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AHC Media

CMS announces delay in two-midnight rule enforcement

Pending bill may add another year to the hold

On January 30, the Centers for Medicare & Medicaid Services (CMS) announced a delay until Oct. 1, 2014, in post-payment Recovery Audit Contractor (RAC) audits of hospital admissions to determine compliance with the contentious "two midnight" rule.

Apparently, delaying enforcement was not enough to silence critics. Barely a month passed before two senators introduced a bill to delay the rule by another year and mandating that it be altered with input from the very stakeholders who dislike the regulation and have made their feelings so well heard.

Senators Robert Menendez (D-NJ) and Deb Fisher (R-Neb.) introduced the Two-Midnight Rule Coordination and Improvement Act on March 5. It would require a new regulation based on input from hospitals, physicians, and other interested parties. It would also give the force of law to the enforcement delay announced by CMS.

Meanwhile, the Probe and Educate prepayment audits conducted by Medicare Administrative Contractors (MACs) continue. At Middlesex Hospital in Middletown, CT, they have been having them fairly regularly, says **Linda Jo Spencer**, compliance officer for the facility.

"We have done well on them," she says, but that is despite the fact that if there are questions, it can take months for CMS to provide guidance. "It is hard to comply with something that still has so much about it that is not clear."

The hospital's director of quality, **Claire Davis**, RN, MHA, CPHQ, FNAHQ, adds that it is more than just the staff not being able to figure out the rules, but also the public. "We get complaints from patients and their families," Davis explains. When patients are released sooner than they might have thought or without being admitted, they get upset. Davis says it has impacted patient satisfaction scores in some cases.

Ultimately, the courts or Congress will step in to sort out what is a bad attempt to fix a real problem, says **Mark Safalow**, MD, the hospital's director of utilization review. "As doctors, we have to be sure we are aware of those one-day admissions and that they are appropriate," he says. "We needed to be made aware of those long observation patients, too. But this rule? Two midnights is just arbitrary."

Davis notes that two midnights can be as little as 24 hours and 1 minute, or nearly three days. Her colleague, **John Machado**, DO, the head of the

hospitalist program at Middlesex, wonders what to do when a patient is admitted at 9 p.m. but the hospitalist does not see that person until 2 a.m. The orders then come in two hours after midnight. So is the clock set for when the admission starts or when the physician orders are in?

"This is the kind of question we keep having," Davis says. "We should be about doing what's right for the patient every time and documenting it." Trying to fit every patient into this rule that has only two boxes just is not working, she continues. It is hardly surprising that there have been delays and continued calls for change.

The proposed legislation that might bring change — S.2082 IS — is currently in committee and had not been scheduled for any debate as of press time. The text can be seen at http://beta.congress.gov/113/bills/s2082/BILLS-113s2082is.pdf.

Information about the RAC audit delay can be found on the CMS website at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

Information about the ongoing Probe and Educate prepayment MAC reviews is available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/UpdateOnProbeEducateProcessForPosting02242014.pdf.

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Checklists come to nursing

Program bumps teach lessons going forward

Sometimes the best lessons come when things do not work out as planned. **Nathan Rozeboom**, RN, MPH, CCRN, a nurse manager at Harborview Medical Center in Seattle, learned that in the aftermath of a project for his master's degree three years ago. At the time, he was assistant manager in a neuro intensive care unit.

"I felt like we nurses needed to standardize how we approached report," he says. "Every nurse was doing something just a little differently. And as a unit, we weren't doing very well at checking patient ID bands, nor were we regularly checking patient IV drips or alarms together at the change of every shift."

There had been a few instances where a

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patient's intracranial pressure (ICP) was vastly different for the incoming nurse than what the outgoing nurse reported. Rozeboom explains that this potentially could lead to a patient decompensating if the readings were wrong and potential problems were missed: "The patient's brain could swell dangerously if you miss early signs like increasing pressure."

Importantly, this kind of error is something that can be addressed quickly and simply if the nurses just checked the readings together. "It would also be a good opportunity for education if one nurse was not following proper procedure," he adds, "or if one of them was reading the pressure incorrectly."

There were cases where patients could have been potentially harmed, and Rozeboom says he tried to publicize those near-misses so that the nursing staff would understand the need for change.

Another problem was the very place where nurses were doing handoff — not at the bedside, but gathered by the desk on the unit. That often led to digressions away from the subject at hand — the patient — to issues like an upcoming Joint Commission survey or someone's upcoming wedding or vacation.

Rozeboom brought up the idea of creating safer handoffs to his unit best practice committee and mooted the idea of a checklist — he is a fan of Atul Gawande's book, *The Checklist Manifesto* — as well as starting bedside shift-change reporting. His literature searches showed that there hadn't been anything like it done in a nursing situation before, but his sense was that it would positively impact both staff and patients.

After approval, he sent out a short survey to nursing staff to gauge their interest and solicit ideas about what items should be on a checklist, how safe they thought shift change reports were currently, the points they thought could be made better, and the issues they thought were potential barriers to change. About half the staff responded to his survey.

Educational rounds

Rozeboom created posters to put around the unit for the two weeks prior to implementation as a way to educate staff on the new program, and the checklist was laminated and attached to every bedside computer in the unit as a reminder. "We thought about making a paper checklist but did not want to kill a million trees," Rozeboom says. It was not then an option to put it into the EHRs.

The entire staff were involved in educational rounds on the new process. And because Rozeboom says "nurses love free things," he had pens made to give out to the staff that said "Patient Safety First." He composed a letter for patients and their families explaining the new handoff process and the rationale behind it.

A post-implementation survey was planned for two months after the project started. Once given, the response rate for that was 60%. Everything was set for success. Except it did not turn out as well as Rozeboom hoped.

There were certainly champions among the nurses and positive outcomes from the changes. Among them:

• While the pre-survey showed only 13% of staff thought that handoffs were safe all the

Recent research on the benefits of bedside report

• Maxson PM, Derby KM, Wrobleski DM, Foss DM. Bedside nurse-to-nurse handoff promotes patient safety. *Medsurg Nurs*. 2012 May-Jun;21(3):140-4; quiz 145. — http://www.ncbi.nlm.nih.gov/pubmed/22866433

• Hagman J, Oman K, Kleiner C, et al. Lessons learned from the implementation of a bedside handoff model. *J Nurs Adm*. 2013 Jun;43(6):315-7. doi: 10.1097/NNA.0b013e3182942afb. — http://www.ncbi.nlm.nih.gov/pubmed/23708496

• Cairns LL, Dudiak LA, Hoffmann RL, Lorenz HL. Utilizing bedside shift report to improve the effectiveness of shift handoff. *J Nurs Adm*. 2013 Mar;43(3):160-5. doi: 10.1097/NNA.0b013e318283dc02 — http://www.ncbi.nlm.nih.gov/pubmed/23425914

And one golden oldie:

• Anderson CD, Mangino RR. Nurse shift report: who says you can't talk in front of the patient? *Nurs Adm Q*. 2006 Apr-Jun;30(2):112-22. — http://www.ncbi.nlm.nih.gov/pubmed/16648723 ■

time, after the project, that number rose to 64%.

• Checking the patient ID wristband improved from 29% "All the time" before the new process started, to 50% "All the time" in the post-implementation survey.

• Family satisfaction hit 100% during the implementation month and for three months after.

• While errors did not decline significantly, there were stories about near-misses caught because of the checklist.

Despite those successes, there were also nurses who seemed adept at finding reasons why they couldn't do a bedside report. *(For a list of common reasons and Rozeboom's responses, see story, below.)*

About three years after Rozeboom's project was implemented in the neuro ICU, about half the nurses are still using the bedside report practice and checklist process, he says. Because he was not the manager on the unit, Rozeboom says he couldn't mandate that all nurses use the new protocol at the time. He kept at the staff, jollying them along and trying to troubleshoot the barriers or find out why specific nurses or managers did not like using the process.

Sometimes, a good catch of a near-miss would result in a convert to the process, Rozeboom says. But for many nurses, it was a non-starter. "I think a lot of nurses are scared of two things — first of talking about scary things in front of patients and families. But they want to know." Increasingly, national regulatory and professional bodies are recognizing the

Common reasons against in-room report

And potential responses

It is not always easy to get people to change behaviors. **Nathan Rozeboom**, RN, MPH, CCRN, a nurse manager at Harborview Medical Center in Seattle, experienced that when he tried to get nurses on a neuro intensive care unit to start giving report in the room with patients and their families. There was always a reason why some nurses just couldn't do it.

But with the most common excuses, there is also a good comeback, and Rozeboom says he has learned from his last try at bedside reporting how to answer the nurses who spout these lines the next time around.

1. "We can't because of HIPAA!" In an effort to maintain patient privacy, if you think someone is actively eavesdropping, lower your voice, turn your back, or ask them not to, he says.

2. "The family is a pain!" Have a little compassion, he says. They are worried, tired, scared. And possibly a pain. If they have a lot of questions and comments, explain that you need to finish report and shift change. Tell them that as soon as you are done, you will come back to listen and answer. Have a pad of paper and pen available for family members so they can jot questions and notes down in your absence.

3. "It slows down report!" Actually, research shows it is faster to do bedside reporting because there is less diversion among the reporters — no coffee cups, no discussion about the latest episode of *The Walking Dead* or *Scandal*. *(For more recent research on the benefits of bedside report, see box page 39.)* It is all about the patient.

4. "The patient has isolation precautions so I can't take any paper out of the room!" Actually, Rozeboom had infection control specialists explain to nurses that if you put what you are writing on right back in your pocket, you can, indeed, take it out of a room with isolation precautions without fear of infecting the wider world.

5. "The patient has dementia or is a psych patient and report agitates them!" This is perhaps the only common complaint that has some validity, Rozeboom says. While some nurses complain about the awkwardness of reporting with demented patients, that is not when there is a problem. It is when patients are agitated, start to shout and thrash, or say irrelevant things that makes it difficult for the two nurses to communicate. In those instances, you can take report outside the door of the room. But you still have to do those safety checks in the room — that can't be done anywhere else. And keeping report near the patient is a good way to stay on task and focused. ■

importance of patient involvement and understanding, he adds, and being present for the shift report is one more way of increasing that.

Secondly, they are afraid of being caught out in a mistake, or being shown not knowing something. "But sometimes you can turn to the family member and ask them a question when you forget what a situation was, or when something last happened, or when the doctor was last in, and they like that involvement," he says.

After the neuro ICU tried the new process, another intensive care unit also attempted bedside reporting and faced the same issue. But there is increasing support at Harborview for it, and Rozeboom believes that it will likely be implemented by mandate across the entire hospital in the near term. Committees and managers are already talking about it.

"I had hoped for grass-roots buy-in," he says. "I had never done anything on this scale before. Maybe if I had come out with a training video to educate staff or something." Having role-play training before going live might also have made nurses more comfortable with the idea when they finally started bedside reporting in the patient rooms.

Rozeboom thinks often about what went wrong and how to improve on the implementation, and he talks about it with the managers who will likely spearhead implementation of bedside report on two acute care floors in Harborview. A consulting firm working with the hospital to improve patient satisfaction wants them to solidify hourly rounding implementation first, but is keen to start on a project based on Rozeboom's experience after that.

"I learned a lot from this, and I think it could work. You need more than one champion across shifts. You need to mandate it. And I think you have to make a change all on one day, rather than having it creep slowly through the organization," he says.

Preparing the ground

For organizations thinking about this, he thinks a way to get greater buy-in from the start might be to prepare the ground with a smaller initial project. Get the nurses used to the idea of being in the patient room together at shift change in a more informal way, he suggests. "Have a program where the nurse leaving brings in the next nurse to introduce to the patient," he says. "As a nurse, you do not want the person coming after you to see that the room is a mess, that the fluids are about to run out or that the patient board is not complete. It is powerful, and gets the thought of sharing in their minds."

If you decide to go the whole hog, have a gung-ho champion do the reports with the nurses to validate what they are doing, answer questions as they arise, and gently guide them in the right direction if they drift, he says.

"Culture change is not easy," Rozeboom says. "Although everyone agreed that this was a good project and important, there were many strong-willed nurses who liked giving report at the desk and could find a million reasons why they couldn't give report in the room."

For more information on this topic, contact Nathan Rozeboom, RN, MPH, CCRN, Nurse Manager, Harborview Medical Center, Seattle, WA. Email: rozeboo@u.washington.edu. ■

Pushing the envelope in lines of service

Advanced accreditation: a way to tout expertise

If you had to guess what department **Sara Bohling,** MSN, RN, APRN-CCNS, Certified Neonatal Clinical Nurse Specialist, worked in at Saint Elizabeth Regional Medical Center in Lincoln, NE, it would probably be pretty easy. She has a soothing voice meant for calming infants, singing songs, and telling stories.

But behind the soft voice is a nurse devoted to evidence-based care and ensuring that her charges get the most advanced treatment available. That is the reason that about four years ago, the hospital sought advanced certification in both high-risk obstetrics and premature infant care through The Joint Commission. Those are two of dozens of line of service and disease-specific advanced certifications offered by the organization to hospitals that can demonstrate that there are evidence-based care practices associated with the service line or care for a particular disease process, and then can show that they are able to gather and report data, create performance improvement plans related to metrics associated with the evidence-based care related to the service or disease, and show continued improvement in those metrics.

Hundreds of hospitals and other healthcare organizations have pursued the option in the last dozen years, says **Jean Range**, the commission's executive director of certification. The program is based on 28 standards of care from the chronic care model (described in *Health Affairs* in 2001 — http://content.healthaffairs.org/content/20/6/64) that can be applied to just about any chronic illness, condition, or line of service.

While eight of the certifications — those related to stroke and cardiac care, for instance — are overseen by third parties such as the American Heart Association, these line of care and other chronic illness advance certifications are evaluated by the commission. The models are the same, and the processes for certification are the same, she says.

Hospitals gather data for several months on four metrics related to the evidence-based care of the condition or service line, Range says. There is a site visit during which the commission uses the same tracer methodology it does with a regular hospital accreditation survey. If the data collected do not meet benchmarks, then the program may have to create a remediation plan that the commission will have to approve. Only after improvement and achieving a certain level of excellence will the commission grant the advanced certification. The certification lasts for two years, with a long conference call in the off year to gauge progress and trouble-shoot any problem areas.

"This is for facilities that have programs that are over and above standard clinical treatment," says Range. "It is a way to make sure you limit variations in practice and as a means to evaluate your performance.

Indeed, Bohling says one of the main points of having the accreditation is to keep pushing the envelope, which allows her patients to continue to get the most cutting-edge care there is.

Only six hospitals in the country have advanced certifications of preterm labor and high-risk OB, and only nine have it for premature infant care. They are the hospitals that are constantly looking to see what is new and where they can excel, Bohling says. "This is a way for us to maintain the highest quality care according to what the very latest research says."

The program and its staff do not rest on their laurels. Every recertification, they have to submit data on four standards. So they choose four that have the highest impact on patient care. If there are metrics that are sitting pretty at 100% or 0% (depending on the metric), Bohling and her team will choose something else that needs attention, rather than continue to focus their efforts on something they have already mastered.

Bohling's initial four metrics included admission hypothermia, central line-associated blood stream infections (CLABSI), breast milk at discharge, and growth at discharge. CLABSI was retired. Admission hypothermia is still measured, but there have been changes in care process that make continued measurement important. There was also a change in the way nurses measured infant growth. Now they take into account issues such as growth restriction in utero.

Breast-feeding at discharge is another continued metric. It remains difficult, in part because the babies are often so young and ill and hospitalized for so long that it is hard for a mother to continue to pump breast milk for months and months. So they keep working on it, Bohling says. They added appropriately timed extubation for the next certification to replace the CLABSI measure.

"In a regular survey situation, you keep measuring things, even if you are getting good numbers," Bohling explains. "Here, we change our focus because this certification is about growth, rather than maintaining focus. The role of this program is to push us, to advance us."

The survey itself is similar — the site visit feels the same, Bohling says, with a collaborative approach, but an attention to every detail that looks far beyond the data and other paperwork submitted. "It is the same combination of pride and nerves, of showing off all our hard work, but worrying about whether you did not present something in your documentation in as convincing a manner as you could have."

The recognition in the marketplace for the certification is all well and good. The marketing department is thrilled. But for Bohling, the reason behind doing this is patient care. "It is about learning from every patient, about providing teamwork, and about providing the best patient care. And that is what this certification process does for us. It is an extra level of accountability. We are submitting this additional data and proving ourselves at another level."

It also helps them get better at patient care. The reason the admission hypothermia procedures changed came directly out of the advanced certification process, Bohling says. "When we started, we figured we'd be fine on that metric. We were admitting the babies from the C-section

room right across the hall. We'd scoop them right up and into a warm room. Their admissions temps were good. But then a year ago we started doing initial stabilization in the C-section room as part of new evidence-based standards of care. That totally changed things."

Surgeons like to keep OR suites cool — for their comfort and to keep germs from multiplying in a warm environment. "How can we keep a one-pound baby warm in a cold OR?" Bohling wondered. It took a lot of collaboration, compromise, and teamwork to come up with a solution. The doctors gave on the temperature a little and there were some tech solutions related to beds and blankets. "We had some dips in those temperature data when we changed the process initially, but we worked together to improve that, and they are back up again."

The advanced certification also spawned regular conversations between team members. "Before, we had monthly multidisciplinary meetings," Bohling says. "We weren't in the groove of talking much more than that, but it improves the care of our babies if we do. That has changed over time, too."

She believes that anyone who thinks they have a line of service where they are providing the best level of evidence-based care should pursue this. "It is not for the faint of heart, but it is an honor, and it pushes us forward."

Keeping staff to a higher standard

Susan San Marco, RN, WCC, the ostomy and wound care service line director at Goleta Valley Cottage Hospital in Santa Barbara, CA, agrees that certification is an impetus to stretch staff. Her wound care center is one of only four in the state to have advanced care certification, and the only one in her area.

She spent a year getting ready for certification, identifying areas that needed a quality improvement focus. She was lucky to find a mentor in a hospital that had pursued certification before her — John Muir Medical Center in Walnut Creek, CA. The people there were very willing to talk to San Marco about their experience and offer advice to her.

She decided to focus on patient satisfaction because while they strove to stay at 100% all the time; in wound care, that can be a hard thing to do. People with wounds that aren't healing well are usually less than compliant. They may not be happy people to begin with. San Marco wanted to make sure she and her team were doing all they could every day to ensure the highest patient satisfaction.

She also looked at metrics like the heal rate, median days to heal, and outliers who aren't healing in an appropriate amount of time — more often than not consisting mainly of those non-compliant patients.

San Marco started collecting data on those four areas and began work on her presentation, featuring performance improvement goals and plans, and an overview of the wound care program. She made sure to talk about what set Cottage Hospital apart from other clinics in the area, and how the care people received impacted the community. "When you have a regular survey, the commission will look at your EMR and your environment of care. But with this, they are doing that in much finer detail in a single line of service."

The education the patients get, whether it is received in a useful manner, and how San Marco knows that they are understanding it were all key elements of her presentation. "It can be really hard in wound care to do this in a wound care clinic, because we do not usually have these patients all day every day," she says. "Most are in the outpatient clinic and we get them for an hour. We have to assess how they are doing overall, assess the wound, identify barriers to healing, identify educational opportunities, and ensure they understand those. We have to give them multiple resources — verbal and written. We have to review those resources, and teach the caregiver or family. And all that time, we need to be preparing them for discharge, telling them what has to happen for them to get better and figure out what issues there are in the home that might be barriers to that."

They managed to impress The Joint Commission, gaining certification last summer. "In leading my staff through this, we have raised the bar and the professional expectation of the care we give," San Marco says. "Our commitment to excellence is a team sport. We have seen increased collaboration, better communication, and a real sense of pride."

Her nurses are very self-driven, but they also hold each other accountable, she continues. They are also sure that what they are doing "is not just the ordinary, but the extraordinary," San Marco says. "The program we have in place has a goal

of exceeding what is expected. We have an enthusiasm for what we do, and our patients — who are already happy with our performance — see that in our work. They know we are always striving to improve. They see we constantly look to improve."

She says anyone with a stellar program should consider advanced certification. Be open with your progress toward goals and share data with everyone. Look for outliers and study them, because you can learn the best lessons from the cases where things did not go as planned or turn out as you thought they should.

"We learn so much so quickly now because of the data we collect," San Marco says. "We do not have to wait until something is catastrophic to see it or do something about it."

The certification process also helped San Marco become more organized with her data, and more open in sharing it. "We talk about it regularly and share it with everyone," she says. "We round on every patient and have outlier meetings every month. We are not as mature as some wound centers, and there are probably tools that they use we do not know about yet. But this has moved us into a different realm. We know things now we did not know before, and if you do not know, you can't improve."

Do not be intimidated, San Marco says. "This process will strengthen your team and your program. It will show you where you are weak and where you need to get stronger. It may seem like this is a lot of work, but embrace the challenge."

More information on The Joint Commission's advanced certification program is available at the website at http://www.jointcommission.org/certification/advanced_certification_diseasespecific_care.aspx.

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Aha moment leads to new burn protocol

Temp management cuts mortality in burned kids

It happened a lot: A burn patient with areas of 30% or more burned would go into surgery for debridement and come back to recovery with an extremely low body temperature. There, **Debbie Laws**, RN, would spend an entire 12-hour shift trying to make sure the patient did not die. While doing an evidence-based practice course and looking for a quality improvement project, Laws had four such patients. It got her thinking: What do low temperatures do to the body? And is there anything that can be done to make these patients more stable?

Her quality project seemed to find her.

Laws said most of the research into patients with burns over 30% or more of their bodies comes out of the military. Because the skin is gone, there is nothing to keep the heat from escaping, and the core temperature can drop by as much as 20% without warming assistance. That makes the body hemodynamically unstable. It is exacerbated in operating rooms, which are kept cold, and by blood and IV products, which are usually kept refrigerated and delivered cold to the patient.

So patients who are already at risk for chilling are sent to a cold environment, unwrapped for surgery, and given cold fluids, Laws says. It was not a recipe for making them well. "It would take us a whole shift to stabilize them after a surgery," she says.

Some of the solution was easy: Use blood warmers. The hospital has them, but was not using them. The other parts of her protocol also made a lot of logical sense, but simply hadn't been put together in a package:

- Get the patient's core temperature up before surgery so that he or she is toasty before heading into a cold environment.
- Use hats and socks to keep whatever body parts you can warm.
- Break surgeries into parts if they cover a large body area or if there are surgeries on multiple parts of the body.
- Uncover as little of the body as possible at a time in the operating room.
- Use bed warmers when possible.
- Teach ABC + T to the community.

The last part relates to stabilizing patients before they come to the burn center. First responders usually concern themselves with ABC — airway, breath, circulation. But for large-area burns, temperature is key, Laws says. She notes that the inclination is to pour cold water on a burn. But for a large burn, that risks putting the body into shock and reducing the core temperature of the victim to the point that you put the patient at risk of harm or death by doing so. Laws is publicizing ABC + T for Temp to hospitals, emergency medical personnel, air ambulance services, and the wider community.

She is asking stakeholders how to help them to remember the importance of keeping burn victims warm, especially in air transport situations: It can be cold in a helicopter.

Before the project started in December 2012, patients were routinely coming back from surgery with body temperatures at 90 degrees F before Laws implemented her program. The data she collected show the number declined by 60% to about 20% of the total returning with temperatures below the goal of 97.7F. "And it's been a long time since there was someone whose temp was all the way down to 90," she says.

Compliance with the protocol is at 95% on her unit, and just about all patients are making it back from dressing changes with their temperatures stable at the goal point.

Laws has presented her findings at conferences and fielded calls from other hospitals who are interested in her research and the protocol she developed.

For more information on this topic, contact Debbie Laws, RN, Arkansas Children's Hospital, Little Rock, AR. Telephone: (501) 364-1100. ■

Did the HEN lay an egg?

Slow progress on quality goals

The Hospital Engagement Network (HEN) — a joint effort of the American Hospital Association and the Health Research and Educational Trust — released its annual report last month, showing some slow progress on key quality metrics, but a lack of progress on many of the goals touted by the organization.

It could be the last year for the network, although there is a potential for another year to be optioned. Thus far, 1500 hospitals in 31 states are participating. According to the network, there were some 70,000 patients helped to get better care, with an associated cost savings of more than $200 million.

It sounds appetizing, but the data in the report (*available at http://www.hret-hen.org/index.php?option=com_content&view=article&id=103&Itemid=256*) shows that a lot of the measures of quality are lagging. For example, goals were not met related to adverse drug events, central line-associated blood stream infections (CLABSI — down 23% in intensive care units), falls, early elective deliveries (although there was a decline of 57% in this), hospital-acquired pressure ulcers (which decreased by a quarter, but didn't make goal), venous thromboembolism (VTE), ventilator-associated pneumonia (VAP — down 13% in ICUs and 34% across all units), and unplanned readmissions.

Indeed, the only two items that met goals were surgical-site infections (SSI) and catheter-associated urinary tract infections (CAUTI).

The network reports did fire off a list of lessons learned though, including:

- Just because hospitals are already collecting a ton of data doesn't mean reporting some more is easy.
- One-on-one coaching helps teach organizations time-saving tricks for data collection and reporting.
- Chief nursing officers are underutilized resources for spreading new processes and as a conduit between leadership and frontline staff.
- Showing leadership their data and status is a way to increase interest in a project or program like HEN.
- Hospitals are stretched thin by all the different quality initiatives they belong to.

Should the option year of 2014 be granted to HEN, there are some lofty goals set, including 80% reporting for the 1,500 participating hospitals and specific goals for each topic area. Examples include

- expanding efforts for CAUTI reduction to all hospital settings and avoiding catheter placement in emergency departments;
- getting early elective delivery rates below 2%;
- adding OB hemorrhage and preeclampsia prevention to obstetric adverse events list;
- expanding VTE to all surgical settings;
- creating a national readmission reduction

campaign.

Other areas of interest include working with hospitals to reduce sepsis and MRSA, and working with the American Hospital Association Institute for Diversity on issues of healthcare disparity as they relate to HEN topics. ■

HCUP outlines costliest surgical procedures

OR patients less likely to die than medical patients

Go to the hospital for an operation, and you're less likely to die, but your cost of care is, on average, two times as expensive as a non-surgical stay. The length of stay, though, wasn't much different: Five days for a surgical patient compared to 4.4 for a non-surgical patient.

Of course, it all depends on what you're going in for.

There are 20 procedures that account for more than half the total cost of operations in a given year.

Orthopedic procedures such as hip replacements ($17,200 mean cost) and spinal fusions (a mean of $27,600) are among the most expensive.

But the second most common operation in the country is a circumcision, and the mean cost of that isn't a bargain either: it runs $2,000.

C-sections are the most common surgeries — there were 1.2 million of them, or 8.1% of the total, with a mean cost of $5,900.

Data like this come courtesy of the HCUP Statistical Brief 170: Characteristics of Operating Room Procedures in US Hospitals, 2011 (*http://www.hcup-us.ahrq.gov/reports/statbriefs/sb170-Operating-Room-Procedures-United-States-2011.pdf*), which outlines information on the 15.6 million operations from 2011, which had a total cost of something north of $180 billion.

The top 10 surgical procedures and numbers performed that year were:

- cesarean section – 1.27 million;
- circumcision – 1.1 million;
- knee arthroplasty – 718,000;
- percutaneous coronary angioplasty (PTCA) – 560, 000;
- laminectomy – 525,000;
- spinal fusion – 488,000;
- hip replacement, total and partial – 467,000;
- cholecystectomy and common duct exploration – 449,000;
- hysterectomy, abdominal and vaginal – 389,000;
- colorectal resection – 333,000.

The top 10 surgical procedures by aggregate cost in 2011 were:

- spinal fusion – $12.8 billion;
- arthroplasty of knee – $11.3 billion;
- percutaneous coronary angioplasty (PTCA) – $9.7 billion;
- hip replacement, total and partial – $7.96 billion;
- cesarean section – $7.41 billion;
- colorectal resection – $6.75 billion;
- coronary artery bypass graft (CABG) – $6.4 billion;
- heart valve procedures – $6.07 billion;
- cholecystectomy and common duct exploration – $5.05 billion;
- treatment, fracture or dislocation of hip and femur – $4.28 billion. ■

Pained patients = unhappy patients

A poster presentation at the annual meeting of the American Academy of Pain Medicine in March showed a correlation between patients who had high post-surgical pain and low patient satisfaction scores.

Dermot Maher, MD, and colleagues from Cedars-Sinai Medical Center in Los Angeles looked at responses from nearly 3,000 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys filled out by surgical patients between March 2012 and Feburary 2013.

Two questions about pain management and two about general satisfaction showed a "statistically robust" relationship. The author notes that given how influential "a patient's perception of pain" is, it has the potential to overshadow positive elements of patient care.

Spine, non-spine orthopedics, and obstetrics and gynecology had the largest correlations to the pain scores, according to Maher. ■

Patient engagement spurs better health

Foundation aims to help you help them

It will be no surprise to quality professionals that research shows that patients who lack the skills and confidence to manage their own healthcare often require more of it and incur higher healthcare costs.

But for a lot of patients, it's a whole new world, and figuring out how to get those patients involved is a new world for healthcare organizations.

The Robert Wood Johnson Foundation is here to help. The foundation released an interactive package that outlines how many organizations are already trying to engage patients as active participants in their own healthcare.

The videos, resource guides, and interviews include real stories from patients, providers, and payers.

The issue brief is available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf411217. ■

COMING IN FUTURE MONTHS

- ICD-10 and you
- The latest in infection control
- Accreditation field reports
- The future of quality measurement

CNE QUESTIONS

1. CMS has delayed what aspect of the two-midnight rule?
   a. Enforcement until October 2015
   b. Post payment audits until October 2014
   c. All MAC audits until October 2015
   d. Prepayment audits until October 2015

2. Bedside rounding improved the sense of good handoffs among nurses from what to what (from a pre-implementation survey to post-implementation survey taken two months later)?
   a. 10-54%
   b. 10-100%
   c. 13-64%
   d. 10-50%

3. How many programs have received advanced certification in preterm labor and premature infant care?
   a. 15
   b. 6
   c. 9
   d. 12

4. How much can your core temperature drop if you have a 30% burn?
   a. 20%
   b. 30%
   c. 40%
   d. 50%

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. ■