We have an online link for all projects now, and a work group will screen them, pitch the ones that seem like a fit, and then they are scored by the group based on an evidence-based criteria set. Then they are sent to the best committee for approval, to be tabled, or to be put on a wait list. That allows us to evaluate new things, as well as keep up with what is already ongoing. Before Baldrige, we did not even have an index of all the teams and projects that were going on in the hospital." Now, they have more than a list. They have even been able to streamline what had been a kind of project free-for-all. Some projects have been sunsetted, while some are monitored less often but still watched in order to look for problematic data changes, Cooper says.

The site visits are particularly ripe for "aha!" moments, she says. During the first one, Cooper couldn't answer the question, "How do you know what you are doing is effective?"

"We knew our outcomes were good, but we had to be better at looking at whether the processes that led to those outcomes were effective, and that we had a way to objectively evaluate that." It's like asking someone who is wearing shoes how she knows she is well shod. You know you are, but you never think of having to prove it to someone, in a way that measure the effectiveness of your daily shoe-tying ritual.

She gives an example of a patient experience team the hospital had. "After a year, we thought we had to step back and look at the team. So we surveyed them and asked them all what might make it better, whether it was a valuable use of time. Through that, we learned we were putting a lot of effort into this team, but we weren't moving the needle at all. The focus group wasn't having any impact. So we restructured it, and now the system we have in place is more effective."

Another example she gives involves her performance improvement processes. Cooper wondered how she could know if they were effective. So she now uses an improvement capability assessment tool that looks at seven specific dimensions of performance improvement. That helps to identify gaps and focus Cooper and her team on finding the important areas to expend their energy, she says. "Learning to assess our processes trained us to be objective, evaluate how we were doing, and to get input from other people involved in the work."

The Baldrige criteria also brought a spotlight onto benchmarking that Baylor Plano hadn't had before. "We hadn't been going outside the organization enough," she says. "We had focused on comparing metrics with others, not processes." So, like Sutter Davis, they went to companies like Ritz-Carlton to benchmark service, to a local company, Park Place Lexus, for hiring practices, and to Virginia Mason Hospital in Seattle for innovation. It's not enough to know about how you do on numbers, but how you compare on the things that lead to the numbers, she says.

It's hard to point to any one change that Baldrige led to and say, because of that, mortality is lower, or financials are better, says Cooper, but like Wagner, she is sure that this years-long journey has been worth it. "This is not something that happens overnight," she says. "It's not like one day you aren't doing this and the next it's all in place. It takes time to weave it into the fabric of your organization. But without a doubt in my mind, it is all connected. I am sure that because of Baldrige, we have shown improvement in key measures — mortality, board engagement, staff retention."

You can't have this be a little side project — it's something that the leadership has to buy into from the start because it involves incorporating

the principles of Baldrige into every level of the organization, Cooper says. "This has to become your guiding vision. But when it becomes part of your culture, how you do business, good things happen."

For more information on this topic, contact:

• *Janet Wagner, RN, Chief Administrative Officer, Sutter Davis Hospital, Davis, CA. Email: wagnerj@sutterhealth.org*

• *Pat Cooper, MSQA, RHIA, Director of Healthcare Improvement, Baylor Regional Medical Center at Plano, Plano, TX. patcoo@baylorhealth.edu* ■

Just-in-time concept for patient satisfaction

Fixing complaints on the fly at the VA

When most people talk about asking patients about their care, they think of it in terms of a post-visit satisfaction survey. Not so for **Bonnie Haupt**, MSN, RN, CNL-BC, CHSE, an acute care clinical nurse leader and simulation specialist at the VA Connecticut healthcare system in West Haven. She's thinking about the one day a week when she spends a couple of hours asking a couple of patients pointed questions about how things are going right now, and then, whenever possible, fixing anything she can while that patient is still there to see it getting done.

This just-in-time thinking is usually reserved for retail stocking systems, certainly not for healthcare, and most certainly not for government healthcare, but at the VA hospital in West Haven, what Haupt and her team have implemented has caught the ear of so many other facilities that she spends time each week fielding calls from other VA facilities, as well as private hospitals affiliated with academic institutions, wondering how they can emulate what she does.

The hospital was having trouble getting timely reports from government Survey of Healthcare Experience of Patient (SHEP) surveys that enabled them to make a real impact on patients. So Haupt decided to start weekly veteran experience rounds, where existing patients are asked some questions and asked to share their experience with Haupt and other members of the VA staff. Haupt doesn't choose the patients; she only asks that patients be coherent and willing to talk. She actually prefers to avoid patients that the staff tell her are nice, funny, kind — she wants someone who she's sure will be real with her.

Each conversation is supposed to be about 20 minutes, but most of the time, once the patients start talking, the conversations tend to flow and they last about a half hour or 35 minutes. Haupt goes in with a rotating group of other staff — sometimes it's the director of nursing, sometimes a lead physician. It might be someone from environmental services one week and food and nutrition the next. Team members from every echelon and every department are included.

Questions include whether patients think they were treated with respect, whether the plan of care was clear or if some test or procedure was a surprise, whether their spiritual needs were being met, whether there are any environmental complaints, how the food is, whether they would recommend the facility to another veteran who might have the option of going to a private facility, whether they are adequately treated for pain, if their team communicates well with them and with each other, and what the VA team could do to make their stay better.

Initially, she says, other staff members were less than thrilled at being included in the project, but nearly a year later, she has to turn people away, limiting them to coming only when scheduled, and keeping the group going into the conversation at no more than five or six — as a teaching hospital, usually there are interns and residents present along with Haupt and that day's scheduled partner. "The patients here — they'd have a whole crowd in, no problem, but I don't want to overwhelm them," she says.

Any complaint that can be quickly resolved is handled as soon as possible, often while the round is taking place — for example, replacing light bulbs, getting a copy of that day's plan of care, or even a refill on a cup of coffee.

After each round, Haupt enters the data into a spreadsheet program for trend tracking, and a report that is shared with leadership and front-line staff, whether they were part of that week's round or not. Some of the problems can be dealt with quickly. For example, Haupt mentioned one soldier who complained that whenever a phlebotomist came in to collect blood from a patient in one of the other two beds in the room in the middle of the night, he turned on the lights over his bed, too, waking him from a sound sleep. "We thought

it would be a staff education issue," she says. It turned out to be more of an old building issue: A quick investigation showed that there were two light switches, one of which covered two beds. It took a work order and a little time, but that problem was fixed.

Another old building problem that was turned up by talking to patients was that some rooms don't heat as well as others. So the hospital has instituted a night-time sleep menu. A student takes a cart around asking patients if they'd like a warmed blanket, a cup of tea, headphones for their TV, or a noise machine.

She has spotted trends quickly that would have taken months to discover due to the lag in SHEP reports. One of them included noises from unexpected sources. "We had a lot of people tell us about the noise of the janitorial equipment," Haupt says. "In the daytime, even when talking to the staff, when there was other ambient noise around, you could hear the wheels on the garbage cans going down the hall. Imagine what that would be like at night."

Haupt investigated and found out that the VA facility in Boston had purchased some quiet wheels. She spent a day following janitorial staff around there listening to see if they were quieter, put in a purchase order, and watched the complaints about janitorial noise drop.

Wayfinding for family members is another issue that came out of the patient conversations. New signage should be up shortly as a result of that, she says.

"With the director-level people seeing these complaints, right from patients in a real-time basis, I think it helps to get things fixed faster," she says. "It's right there, in their face, and it comes from people they saw today and will see tomorrow."

The total time investment is about 90 minutes a week, plus whatever follow up is needed to fix the problem. She thinks it's worth it. And the actual rounds? They're more like a chat than a job.

Other veterans who are in the hospital or who come in after a buddy has participated now want to be a volunteer for her rounds. So far, she has enough capacity to add the extras on to her two randomly selected patients. Her success hasn't gotten the better of her yet.

The VA, however, has got wind of it, and others are interested in replicating what she has done. She doesn't see why anyone can't. The numbers are small, but over time, even the information you get from two or three patients a week can add up to tremendous change. Already, the SHEP scores are up, and she's happy to think that the patient rounds and just-in-time fixes are part of it.

For more information on this topic, contact Bonnie Haupt MSN, RN, CNL-BC, CHSE, Acute Care Clinical Nurse Leader, Simulation Specialist, VA Connecticut Healthcare System, West Haven, CT. Telephone: (203) 932-5711 ext. 7323. ■

What's wrong with care transitions? Ask patients

Study uses current patients to ID problem areas

The patients who come into hospitals are often very ill and not in the best state. But give them a chance to help improve care, and if they are able, they are almost always willing. At least that's the experience that **Jennifer Lee**, MD, has had as a hospitalist at New York Presbyterian Medical Center/Weill Cornell Medical College in New York City. She made talking to patients part of her work for a study published in the November 2013 issue of the *Journal of Hospital Medicine* that looked at how to better understand — and thus improve — patient care transitions.[1]

The study was designed to look at the various roles around the patient, the issues that connect them to him or her, and how they impact care. The hope is that with increased understanding and study, there will be better ammunition to fire at unplanned readmissions.

Lee was interested in looking at transitions because despite years of research, nothing much seems to have changed — "the needle hasn't moved," she says. "The patients are sicker, more complicated, and they don't have the support that there used to be. We move away from our families, and the patients who come in often don't have anyone who is close to them. There are a lot more factors that come into play in trying to keep them healthy."

In looking for ways to prevent readmissions and keep patients from falling through the cracks, researchers are seeing some answers, but they are often prohibitively expensive. Or seemed to be in the past.

One of the elements of her work that is different

from many others is her use of existing patients for focus groups as part of the study. Not former patients or just family members, but actual patients. Getting patients involved in quality improvement and patient safety projects is recommended by many national organizations, but given the reality — Lee's comment above about sicker patients, for instance — it's not always easy to do. Some manage, but for large hospitals, it can be difficult, says Lee, and many have informal rosters of former patients and family members they use.

But in this case, Lee was able to make it work. She calls them a "captive audience that has a lot to say." Getting their perspective was a vital part of her study, she says. "There are things you think you know and maybe you take them for granted. But you hear it actually verbalized and it makes so much sense. There is a wealth of information you have access to through them."

Her research doesn't just focus on the patient, though, but on getting information from the other team players — physicians, nurses, social workers.

A given role may be played by someone else; for instance, a social work or visiting nurse role may be played by a daughter or next door neighbor, she says. In these times when families are far flung, finding out who plays that role could be key to eliciting key information. For instance, knowing that the house smells of urine, or that there are rodent droppings — that would be important to know before discharging a patient back to that home, she says.

In her paper, Lee and her colleagues used patient and care team interviews to come up with five patient-centered themes that can have an impact on transitions of care and readmissions.

They are teamwork — as in having a good team that collaborates and communicates; health system navigation and management — this may require more institutional or governmental change to make it manageable for everyone, or more dedicated people to help older sicker people learn to navigate it; illness severity and health needs — obviously sicker patients have greater needs and are more likely to bounce back; psychosocial needs — taking into account not just what their status is under usual circumstances, but what they are under these new and more stressful ones; and medications — what they take, can they get it, do they understand it all, and will they comply.

All of these areas have spheres of influence that intersect with various actors around the patient — the roles Lee spoke of before.

If any lesson can be taken from her research at this early stage, it is about improving communication between all team members, whether they are people you have always worked with in the hospital or are people you are just getting acquainted with outside your facility. Lee notes that the organizations that have made a dent worth talking about in readmission rates are the ones like Mayo, which have extremely robust accountable care organizations set up, with a large degree of communication between primary care providers, social workers, visiting nurses and the inpatient providers who took care of the patient before discharge.

"We don't have the kind of connectivity here that they have there, so I don't know if we can have as great an impact on the numbers as they have," says Lee. "But I think we can improve patient satisfaction and patient safety."

As research continues, Lee encourages everyone to be familiar with the American College of Physicians transition guidelines (http://www.acponline.org/acp_news/misc/apr11/page%20252.pdf). And then start talking — not just to other team members, either. Talk to patients. If they are coherent, you can get useable information from them. Lee still asks questions of patients from the study template — some as simple as checking phone numbers and others more complex and related to medications. She asks about the home situation, knowing that the social worker will, too.

At the very least, the extra time Lee takes with the patients provides them with more education. At most, she gains valuable information from the patients. "It can be eye-opening."

REFERENCE

1. Lee JI, Cutugno C, Pickering SP et al. The patient care circle: a descriptive framework for understanding care transitions. *J Hosp Med*. 2013 Nov;8(11):619-26. doi: 10.1002/jhm.2084. Epub 2013 Oct 12.

For more information on this topic, contact Jennifer Lee, MD, Division of Hospital Medicine, New York Presbyterian Medical Center. New York, NY. Email: jel9026@med.cornell.edu. ■

All the tools in the box and no one to use them

Underused methods to cut readmissions

You join a collaborative because you want access to data and ideas. Together you might find something out that individually you could not. That's the theory. And it works. Over and over in healthcare there have been successful collaborative efforts on everything from heart attack data to surgical infections. But according to a study in the November issue of the *Journal of Hospital Medicine*, hospitals aren't using tools available to them in collaboratives designed to reduce rehospitalizations.[1]

The study looked at hospitals that were enrolled in one of two collaboratives: the State Action on Avoidable Rehospitalizations (STAAR) initiative, launched in 2009 by the Institute for Healthcare Improvement that operates in four states — Massachusetts, Michigan, Washington, and Ohio — and the Hospital to Home (H2H) project, sponsored by the American College of Cardiology. The STAAR project was designed to leverage community organizations and hospital leaders, while H2H focused on specific patients — heart failure and myocardial infarction — and used a series of challenge projects to engage participants.

The study in question received completed surveys from 599 hospitals, says **Leslie Curry**, PhD, a senior researcher at the Global Health Leadership Institute at Yale and one of the study authors.

The surveys asked hospitals about the strategies they were using from the collaboratives, and the results were startling. *(For a list of the strategies asked about, see box page 21.)* Only just over half of the hospitals in both groups reported having quality improvement teams devoted to reducing readmissions; half or fewer of the hospitals reported that they monitored how quickly discharge summaries were sent to primary care providers or whether patients had appointments with primary care physicians within seven days; less than 20% in either initiative measured if patients were being readmitted to another hospital; most of the hospitals in both programs did not have a pharmacist in charge of medication reconciliation; most patients did not get discharged with an appointment already made for follow-up care; and less than half the hospitals in either program had anyone follow up on pending test results that come in post-discharge.

The authors note in the paper that these strategies have been in the literature as good ideas for a few years now, so what gives? Curry thinks that part of it is that the evidence base is not as clean as it could be. "Something like how to reduce your door-to-balloon time is a lot clearer than how to reduce your readmissions," she says. She also notes that these are two very different collaboratives. STAAR is the big innovator, and it's focused on what's going on in four states, not four walls. It's looking across stakeholders, so it could be that what this survey asks might not be applicable to the way these particular people are thinking.

She doesn't want to take away from "great, well-meaning people" who are doing this work and finding progress slow. "Some people are seeing readmission rates falling, but maybe it's hard to see what is considered statistically meaningful change. But there is still room for improvement. We have to figure out why, with all this effort, that is."

A lot of the problem may be time and manpower related — getting all the things done that recommendations suggest with the people on hand in the time required: it could be too much except on the slowest of days. "Nurses and pharmacists and social workers know what they have to do, and if they have time, they can do it. But this is very complex, to coordinate all the communications and all the paper," Curry says. "And there is still uncertainty about what works. The evidence is not compelling. If there are two things you should do, which two? And are they the same two that the hospital across the street should do?"

So if you don't know which two items are silver bullets, should you do nothing? No, she says. Choose three or four items from the list and you'll probably improve your performance. Remember too that readmissions are not all about what happens in the hospital, but about what happens in the community. Increasingly, hospitals will have a financial stake in what takes place out there as well, so while Curry says it's "kind of nebulous how to connect in a way with those other folks in other parts of the continuum," it's worth your while to start thinking about that now. In the not-to-distant future, you'll come out ahead for having done so, and so will your patients.

"Look at the 10 strategies and think about your facility," says Curry. "Focus on a few that you think will work best where you are. More is

better, but be gentle, and pick something where you can do some internal tracking and get an easy early win. That boosts your ego so you can tackle some of the harder stuff."

Lastly, Curry says if you have not made really good friends with everyone who works in the emergency department, do. They should be the quality departments' best friends because no one knows better about the patients who come back into the hospital when they should not, "and this is an area for contribution and reaching out."

REFERENCE

1. Bradley EH, Sipsma H, Curry L et al. Quality collaboratives and campaigns to reduce readmissions: what strategies are hospitals using. *J Hosp Med*. 2013 Nov;8(11):601-8. doi: 10.1002/jhm.2076. Epub 2013 Sep. 6.

For more information on this topic, contact Leslie Curry, PhD, MPH, Senior Research Scientist, Global Health Leadership Institute, Yale University. New Haven, CT. Email: Leslie.curry@yale.edu. ■

Strategies for reducing readmissions

Source: Leslie Curry, PhD, MPH

Quality Improvement and Performance Monitoring:

- Have a QI team for reducing readmissions for heart failure or acute myocardial infarction or both
- Monitor the percent of patients who have follow-up appointments within a week of discharge
- Monitor 30-day readmission rates

Medication Management:

- Providing patient education about the purpose of each medication and alterations to the medication list
- Having a pharmacist primarily responsible for doing medication reconciliation at discharge
- Having a pharmacy technician responsible for taking a medication history as part of the medication reconciliation process

Discharge Follow Up Procedures

- Patients receive an emergency plan
- Outpatient appointment arranged before discharge
- Outpatient physicians alerted to patient discharge within 2 days of discharge
- Patients called post-discharge to follow up on post-discharge needs or for additional patient education

OR radiation is a top 10 technology hazard

ECRI urges broader radiation monitoring

The rapid growth of image-guided surgery has revolutionized procedures and reduced recovery time for patients, but it has increased risks of radiation exposure to the operating room staff.

To alert hospitals of this emerging hazard, ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, has included radiation in "hybrid" ORs as one of the nation's top 10 health technology hazards for 2014.

The concern arises because radiation use in the operating room has become much more common with the use of advanced imaging systems to guide surgery. "Suddenly, you're introducing a technology that has the potential to deliver a much higher dose than has previously been the case in the OR," says **Jason Launders**, MSc, director of operations for ECRI's Health Devices Group.

Traditionally, radiation safety officers monitor radiation exposure in radiology departments by assigning badges to the affected employees. Those badges are collected regularly, such as monthly, to monitor employees' cumulative dose. The goal is to keep the dose as low as reasonably achievable.

Yet with broader uses of radiation throughout the hospital, it has become more difficult to track employee exposures, says Launders. "There is an opportunity here to reexamine your radiation safety program and make sure you are doing what is necessary to keep your staff safe," he says.

By highlighting the hazard in its top 10 list, ECRI hopes to spur hospitals to give more attention to these other uses, he says. So far, there are no reports of adverse events related to radiation use in the operating room, he says.

"We think people should be looking at these issues now," says Launders.

Include float staff in training

The first step is to determine where radiation is being used in the hospital, outside of traditional radiology. This includes imaging technology in the OR.

All of the employees who could be exposed should receive training about ionizing radiation and preventive measures, according to the ECRI recommendations. Because OR staff often float among different rooms, it's important to

include everyone who could work in a hybrid OR, Launders says.

It's important to engage the OR staff and managers in this process, he says.

The amount of ionizing radiation that can be present in an OR varies based on a number of factors, including the length of the surgery and the techniques of the surgeon.

One way to educate OR staff about the presence of radiation is to give them electronic badges that display the radiation exposure on a real-time monitor in the room. Sometimes by simply moving a few feet, they can greatly reduce exposure, Launders says.

"There's no better way of teaching people than giving them instant feedback," he says.

Lead aprons are important protective gear, according to ECRI. Other barriers also may provide a benefit.

As imaging becomes an increasingly important part of surgical procedures, hospitals will need to continually adapt their radiation protection programs, he says. They also will need to keep lifetime exposure records for those who are monitored, he says. ■

ECRI: Protect OR staff from radiation

ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, offered these recommendations for handling radiation hazards in hybrid ORs:

- Verify that all hybrid OR staff (including surgeons) obtain OR-specific radiation protection training and that they put this training into action. Consult with a medical or health physicist when developing your radiation protection and safety program.
- Nominate a member of the hybrid OR team to assume the day-to-day responsibility for verifying that radiation protection policies and procedures are being followed. This role is not to be confused with that of the radiation safety officer (who oversees procedures for the entire organization).
- Assess the adequacy of existing built-in radiation protection infrastructure. Consider implementing additional personal radiation safety equipment as needed, such as specialized radiation shield garments.
- Consider implementing real-time monitoring to ascertain the effectiveness of radiation safety training, particularly if the analysis of badges proves ineffective at determining the cause of — and steps needed to correct — clinician overexposure. ■

New HAI data posted on CMS Hospital Compare

Patients can compare infection rates

New data recently posted on the Hospital Compare website of the Centers for Medicare & Medicaid Services (CMS) allows patients to see how their local hospitals are doing in preventing *Clostridium difficile* infections and methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections, the Centers for Disease Control and Prevention reports.

The data on healthcare associated infections (HAIs) were first reported to the CDC's National Healthcare Safety Network (NHSN) as part of the CMS Hospital Inpatient Quality Reporting (IQR) program. Under the IQR program, hospitals have a financial incentive to report the quality of their inpatient services by tying the reporting of designated quality measure data to their ability to be paid the full amount of the annual update to the Medicare inpatient payment rate. The HAI data and other quality information is then publically available on the CMS Hospital Compare website. (http://1.usa.gov/1bK1uk3)

The most recent numbers represent only the first quarter of 2013, and measurements of how hospitals are doing are expected to be more precise and provide a more complete picture as more information is collected over time, the CDC stated. The next update, representing six months of data, is scheduled for April 2014.

"The Hospital Compare website enables consumers to make informed choices and gives hospital leaders and their staff comparative information to help drive improvement," says **Patrick Conway**, MD, CMS chief medical officer and director of the Center for Clinical Standards and Quality. "Central line bloodstream infections have decreased more than 40% through transparency and improvement efforts, which has saved thousands of lives, and we hope to see the same positive results for these other two."

C. diff causes at least 250,000 hospitalizations and 14,000 deaths every year, and was recently categorized by the CDC as an "urgent threat" to patient safety. On the other hand, although still a common and severe threat to patients, invasive MRSA infections in health-

care settings appear to be declining. Between 2005 and 2011 overall rates of invasive MRSA dropped 31%. Success began with preventing central line-associated bloodstream infections caused by MRSA, for which rates fell nearly 50% from 1997 to 2007, the CDC reported.

Some facilities that do not currently have a sufficient amount of data to collect may not have their infection ratios included in the Hospital IQR Program and subsequently, on the Hospital Compare website. For example, the number of *C. diff* and MRSA bloodstream infections in some smaller facilities might not provide enough information to calculate infection ratios until they report additional calendar quarters of data.

In accordance with the clinical quality measure used by CMS and CDC for laboratory-identified *C. diff* and MRSA bloodstream infections, the Hospital Compare website only reflects hospital-onset infections, which are defined as those detected after patients are hospitalized for a minimum of three days. Patients with community-acquired infections — a continuing problem with MRSA — are not included in the infection counts for the CMS quality measure.

Major teaching hospitals, hospitals with more than 400 beds, and those with high community-onset rates continue to have the highest risk for *C. diff* and MRSA bloodstream infections, all of which is taken into account by risk adjustment when the clinical quality measure is calculated, the CDC explained. CDC and CMS encourage hospitals to participate in a variety of federal HAI prevention efforts, including those made available through state health departments (http://1.usa.gov/1cwA9Tv); CMS Quality Improvement Organizations (http://go.cms.gov/IZIlDW); and the Partnership for Patients Hospital Engagement Networks (http://partnershipforpatients.cms.gov/). ■

COMING IN FUTURE MONTHS

- Ready or not it's ICD-10
- Creating a search engine for hospital quality
- Accreditation field reports
- Improving care transitions

CNE QUESTIONS

1. Baylor Plano has a fantastic first year employee retention rate. What is it?
   a. 95
   b. 90
   c. 94
   d. 96

2. To solve a problem with cold rooms, the Just In Time program led to what response at the VA in West Haven, CT?
   a. New thermostats
   b. Flannel sheets
   c. A sleep menu program
   d. Warmer pajamas

3. Which one of these is not one of the five patient-centered themes identified in Jennifer Lee's transitions of care research?
   a. Medications
   b. Illness severity
   c. Insurance/financial stability
   d. Psychosocial issues

4. ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, has included radiation in "hybrid" ORs as one of the nation's top 10 health technology hazards for 2014. What does it recommend?
   A. A reduction in the use of imaging devices that emit radiation.
   B. Greater radiation protections for patients in the OR.
   C. New construction to make ORs more protective.
   D. Radiation training and monitoring for OR personnel.

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.

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. ■

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. Scan the QR code below or 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. ■