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Sharing data works in Wisconsin

Hospitals band together to outperform nation on key data

Healthcare can be a competitive industry, with individual hospitals and organizations unwilling to share information for fear of giving something away that might provide a competitive advantage to a facility or health plan across town. But in Wisconsin, a collaborative leveraged off the national Partnership for Patients program has led hospitals big and small, even in the most competitive markets, to share data, information, and best practices in an effort to improve care. The results have been nothing short of remarkable, says **Kelly Court**, MBA, chief quality officer of the Wisconsin Hospital Association, and no one's business has suffered from the sharing.

Among the results:

- more than 3,500 unplanned readmissions prevented;
- associated reduced hospital costs of more than $34 million;
- 291 early elective deliveries avoided, a 78% reduction;
- 37% reduction in surgical-site infections, saving an estimated $4.5 million;
- total estimated reduced healthcare costs from all aspects of the program of more than $45 million;
- third best state in the nation for Centers for Medicare & Medicaid Services (CMS) Value-Based Purchasing Program incentive payments.

The state Partnership for Patients project started in 2012, she says, and aligned with the high-volume conditions and patient safety concerns CMS had already identified. To date, more than 100 hospitals in the state are active, participating in webinars and engaging some 1,800 quality improvement teams in activities. They have reduced readmissions, hospital-acquired infections, adverse insulin reactions, and the average length of stay. Costs per stay have gone down.

Court says that Wisconsin has a long history of transparency. The Wisconsin Collaborative for Healthcare Quality (wchq.org) has been around since 2003, sharing information on a variety of all-patient, all-payer data, with comparisons to state and national benchmarking data included. (You can see an example at http://www.wchq.org/hospitals/.)

"We did this before Hospital Compare," she says. "We provide a lot of support for sharing best practices. Very occasionally, we get — in a competitive market — someone who doesn't want to do that. But it's rare." What is really unique, she continues, is the level of engagement among

small and medium-sized hospitals. "All of the rural hospitals are participating, sometimes even more aggressively than the bigger ones. They seem more likely to share. They really just want to help each other, and help their patients."

The national goals were to reduce readmissions by 20% in each state, and other areas of harm by 40% within three years. Court says Wisconsin hospitals are on their way, and quarterly data reported since the annual report (http://www.wha.org/Data/Sites/1/quality/WHA2013QualityReport.pdf) was released at the beginning of 2014 show the trend is continuing.

While there is an element of truth in the notion that all healthcare practice is local, and that what works in one setting may not work in another, Court says that Wisconsin hospitals only tackle problems where there is a "best known practice," which means that just about anything suggested can work in any of the facilities with the minimum of tweaks for local conditions.

Making it work

"But what we do find is that cultures can be different," she says. "There is a different tipping point for the number of staff that have to buy in before something becomes widespread. In a large unit, it might take six or eight nurses being on board with something to get a new practice embedded in the culture. Some hospitals will need everyone on board to make a new practice work."

The oft-stated truth that the will to change has to start at the top holds true, too. "Senior leadership has to want to drive the hospital to better outcomes," Court notes. She adds, "The middle managers, though, can be as or more important. They control the staff time. They hold the front-line staff accountable. If we say we will make follow-up calls to discharged patients, the middle managers are the ones who get that done. They get the team together. They make sure there is time available for them to be involved in learning webinars."

The senior staff may sign off on an idea, but if the middle managers do not believe in it, they can be a huge road block. Court continues: "The nursing managers are some of the most important people to engage and help to understand why changes in practice are important. They are the nurse owners and the process owners of the things we are trying to change."

They can also be the cheerleaders when changes you make don't have the intended or dramatic impact you'd like. For example, Court mentions ongoing struggles with pressure ulcers and falls that Wisconsin hospitals continue to have. "The issue with them is that you have to do all the things, every time to prevent them. It's not like giving an antibiotic before surgery, which is some-

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thing you get done once. It's an around-the-clock process change. And there just isn't a lot of breakthrough science on how to prevent either issue."

People get burned out, Court says. Hourly rounds are hard to get done. Nurses know they need to do assessments on every patient. "The number of people you have to touch, the number of times each day — that makes it very difficult." There has been some success, though. In fall prevention, one hospital is using simulations with patients, nurses, and physical therapists to identify potential risks that aren't evident through daily nursing care. Other facilities focus on particular kinds of patients, such as those with delirium, who are at particularly high risk of falls.

On the other side, though, are some of the more successful projects that the hospitals have engaged in, like reducing elective deliveries before 39 weeks. "That project was really just getting physicians to say no, you aren't going to do it," Court says. It involves getting a champion — in this case a physician — who will drive the change.

"There are always apocryphal stories about why you have to have an early delivery, but we have to convince them that stories can't become a rationale for improper early deliveries. You have to have people in the middle who are willing to have hard conversations with your medical staff," Court says.

Doctors respond to science, and data supports reducing these: 5% of planned early deliveries result in an infant being admitted to a neonatal intensive care unit, adding more than $15,000 in costs for an average case. There are now medical criteria used for such deliveries, and scheduling processes that make it difficult for a doctor to put an early delivery on the calendar without meeting those criteria.

Court says that improving patient and public education is also helping, and the state is partnering with March of Dimes to help "turn off the public demand" for early elective deliveries.

One way that Court says hospitals are keeping staff from thinking about the quality push as "another thing on the to-do list" is by creating a compelling story for staff. Making something personal, appealing to their hearts — she notes that one hospital used the phrase "40 weeks, chubby cheeks" relating to its efforts to stop early elective deliveries. It's something that puts a picture in your head, rather than a number.

She also thinks that while focusing on outcomes measures is important, it can leave a gap in front-line staff knowledge of their performance. "Process drives outcomes," Court says. "Doing small tests of change requires testing processes, which means that we need to measure those, too." The program will be focusing on process measures in the coming year, in part as a way for staff to get some real-time feedback on their performance. They may not see outcomes move on a graph quickly, which — as in cases like fall prevention — can be disheartening. But they can see their improvement on the processes that are known to reduce the likelihood of falls.

Court says everyone knows the things that need to be done to improve care and safety — or they can easily find it out if they don't have it memorized. There are evidence-based methods available. Your job as a quality manager is threefold, according to Court:

First, understand your culture's readiness to adopt change. If it's change-averse, try putting a face on the data. It can make it more real. Finding a person to tell a story about a preterm birth or a hospital-acquired infection can make a difference.

Second, understand where you need to improve. Do your gap analysis. Court says when you know what you are lacking, make a plan for improvement. "This is where you steal shamelessly from organizations and units that are doing it well. Learn from success."

Last, understand your real role. "You lead the work, but the people who own the process need to own the work," Court says. "The nurse manager or clinical expert should be in charge of the project. You should be the back-up. Because only that clinical person can hold other clinical staff accountable to get something done and to hold the gains when you have."

There is a fourth that Court thinks of, too: learn to love the little. "We are all about instant gratification in our society and don't have a lot of patience and persistence. So learn to focus on small tests of change, and realize that if you don't solve something this time, you can try something else. Change isn't a straight line. There are bumps in the road. And there are always things that don't go the way that you want. Some problems take years to get to where they are. You can't expect to change behaviors and work patterns to something different overnight."

For more information on this topic, contact Kelly Court, Chief Quality Officer, Wisconsin Hospital Association, Fitchburg, WI. Telephone: (608) 274-1820. ■

Consortiums, system win quality kudos

Awards show value in working together

The benefits of giving up data once considered secret in the name of patient safety and quality improvement were lauded at the annual John M. Eisenberg Patient Safety and Quality Awards when the National Quality Forum and the Joint Commission chose two consortia among its honorees.

The winners named in January include the following:

- The Institute for Clinical Systems Improvement (ICSI), Minnesota Hospital Association (MHA), and Stratis Health, which were recognized for their Reducing Avoidable Readmissions Effectively (RARE) Campaign;
- Anthem Blue Cross, the National Health Foundation, the Hospital Association of Southern California, the Hospital Association of San Diego & Imperial Counties, and the Hospital Council of Northern & Central California, which were recognized for their initiative "Patient Safety First…a California Partnership for Health";
- Vidant Health of Greenville, NC, which was honored for its patient training program;
- Gail L. Warden, President Emeritus of Henry Ford Health System in Detroit, who received the individual achievement award for his continued work to improve and assure the well-being of hospitalized patients.

The ICSI, MHA and Stratis project was designed to work across the continuum of care and focuses on the impact of the data, rather than the esoteric numbers, says **Jennifer Lundblad**, PhD, MBA, President and CEO of Stratis Health, which is Minnesota's Medicare Quality Information Organization. So instead of noting the nearly 6,000 unplanned readmissions avoided, they talk about the 6,000 people they helped sleep in their own bed.

There are 82 participating hospitals, which combined account for 85% of Minnesota's annual unplanned readmissions every year. Over two years, Lundblad notes, there were 5,441 readmissions avoided by providing participating hospitals with tools, support, and help to redesign processes and policies to make the improvements happen.

All three participating organizations were interested in reducing readmissions when they got together in 2009, she says — who wasn't? And they had worked on projects together before. "We realized this was another case where we could get further faster if we worked together," says Lundblad.

"The other thing that spurred us on was that we were at the start of the Medicare penalties," says **Mark Sonneborn**, MS, FACHE, vice president of information services at the MHA. "Everyone was in the same boat with excess readmissions, and there was no disincentive for us to work together."

Indeed, there were health-plan-led efforts to get some group work on the topic going before this consortium got off the ground, says Sonneborn. "We moved from the health plans being the lead to these three groups, with other stakeholders being involved. We went from this being a project to it being a true campaign."

Kathy Cummings, RN, BSN, MA, project manager for RARE at ICSI, says that they grouped reasons for unplanned readmissions into five areas and assessed each organization on those areas to identify "pain points" that were ripe for improvement.

The five areas are comprehensive discharge planning; patient engagement and family inclusion; medication management; care transition support — of the patient from the hospital to the next point of care; and care transition communication — between care providers.

The goal was to reduce the state level of readmissions by 20%, and then for each facility to set its own goal based on where it was initially and what its particular problems were, Lundblad says. The framework for improvement was flexible but evidence-based, giving each hospital some leeway to choose elements for implementation that would work best for its particular situation, but also be sure that they would have a positive impact.

Translating rates into something meaningful and patient-centered was key to getting patients, families, providers, and the wider community invested in the RARE program, Lundblad says. They use a pillow as the campaign thermometer measure, with the stack getting higher for the increasing number of nights at home that patients sleep when they don't go back to the hospital

unexpectedly. "It keeps the patient at the forefront of the mind," she says. "This is about real people being at home where they want to be. People can rally around that."

The goal was 24,000 more nights at home, and the goal was not just met but exceeded, says Cummings. There were 6,000 fewer readmissions, which met the numeric goal, and Sonneborn says the percent rate is at about 15% currently. For the third quarter 2013, the data was at about 7,030, and he thinks the final quarter data should hit about 7,500 when it comes in.

Meeting the goals the campaign put in place, Sonneborn says, requires not just the small and medium-sized hospitals to play ball, but the larger facilities, too. And if there are hospitals that are going to balk at sharing data and information, it is more likely to be the big ones, he says. Or they will sign up, but then not really participate or engage fully. "We did a lot of arm twisting to get them to do the work," he says. "It was challenging."

Sometimes, it meant personal calls to CEOs and hospital administrators. Sometimes, it meant getting participating CEOs to call their peers. Indeed, positive peer pressure played a key role, says Cummings. "When [Sonneborn] published the data, hospitals can see how they compare to others. That's a real impetus to really participate."

Lundblad notes that a lot of people will say that things are different in Minnesota, that sharing data has such a long history, it's no big deal. But she says the strong tradition of transparency doesn't always work. And "no one waved a wand and said you can be collaborative, making it happen all at once. It took work and leadership to make it happen. And it takes continued work to keep making it happen."

Even after getting everyone to play a real part, it can take continued hand-holding. Sometimes, a small change can take time to reap rewards, especially in a really large organization. "It can take months," Cummings says. "There can be pushback on participating when you don't see a result."

Think of something like the HCAHPS scores, which only come out annually, Cummings says. If moving that score is part of a goal, waiting to see a result can be achingly difficult. That's why interspersing long-range goals with other, nearer-term ones that can be trended more often is important.

The campaign has been largely aimed at hospitals, but will be expanded throughout the continuum of care in the future, says Lundblad. "Maybe we could have done it earlier, but we had our hands full with more than 80 hospitals. We hoped they would reach out to their associated enterprises, but they said they wanted to improve their own situation before they did that. Now we need to move far and fast through long-term care and other parts of the continuum."

The project has been a success largely because the environment was right for the organizations to work together, says Sonneborn. Medicare, commercial plans — no one wants to pay for unplanned readmissions. He notes, too, that in the Twin Cities in particular, there is an increasing percentage of total cost of care contracts, and readmissions are costs, not revenues.

Lundblad thinks that the exceptional assessment they used — which was based on the many publicly available assessments, like Project RED (http://www.bu.edu/fammed/projectred/toolkit.html), or Yale's CORE calculators (http://readmissionscore.org/) — helped hospitals come up with appropriate improvement programs designed to merge with the specific gaps identified.

And Cummings cites the advisory committee for RARE, which included patients, home care, health plans, and skilled nursing facility personnel. All were asked for each of the five areas mentioned above: What are the places you think need improving, and what are the basic needs in each area? They came up with a list of recommended actions, which is available on the RARE website (http://www.rarereadmissions.org/documents/RARE_Recommended_Actions_Care_Transitions.pdf).

In the end, it all comes down to the basics, Sonneborn says. It's eating your veggies. Look retrospectively at your patients who have come back and figure out why they were at risk. If you don't do this, you don't have a chance of getting a handle on the problem."

Reducing errors reduces costs

Anthem Blue Cross, the National Health Foundation, the Hospital Association of Southern California, the Hospital Association of San Diego & Imperial Counties, and the Hospital Council of Northern & Central California launched Patient Safety First: A California Partnership for Health in 2010. The idea was to bring people from the various California regions and multiple organizations together to try to reduce several healthcare-acquired infections to zero, sepsis mortality reduced by 30%, and preterm induction deliveries reduced to 5% or less. Doing so, they say, could

save millions of dollars and thousands of lives.

So far, there are 182 hospitals participating, with an estimated 3,500 lives and $63 million saved. The first phase focused on hospital-acquired infections, perinatal care, and sepsis. The next phase was just rolled out.

The healthcare-acquired infections tracked included ventilator-associated pneumonia, catheter-associated urinary tract infections, and central line-associated blood stream infections. Those were the data points with a goal of zero incidents, says **Tracy Wang**, public health program director for Anthem Blue Cross.

Wang says that regional hospital associations did most of the heavy lifting, hosting learning exchanges through which best practices were disseminated. Among them were using a rapid response team for sepsis infections; using checklists and bundles with central lines or catheters; implementing hard stops when scheduling births so that early deliveries cannot go on the calendar without medical necessity; and providing resources for hemorrhage related to perinatal birth trauma. *(More examples can be seen in the annual report at http://www.nhfca.org/psf/docs/760.NHF_EndOfYearReport_FINAL.pdf.)*

The National Health Foundation collected data, and collated and benchmarked it for the region and the state as a whole. The data was blinded, with participating hospitals unable to see how their peers did.

Phase 1, which lasted three years, ended in 2012. Phase 2 began last year and includes three more metrics — *Clostridium difficile* reduction, surgical sponge/foreign object retention after surgery, and reduction of cesarean section rates for first-time mothers by 10%. While these data have been collected since last year, there are no interim figures available yet, Wang says.

The other goals weren't retired but were moved into a pay-for-performance program to sustain them, says Wang.

It wasn't easy to launch such a wide-ranging effort between so many different organizations, she notes. And they found that just because someone said they'd participate and signed on the dotted line doesn't mean they'll put any effort into it. Anthem helped solve that problem by creating a demarcation on its provider finder site for those who submitted data, indicating they participated in this important patient safety/quality improvement effort. "That helped us to increase data submission a lot," Wang says.

They also had a problem capturing data related to induction of delivery at less than 39 weeks. "The ICD-9 code doesn't tell you when it was, just whether it was 37 weeks or above. So we had to find additional data consultants to work with those hospitals that were having difficulty capturing that specific data."

All of those issues were eventually smoothed out, she says, and she thinks that collaboratives are an underutilized resource. People are often afraid of sharing information and best practices for fear of giving away some imagined competitive advantage. But, Wang says, "If something is working in your region, you should be able to build on that. Don't reinvent the wheel. It means you can find solutions faster."

Lemons from lemonade

When a blood event resulted in a patient death at the Greenville, NC-based Vidant Health in 2006, it was a wake-up call for the eight-hospital system, says **Joan Wynn**, PhD, RN, chief quality officer. "It caused us to examine our culture and oversight, and we started a systemwide patient safety training program. From the bedside to the boardroom, that tragic event galvanized us."

It was this program for which the system won the Eisenberg award. It involves four hours of didactic training for every single employee and medical staff member in the system — more than 8,000 people — from housekeeping to CEO. The system uses a train-the-trainer program, Wynn says, which allows physicians to hear a message from their peers, and likewise other staff members, making it more likely that they will accept the teaching and any new procedures and policies.

The program includes leader bundles that are designed to improve the situational awareness of department leadership, as well as daily check-ins where employees touch base with those department leaders at the start of each shift. They go over a three-point agenda, regardless of department: What happened during the previous shift (or the previous day in the case of executives and administrative departments who have just a single shift per day), what is anticipated during the upcoming shift, and any successes or concerns that any team member wants to address.

Longer-range quality planning also changed as a result of the 2006 event, Wynn says. That was based on four key points: board leadership, aggressive transparency, building patient/family partner-

ships, and leader/physician engagement.

Under the first element, board leadership, the goal was to teach board members to oversee quality issues just as they did other elements of health plan functioning, such as finances. Outside experts, like UC San Francisco's Bob Wachter, were brought in to teach board members the quality ropes. "As their literacy in the area grew, they started taking a more active interest in it," Wynn notes. They began doing quality rounds. By 2008, the board had progressed so far that the Institute for Healthcare Improvement named it a "Board on Board" and asked it to be a mentor to other boards that were interested in being more proactive in areas of quality and patient safety.

Regarding transparency, Wynn says that applies not just to data that the employees and medical staff can see, but that the public can see, as well. The information is exactly the same. The public Web page includes core measures and patient experience scores like many other health plans. But it also includes data on hand hygiene, pressure ulcers, and falls, and in easy-to-understand numbers rather than a rate.

"We found that using a raw number makes more sense," she says. "Point zero zero one doesn't have as much meaning as five patients with an infection." The data on benchmarks is also there, as is the information on the number of visits. The goal is to be in the top quartile or top 10% of any given measure. And any person can see any piece of data he or she wants. Nothing is off limits.

Patient and family partnerships continue to develop in the system. There is a cadre of patient advisors, Wynn says, who partner with them on safety and quality work. "People ask where we find people to do this with us, but it's really not hard." She notes that any patient or family member who has experienced a "miracle" in a hospital is a great bet to want to be part of such a group. And those people who have experienced a tragedy? They, too, are usually very keen to make sure such an event never happens again. The key is in the asking. "You have to recruit and collaborate with them, and then make use of what they have to share."

One way patients have been used is to put a face on data. In 2010, one patient talked to the board about her 90-day odyssey as a patient with ventilator-associated pneumonia (VAP). She had to be put in a drug-induced coma to heal. Her experience made VAP more than a number on a dashboard. "You could have heard a pin drop in that room when she told the story," Wynn says. "The data just came to life."

Another story involved the brother of an employee, who died alone in an ICU because visiting hours didn't allow someone from his family to be with him. That particular story led to a change in policy so that family members won't be haunted by the idea of a loved one being alone at the end of life. Now, Wynn says, there is a patient story told just about every month at the quality committee meeting.

Leader and physician engagement means ensuring that the people in those roles are sponsoring quality projects. Now, a physician or leader is listed on every single project, which helps to ensure buy-in from other people in the organization. It also ensures accountability: If something doesn't work and the data isn't moving, there is a person who is responsible for making sure another tactic is given a shot. "If no one has a name on the project, then that's exactly who will check in to see how it is going," she says.

Over the past few years, the training program has reaped rewards, but it wasn't without its bumps in the road, Wynn says. For instance, in the data reporting process, they looked at many ways to report information that was meaningful to all users. While a lot of scientifically minded people prefer information on rates, for the average person, it is more meaningful to use raw data. It also brings the issue back home to real people impacted. "It's hard to explain to someone in environmental services the concept of rates and benchmarks and averages," she says. "But when you say that this many people have a central-line infection, and it comes from bugs in the environment, which means they didn't clean well enough — that means something to them." By including contextual data on number of visits and national benchmarks, Vidant was able to appease the scientifically minded physicians while still having information that made sense to the wider public.

Wynn thinks it's pivotal to engage patients and families in the quality process, and while it can seem hard to do, there are methods to getting a group of patients and family members on board with your quality and safety efforts. The easiest way is to look at employees who have either been a patient or who have had family members or close friends in the hospital. They are well-placed to ask if the patient or family member would be interested in helping to serve on a quality committee or help with a quality project.

She also believes you should get over your fear of reporting data for all to see — or help your leadership and medical staff get over it if that's what's holding up wider sharing. "Putting up the raw numbers makes it simple and understandable to everyone. There are people attached to those decimal point numbers."

If there is an adverse event, raw numbers makes it easier to explain and builds the will to improve, Wynn says. And it's not as if you have to put it all on your website at once, either. It can happen over time, starting with some of the best practices you've already mastered.

Besides, Wynn concludes, knowing that data sharing is coming down the pike is, in itself, a great goad to improvement. "When they knew we were going to put hand hygiene data on the website, you can bet they started to make sure they were doing well on that element."

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Patient engagement data slow in coming

Getting the words right can help

Patient engagement is one of the hottest topics around, with organizations as lofty as the Institute of Medicine recommending that patients be given ways to provide input into their medical care. But a recent analysis of patient engagement studies in acute care settings shows that there isn't a whole lot of study on the topic in the acute care setting, and what there is doesn't use consistent terminology, meaning it's nearly impossible tell what impact something has, whether interventions have unintended consequences, or if expending resources on items like tablets for patients to use makes any sense in terms of quality of care.

The study, published in November in the *Journal of the American Medical Informatics Association*, found just three randomized controlled trials involving patient engagement.[1] Overall, only 17 studies were located that met the authors' criteria for patient engagement in an inpatient setting.

Jennifer Prey, a PhD student at Columbia University, who is the first named author on the study, says that while there is a lot known about what people are doing related to patient engagement in the outpatient arena, there just hasn't been a lot of examination of what is going on related to the acute care setting.

The group decided to look at communication access tools such as tablet computers, which can be provided to patients for a variety of reasons — entertainment, general health information, enhanced decision support, personalized patient information, or advanced communication.

"Hospitals are very isolating environments," Prey says. "You are alone a lot, but when people come in, you don't know them." Getting them involved in their care is something of a missed opportunity. So how do you capture it? For some researchers, giving them a device that includes information important to their care is one way. "But what do you give them? What do you share with them? When do you give it to them? And if the patient is not engageable, do you give it to the family member? How will your policies and procedures have to change to accommodate that?"

Those ideas are what haven't yet been carefully studied, nor has the language with which to make pronouncements on the topic been settled.

Things are improving, though. Prey notes that at Columbia they are starting enrollment in a randomized controlled trial where patients are given dynamic access to information via a tablet, usual care, or entertainment via a tablet. The outcome will be a patient activation measure. Separately, she says they are also conducting surveys with clinicians on what data to share, with whom, and doing interviews with patients to see what kind of information they might want to see on a device during an inpatient stay.

Across the country in Seattle, Virginia Mason Medical Center is working to create a standard-

ized list of patient engagement words to use in some of its surveys. As published in the December issue of *Healthcare*, the list of 35 positive and negative words was culled from a larger list and designed to provide reliable "emotion" words for patients when they filled out surveys.[2]

According to **Jennifer Phillips**, innovation director at the hospital and one of the authors of the study, trying to quantify emotional experiences meant they needed to have a set list of words that were always able to be labeled positive or negative. Virginia Mason has its own management system modeled on Lean and the Toyota system that calls for regular rigorous measurement. "We were finding as we were adopting some strategies that if we wanted to quantify an emotion experience and have it be a defect for a negative emotion, we needed to be sure that we could quantify the words as negative," she explains.

Certain words that were used in the past were dependent on context, Phillips explains, and that wasn't something you could include on every survey — although some allowed for it. Think about the word "anxious," which can mean nervous, excited, or upset. And patients are also prone to accept mediocre service, so that using what is perceived as a neutral word may actually be a way of saying in another context that the experience was bad.

It was thus important to have strong positive and negative words for survey purposes. They also included a single neutral word: okay.

The list can help the organization to calculate metrics, or it can be used as a conversation starter in situations where patients can give more context to their words. "We are finding a real power when we can quantify the emotional experiences of our patients," Phillips says.

An example of a project the list is being used for is in critical care, where they were working on improving the transition of patients from that unit to telemetry. "That's a good thing, but as they used the experience based design method with families, caregivers, and staff — patients were usually out of it in that setting — families would perceive that the patient, who they were told was being moved to a lower level of care, was going to be getting care that was not as good. It busts our assumption about what words mean."

Family members had a questionnaire that included various touch points in the process: How did you feel when your loved one was admitted?; how did you feel when your loved one was cared for by the nurses? "It can look like a process flow map," Phillips explains. At the point of transfer, it was evident that family members felt confused. They were circling words and writing comments — they do both questionnaires and interviews — that clearly showed this confusion about the term "lower level of care."

That led to two changes. First, nurses in receiving units came to do a bedside handoff with the family present. If there was a potential issue indicating the patient might not be ready for transfer, it was discussed then, and brought to the nurse manager if necessary. This has led to improved communication between the nurses, and between the nurses and the family members, making everyone happy.

Some of the words that didn't make the list are surprising. To do so, 80% of focus groups had to agree it was positive or negative. Comfortable didn't make it. "The feeling was, can't we do better than that?" Phillips says. Anxious, bored, alone, calm, confused, embarrassed, nervous — they all failed the test. Relieved nearly made it, at 77.5%, and worried, at 79.9%, wasn't quite negative because 19.1% thought it was a neutral word.

The complete list of positive words is: Compassion, confident, empowered, enjoyment, enthusiastic, great, grateful, happy, hopeful, joyful, loyal, optimistic, peaceful, pleased, safe, satisfied, secure, sense of accomplishment, successful, valued.

The list of negative words is: Afaid, angry, disrespected, disgusted, depressed, frustrated, guilty, hatred, hopeless, ignored, insecure, jealous, resentful, sad.

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2. Russ LR, Phillips J, Brzozowicz K, et al. Experience-based design for integrating the patient care experience into healthcare improvement: Identifying a set of reliable emotion words. *Healthcare* 1(3) 2013;91-99.

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Tubing safety resource released

Small-bore connection issue addressed

A long-term problem with tubing connectors used with IVs, naso-gastric feeding tubes, and other medical tubes that could lead to patient harm or even death is being addressed by a resource released by the Association for the Advancement of Medical Instrumentation (AAMI) and other stakeholders.

So-called luer connectors are used for narrow tubes that allow tubes for one kind of medical tubing to be used with an unrelated system. A design issue has been a problem since at least 2006, when the Joint Commission released a sentinel event alert (https://www.premierinc.com/tubingmisconnections/downloads/jcaho-sentinel-event-issue-36.pdf) related to a wide array of tubing connections, including central intravenous catheters, peripheral intravenous catheters, naso-gastric feeding tubes, percutaneous enteric feeding tubes, peritoneal dialysis catheters, tracheostomy cuff inflation tubes, and automatic blood pressure cuff insufflation tubes. At that time, there had been hundreds of reports to a variety of organizations of misconnection issues, and some 10 to the commission.

While new design standards are in the works for small-bore connectors, which will reduce the problem, in the interim, the resource paper — available free at the AAMI website — http://www.aami.org/hottopics/connectors/Stay_Connected_10152013.pdf — for the time being, you have to make do with the old ones. The resource makes clear that even if you think you've never had a problem with your connectors, you should be aware of the potentiality, and prepare for the changes that are coming. "Many tubing misconnections are discovered before there is harm — these are generally not reported," the paper notes. "All organizations are one human error away from a harmful tubing misconnection. All should be concerned about making the care environment safer for patients and clinicians by providing devices that are designed using the principles of human factors engineering…"

Among the examples cited in the sentinel event alert by the Joint Commission in 2006: infusion lines inserted into Foley catheter lines, and epidural solutions put into general IV catheter lines.

The first of the newly designed devices — enteral — should be available at the end of this calendar year, according to the AAMI. Further resources will be made available at the organization's website as further instruments come on line or other concerns or issues are brought up or addressed. ■

Joint Commission issues new imaging standards

First batch effective in July

The Joint Commission has announced multiple changes in its diagnostic imaging standards, with some due to come into force in July, and another batch by 2015. Among them are those related to magnetic resonance imaging (MRIs), minimum competency for radiology technicians, and annual evaluations for imaging equipment by a medical physicist.

Phase one, beginning in July, is primarily concerned with various types of imaging — computed tomography, nuclear medicine, MRI, and positron emission tomography. Phase two includes some types of imaging, as well as personnel issues. It comes into force in 2015 and includes fluoroscopy, cone beam computed tomography used in dental offices and for oral-maxillary surgery, as well as the minimum qualifications for those who perform imaging exams.

Specific changes include:

- minimum competency for radiology technologists, including registration and certification by July 1, 2015;
- annual performance evaluations of imaging equipment by a medical physicist;
- documentation of CT radiation dose in the patient's clinical record;
- meeting the needs of the pediatric population through imaging protocols and considering patient size or body habitus when establishing imaging protocols;
- management of safety risks in the MRI environment;
- collection of data on incidents where pre-identified radiation dose limits have been exceeded.

The prepublication standards for hospitals and critical access hospitals are available at http://www.jointcommission.org/assets/1/6/PREPUB-

12-20-2013-DiagImaging_HAP_CAH.pdf. The complete standards should be available at the Joint Commission website sometime in March. ■

AHRQ study finds drop in heart disease problems

Adverse events for other conditions didn't fall

Patients being treated for heart attacks and heart failure are less likely to have reported adverse events, according to a study published in the January 23 issue of the *New England Journal of Medicine*,[1] but patients with pneumonia or recovering from surgery didn't have similar declines.

The authors looked at more than 65,000 patients from 2005 and 2011. The adverse events studied fell into 21 categories, including pressure ulcers, falls, and drug reactions. The decline in the occurrence rate among heart attack patients was from 5% to 3.7%, and the rate per 1,000 hospitalizations fell from 401.9 to 262.2. For heart failure, the occurrence rate fell from 3.7% to 2.7%. Per 1,000 hospitalizations, it fell from 235.2 to 166.9. There was no meaningful change in rates for surgical or pneumonia patients.

Patients experiencing one or more adverse events — rates for this data point also fell for the two heart-related conditions, from 26% to 19.4% for heart attack and from 17.5 to 14.2% for heart failure — tend to have longer length of stay and a greater chance of dying, but the authors could not definitively correlate that to the actual adverse event or events. However, the authors estimate the improvements among the heart patients saved some 81,000 patients from harm.

REFERENCE
1. Wang Y, Eldridge N, Metersky ML et al. National trends in patient safety for four common conditions, 2005-2011. *N Engl J Med*. 2014 Jan 23;370(4)341-51. ■

COMING IN FUTURE MONTHS

- ■ ICD-10 and you
- ■ Nursing bedside checklist
- ■ Accreditation field reports
- ■ Burn care QI project saves patients, money

CNE QUESTIONS

1. Wisconsin hospitals saved how much money from reduced readmissions, according to Kelly Court?
   a. $45 million
   b. $34 million
   c. $4.5 million
   d. $54 million

2. The California Patient Safety First program has three new goals in phase two. One of the new ones relates to:
   a. CHF
   b. cutting preterm induction to zero
   c. adverse events related to heart attacks
   d. C-sections for first-time mothers

3. Which of the following is not considered a positive word according to Virginia Mason's new patient experience survey word list?
   a. comfortable
   b. happy
   c. successful
   d. valued

4. The luer connector is being redesigned. The first new ones are due out in 2015 and will be for what use?
   a. Foley catheters
   b. epidurals
   c. enteral tubes
   d. blood pressure monitors

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. ■