YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

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

June 2014: Vol. 39, No. 6
Pages 61-72

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

How many patients does it take to engage a hospital?

NPSF report makes suggestions, critics argue for more

When you bring up the topic of patient engagement to hospitals, most of them think immediately of a committee — a patient and family council or having patients and families participate in some way on some of the many committees that help make hospitals run smoothly. But the National Patient Safety Foundation wants you to know there is more to patient engagement than committees, and in a new report, *Safety Is Personal*, it outlined some of the things that hospitals should be thinking about to get patients more involved in their care, how it is delivered, and the running of the organizations that deliver it.

Having a patient on a committee is not ever going to be enough in terms of patient engagement, says **Susan Edgman-Levitan**, PA-C, NPSF board member and the lead author of the *Safety Is Personal* study. At Massachusetts General Hospital in Boston, where she works as the executive director of the John D. Stoekle Center for Primary Care Innovation, patients and family are encouraged to participate in informal ways as well as formal ones. For instance, if marketing is working on an educational pamphlet, they might approach people in the waiting room to ask them about wording or clarity.

The report included dozens of things healthcare organizations could, and should, do that would improve patient involvement, according to NPSF. Many of them have been written of before, but **Leah Binder**, MA, president and CEO of the Leapfrog Group in Washington, DC, says that while they may sound familiar, very few hospitals have implemented more than one or two of them.

"The executive summary of this report doesn't do it justice," she says. "The checklist at the end of it should be hanging on the walls of very hospital in this country. Every hospital and system should be doing all of this, and only then, when they are all doing all of the things in this report, can they complain that the list is boring and derivative."

Places to start

The healthcare industry is "so far from listening to patients too much" that it's hard for Binder to choose one or two places for organizations to

start. Inevitably, it will be in the easier places, such as having a patient engagement committee and getting a patient representative on the board. Next might be getting patients involved in quality. Mimic organizations like Virginia Mason in Seattle, which has a patient tell a story at every board meeting, Binder says.

But there are some much bolder ideas in the report that Binder would love to see implemented by hospitals — and soon. For instance, full open access to healthcare records in real time — an idea buried at the end of the checklist — would potentially have a positive impact on patient compliance with treatment plans. "There is great language in the report about shared decision-making, and about problems that we have with the words compliance and adherence," she says.

One thing she would like to see is to have louder voices in the consumer space that are not funded by pharmaceutical or disease-specific organizations. Hospitals are a great place to help harness that. "Err on the side of too much, and don't worry about patients mucking up. We need disruptive engagement," Binder says. "We need patients who have suffered near misses, errors, and mistakes to tell what has happened. It will force you to look differently at business as usual."

Hospitals aren't strange to us, but to patients they are, Binder continues, so they approach it from a different perspective — a valuable perspective from which hospitals can benefit and learn to think differently.

Including patients

"The healthcare establishment consistently underestimates patients," says **Helen Haskell**, president of Mothers Against Medical Errors, a Columbia, SC-based advocacy group. Haskell was one of the authors of the *Safety Is Personal* report.

"Every institution that tries to do this is afraid that patients will say no. But they don't. No one says no, and the hospitals find this surprising," she says.

Haskell has heard all the reasons why not to include patients in a variety of hospital activities. Along with not being able to find someone, she has heard folks say that they won't be able find people who are smart enough to "get it," or that they will be disruptive, or angry.

But Haskell says everyone who participates in the running of a complex system needs some training, whether he or she is a housekeeper or a CEO. Training isn't a big deal.

As for disruptive presences, they exist in all places, too, and for the most part, people aren't disruptive. If you don't have people generally yelling at meetings, someone new won't yell.

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), $519. 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).

Editorial Questions

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

If you take turns talking, stick to your agenda, encourage polite discourse, and allow everyone a voice, chances are, you'll do just fine, Haskell says.

Families engaged

"I think hospitals are fearful of patient input because they worry it will be critical and upsetting," Haskell says. "But families who are in the hospital a lot are interested and engaged. They want to be a part of making things better. If you ask the nurses and doctors who they think would be a good resource for a project or committee, I promise you, they will have ideas. There is no shortage at all of people who you can turn to. You just have to ask."

The patients and family members should be on committees throughout the hospital, particularly on those related to safety and quality, she says. There should not just be a token one or two, either, and they should reflect the make-up of the population you serve. That may mean searching for bilingual or racially diverse folks, but Haskell again notes that if you ask the frontline providers, they will have some great ideas of strong voices for you to use.

"Don't worry so much about getting the right patient," Haskell says. "You want a true reflection of what is happening. Get the angry voices, hopefully couched in polite terms. You don't want a sanitized picture of what happens in your hospital. You want the real picture. You will learn more that way."

Even a couple years ago, Haskell wouldn't have thought that patient engagement would have moved as far as it has. The trajectory is in the right direction, patients are making it onto committees and getting involved in patient safety and quality discussions. But that's just one part, she says, and it's not nearly enough.

Teaching of caregivers

"What is far more important is the way you interact with the patient at the bedside. Open access to medical records, having bedside rounding at change of shift, family visits at any time, and patient-friendly discharges — those are all things that are at least as important as putting a patient on the hospital board," says Haskell. "They are fundamental changes that patient advocacy groups can tell you about right now, that are about the interaction between the patient and caregiver."

She's working on creating patient-activated rapid response teams so that patients themselves can indicate an emergency. The pushback is the same as the pushback that occurred when families were given the option to call for rapid response teams several years ago in some hospitals — that there will be so many false calls for help that no one will pay attention to the real ones.

Haskell would also like to see better teaching of caregivers on how to be empathic, how to resist reacting negatively to people who might not be behaving well because they are sick or scared or in pain, and how to pay appropriate attention to family members. "That would be a great start," she says.

But if Haskell had a top-three wish list, it would be for all hospitals to allow 24/7 family presence, bedside change of shift rounding, and open medical records.

In the end, this isn't something hospitals will have a choice about, Binder says. "We haven't traditionally asked patients 'is this a good idea' because we haven't viewed them as our customers. But more and more they are paying the bill. In 2012, one in six workers were covered by high-deductible health plans. A National Business Group on Health Survey that came across my desk said that a third of their members' employees would be in the near future. Patients will be paying the bill, and after they ask how much the bill is, the next question they ask will be, 'What do I get for that money?'"

The report by the NPSF can be viewed at http://www.npsf.org/wp-content/uploads/2014/03/Safety_Is_Personal.pdf.

For more information on this topic, contact:

- *Susan Edgman-Levitan, PA-C, Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital, Boston, MA. Email: sedgmanlevitan@partners.edu.*
- *Doug Wojcieszak, Founder, Sorry Works!, Glen Carbon, IL. Email: doug@sorryworks.net.*
- *Leah Binder, MA, MGA, President & Chief Executive Officer, The Leapfrog Group, Washington, DC. Telephone: (202) 292-6713.*
- *Helen Haskell, President, Mothers Against Medical Errors. Columbia, SC. Email: Haskell.helen@gmail.com* ■

Are enough patients engaged in safety issues?

Some say not enough "real" patients involved

The argument goes that given long enough, someone we know, or we ourselves, will be in a hospital, so any one of us, plopped into a hospital committee, counts as a "patient" or "family member," right?

Not so fast. Some say that notion means that the voices of healthcare insiders are strong, while those of regular people who aren't aware of all the issues, who don't speak the language, and who may not be as comfortable speaking up to folks as lofty as brain surgeons and nurse anesthetists are left out of discussions on what could make healthcare better and safer. And when it comes to making it better and safer, the voices you may find most helpful are those of the outsider.

It is not an argument that insiders completely disagree with, says **Susan Edgman-Levitan**, PA-C, a board member of National Patient Safety Foundation (NPSF), and chair of the roundtable that released *Safety Is Personal*, a report on consumer engagement in patient safety through the NPSF Lucian Leape Institute. *(See related story, page 61.)*

The very report came under fire from patient safety critics such as **Doug Wojcieszak**, the founder of Sorry Works!, a patient and family advocacy group. He counted just five of the people involved in creating the NPSF report as true consumers, or 13% of the total — a number Edgman-Levitan and others dispute, putting it at triple that. "Sure, everyone is potentially a patient, and we've all had family in a hospital. But when you only have 13% representation in a room of insiders, the discussion gets skewed. They talk shop. The consumers may feel cowed."

Wojcieszak says he knows each of the five people he calls a consumer listed in the report, and while they are "inside" enough at this point — working for large patient advocacy groups or other consumer-related organizations that they are sure of their voices and opinions — he believes the conversation would be different if there was a larger percentage of regular people involved.

Helen Haskell, the president of Mothers Against Medical Errors in South Carolina and one of the people involved in the *Safety Is Personal* report, says that in some ways, she is of a mind with Wojcieszak, but when it comes to creating overarching policy reports, it is often better to have people who are knowledgeable about the healthcare industry involved. In the particular case of the *Safety Is Personal* report, she believes "there was enough of my kind of voice" involved, and that the patient advocate voices that were there were strong and impassioned, which is what you want, she says.

"I look at the list of people and see some of the most significant champions of patient engagement I know of," says **Leah Binder**, MA, president and CEO of the Leapfrog Group in Washington, DC. "There are some people there who are really bold who were involved, who are willing to champion the cause of patient engagement and don't have a side interest."

In the end, having half the committee made up of patients might not have made a difference to the fiercest critics. And it wouldn't have done anyone any good to take people who were completely green and put them around the table either, says Haskell. "When you are talking about this kind of big picture thing, it is important to have a degree of experience and expertise," she says. "Then you don't spend a lot of time having to go over things like definitions, and people won't be overwhelmed by the scope of the issues we are trying to come to grips with." ■

Falling for successful fall projects

Fall collaborative shares what worked

In the national reports on patient harm, many indicators have seen marked improvement in the last decade. Several hospital infections have become much rarer, with many hospital units going years without seeing a single case. You can see the graphs in those national reports trending downward. But fall rate graphs seem to squiggle along in a fairly even fashion, neither rising much, nor falling much.

Until maybe now. A three-year collaborative through the Joint Commission Center for

Transforming Healthcare finished up with seven hospitals reducing their falls by a total of 35%, and falls with injury by 62%. The extrapolation of those figures if they were national could be significant, given that a third of falls usually result in injury, which result in an extra six days in the hospital, and lead to some 11,000 deaths annually, according to the Center. In a 200-bed hospital, the figures would work out to a reduction of falls from 117 to 45, with a savings of about $1 million.

The participating hospitals included the following:

- Barnes-Jewish Hospital in St. Louis;
- Baylor Health System in Texas;
- Fairview Health Services in Minnesota;
- Kaiser Permanente in California;
- Memorial Hermann Healthcare System in Texas;
- Wake Forest Baptist Medical Center in North Carolina;
- Wentworth-Douglass Hospital in New Hampshire.

The collaboration used a process improvement process that incorporates elements of Lean, Six Sigma, and change management.

Erin DuPree, MD, vice president and chief medical office for the center, says that each of the ideas brought forth by participants was tested. In the end, some 21 targeted solutions were validated. In the next six months or so, an online Targeted Solutions Tool Kit for fall prevention will be available to Joint Commission members. The tool offers step-by-step guides to determining your organization's issues related to falls, barriers to implementing change, and suggested solutions.

Not every solution will work for every patient or even every unit, says **Becky Beauchamp**, MSN, RN, CENP, director of nursing at Wake Forest Baptist Medical Center in Winston-Salem, NC. Oncology units have to deal with patients on chemotherapy; geriatric patients often forget that they should ring for help if they want to get up; patients with brain injuries can be very impulsive. "There are generic things you can do for every patient, but there are also cases you can't foresee, like a first-time seizure or a massive heart attack."

Each kind of fall has a different potential intervention, she says. And each of those falls can take place at any time. It makes prevention exhausting but, because falls are considered healthcare-acquired conditions, all the more imperative.

A fall committee had some success at Wake Forest before the collaborative started, Beauchamp notes. Falls, and falls with injuries were tracked by unit. There was a strategy in place for trying to figure out just what was going wrong when someone fell. But what was missing was the element of working with other hospitals, she says. "We could learn from them, in a very structured way, using the robust process improvement methodology. Even if our interventions differed, the way we collected data would be the same. We used the same failure mode analysis to see gaps and test theories of what contributed to the risk of falling."

Those tools helped all the participants see toileting as a red flag. Patients who were otherwise compliant and anxious not to fall would get out of bed in the middle of the night to use the toilet, or would need to go to the bathroom, but after ringing a call bell, would be waiting too long and try to go themselves. Some patients might be on medications that made them need to go to the bathroom more often; others were not getting enough opportunity to use the toilet. While it seems like an obvious thing, to the participants, finding out how prevalent toileting issues were to fall risk was a big aha moment, she says.

"We found that we were giving diuretics to some patients at 10 p.m. They were needing to use the bathroom well after our 'tuck in' time of midnight," Beauchamp says. That was something that could be easily changed to ensure that the patients were done diuresing well before it was time for bed.

Focusing efforts

The data gathered was much more in depth than anything they had seen before, she says. While before they had information on falls and falls with injury, translated to a rate of falls per 1,000 patient days, the collaborative included more refined data for the two units involved — geriatric and oncology. They had demographic data, medication data, call bell response times, and more. This enabled them to find problem areas — such as call response times — and focus efforts around them.

The data collection was done with help from graduate students and the performance excellence department, and it ended with the collaborative.

Beauchamp says it would be nice to have that level of data available all the time, but it's too resource intensive. For now, they have a nurse manager do additional data grabs monthly on some of the data points they used in the collaborative, but it's not an everyday all-the-time thing on any unit.

"We think this was a great way for us to find out things about our particular population that we might not otherwise have found," she says. For instance, the oncology patients were not traditionally gotten up and moving during weeks-long chemotherapy stints in the same way a surgical patient would be once the anesthesia wears off. If the patient didn't feel well, they were left in bed. But being active helps preserve muscle and prevent future falls, so nurses now assess oncology patients daily, and if they are able, they are walking daily. For the geriatric unit, they implemented a video monitoring system, which other hospitals in the collaborative used with success. "They forget to use the call button, so if we see them moving to get out of bed, we can call into the room and tell them to hold on, someone is coming, and then send an alert out for all caregivers so that someone will get there quickly."

The fall rates at the hospital dropped 42% and injury rates dropped 11% over the course of the collaborative. The things they do now are an amalgamation of items from the solutions kits of the other participants: Some beds have piercing alarms that alert caregivers if patients leave them or if they move beyond a prescribed boundary on the bed. There are "do not pass" zones that require anyone walking by who sees a call light on to step in, engage the patient, and wait for the caregiver with them, no matter who it is, CEO or food service worker. The mobility training from the oncology unit has expanded pretty much hospitalwide: If a patient can move, the patient is up and moving. No more lingering in bed where muscles can atrophy. And all patients get a timed up and go test in which a nurse will determine if they have the stamina, strength and cognitive skills to walk.

Beauchamp suggests that after every fall, you drill down to the contributing factors. Have a debriefing that looks for the reasons why the fall happened, then change the plan of care for that patient. "Even if you don't have the Six Sigma resources, you can look at the information from fall debriefings and see contributing factors," she says. "We found early that we were being inconsistent with our hourly rounding and our handoff communications."

When you figure out your issues, communicate them to others through use of whiteboards in the rooms or interdisciplinary rounds, she says.

At Barnes-Jewish in St. Louis, fall prevention projects in the past had covered most of the usual improvements, such as yellow blankets on the bed, no-skid socks, and video-monitoring. **Laurie Wolf**, MS, CPE, ASQ-CSSBB, performance improvement engineer, says they were looking to dig deeper and find some of the root causes of falls. "We wanted to push further."

There was a lot of buzz about Kaiser Permanente's program out of its San Diego hospital, No One Walks Alone, which treats every patient as a potential fall, and ensures every single patient is accompanied when walking. "It has great results, and that's just the culture of the place," says **Eileen Constantinou**, MSN, RN-BC, practice specialist at Barnes-Jewish. They may implement that, but it calls for a commitment in staffing that many organizations would find daunting. "But what validates it is that we all have the same contributing factors: unassisted toileting, not calling for help. The data is pretty similar," she says.

Digging into data

The project allowed Barnes-Jewish to dig into the data and find something out they didn't know before — that when someone is assisted when they fall, they are less likely to be injured, says Wolf. Unfortunately, assisting a patient to the ground and preventing an injury still counts as a fall — a healthcare-acquired condition.

Many nurses get burned out working on falls. It's often considered a depressing subject, a problem so intransigent that no one wants to work on it. But Costantinou says it is much easier to put the time in to preventing a fall than the two or three hours it is estimated to take filling out paperwork and doing reports after a fall. "There is no single answer," says **Cathie Limbaugh**, MSN, RN, ACNS-BC, OCN, oncology staff nurse at Barnes-Jewish. It is patient by patient and you have to engage each person, assessing his or her risk. Not one of them thinks they will fall, and not one of them realizes the devastating consequences of a fall if they do.

That makes it even more important to do this

deep digging to see what your falls have in common, Costantinou notes. Figuring out where you have issues and room to improve will mean less of the demoralizing post-fall work in the future. "Ask yourself what you do to prevent falls and what you have to do after a fall," she says. "Which would you rather do? But don't think this is something you will ever fix completely. You can't fix it and move on. You can't ever let down your guard on this. Keep paying attention."

For more information on this topic, contact:

- *Becky Beauchamp, MSN, RN, CENP, Director of Nursing, Wake Forest Baptist Medical Center, Winston-Salem, NC. Telephone: (336) 716-2011.*
- *Erin DuPree, MD, Vice President and Chief Medical Officer, Joint Commission Center for Transforming Healthcare, Oakbrook Terrace, IL. Email: edupree@jointcommission.org.*
- *Cathie Limbaugh, MSN, RN, ACNS-BC, OCN, oncology staff nurse, Eileen Costantinou, MSN RN-BC, Practice Specialist, and Laurie Wolf, MS, CPE, ASQ-CSSBB, Performance Improvement Engineer, Barnes-Jewish Hospital, St. Louis, MO. Telephone: (314) 747-3000.* ■

ECRI tackles patient safety issues

Ten worries include 3 from tech list

With data from 1,000 hospitals coming in regularly, top 10 lists are probably easy to create for ECRI Institute PSO, a Plymouth Meeting, PA-based PSO and research organization. The latest by the organization is a Top 10 Patient Safety Concerns report, released in April.

Karen Zimmer, MD, MPH, FAAP, the medical director of the patient safety, risk, and quality group, says this list was created as a compliment to ECRI Institute's Top 10 Technology Hazards list, which was released at the end of 2013. *(See the December 2013 issue of* Hospital Peer Review*, page 133.)* "We have been collecting PSO data since 2009 and have more than 300,000 events in our database," she says. "We thought it was really important to share some of the recurring themes and tell organizations what we think they should be looking at, and consider what they might need to modify."

The issues aren't new for the most part, she says, aside from health IT and drug shortages, which are relatively new on the landscape. "But then again, with IT, that is because health IT was still new on the landscape five years ago. Now that data integrity failure is here, we expect it to decline over time."

The list of 10 was pared down from 20, based on the input of thought leaders and stakeholders from within and outside ECRI, says **Cynthia Wallace**, a risk management analyst at ECRI. While some may be there because numerically there were a lot of the 300,000 events related to them, the list is also based on root cause analyses and research requests that come to the PSO.

"It's not always what's most common that captures our attention," Wallace explains.

Zimmer says that organizations may find their priority lists may differ from ECRI's, but that just about every institution is going to see most of these resonating with them. The differences will be in what order you tackle them.

"Retained foreign objects, falls — these things are almost universal across organizations," says Wallace. But there will be nuances. For example, in retained objects, don't limit yourself to looking in the surgical suites. Look in other interventional areas for retained objects, as well. Similarly, with falls, don't limit yourself to the usual approaches. *(For some new ideas, see story page 69.)*

None of these issues is as straightforward as it may seem, either, says Zimmer. "If it was something simple, with one solution, we would have fixed it. These issues are multifactorial."

And just because you have this top 10 list, don't limit yourself. The 10 that didn't make it included other important items, such as device-related pressure, ED throughput, and tubing-line mix-ups. The full list is:

1. data integrity failures with health information technology systems;
2. poor care coordination with patient's next level of care;
3. test results reporting errors;
4. drug shortages;
5. failure to adequately manage behavioral health patients in acute care settings;
6. mislabeled specimens;

7. retained devices and unretrieved fragments;
8. patient falls while toileting;
9. inadequate monitoring for respiratory depression in patients taking opioids;
10. inadequate reprocessing of endoscopes and surgical instruments.

Numbers one, seven and 10 were also on the top 10 technology hazards list.

The complete list and accompanying report can be downloaded free with registration at the ECRI website, www.ecri.org.

For more information on this topic, contact:

• *Karen P. Zimmer, MD, MPH, FAAP, Medical Director, Patient Safety, Risk, & Quality Group, ECRI PSO, Plymouth Meeting, PA. Telephone: (610) 825-6000*

• *Cynthia Wallace, Senior Risk Management Analyst, Patient Safety, Risk, & Quality Group, ECRI, Plymouth Meeting, PA. Telephone: (610) 825-6000* ■

Does routine pre-op testing benefit patients?

AHRQ report reveals little direct evidence

If you've ever had surgery, you have probably had routine preoperative testing — that is, testing everyone goes through whether or not there is reason to think they have whatever problem the test is for — of some sort. But a new study by the Agency for Healthcare Research and Quality (AHRQ) found that very few studies have been done that could answer whether ordering the same tests for everyone before surgery leads to better patient outcomes. This raises the concern that some routinely ordered preoperative tests may be a waste of time and money at best, and lead to patient harm at worst.

The comparative effectiveness report on the testing (http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1847), found that there is a shortage of evidence for most surgeries as to whether routine preoperative testing leads to better outcomes for patients. **Elisabeth Kato**, MD, MRP, an AHRQ medical officer who oversaw development of the report, says that the idea that more knowledge is better doesn't always hold true, at least when you look at a large population.

"We went into this knowing there was not a lot of research on this," she says. "There was for cataract surgery, so we know that routine preoperative testing doesn't do anything to reduce complications for that. But for just about everything else, there just isn't very much — maybe one or two studies for any given test and type of surgery. There isn't enough for us to draw any conclusions one way or the other."

All tests have potential harm — usually as minor as a needle prick, but they can also lead to a diagnostic cascade in which one test's results lead to the need for another test, and then another and another, perhaps more and more invasive. If the tests uncover an illness that needs treating, the tests are worth it. However, a completely healthy person gets nothing from the testing but the risk. And the healthier the population you test, the more likely you are to get false positives that can set off the diagnostic cascade, Kato says.

The cost of routine preoperative testing is about $18 billion per year, which might be a bargain if we were sure they were making patients safer, but for most surgeries we don't have data that proves that, according to Kato.

What the studies show is that for cataracts programs, it's pretty safe to stop routine testing and only test patients whose history or exam suggest they may have a condition that could worsen if they have surgery, Kato says. For other surgical patients, there isn't much data for routine testing that is not based on the individual patient. For hospital managers who are interested in the issue, Kato suggests, "Get people to sit down and look at your preoperative protocols and discuss the risks and benefits of them. If you have access to data on the routine testing you have done, look at it and see how often it comes back something other than normal. What happened when you had an abnormal result? How many were truly abnormal? If you can, prospectively plan a couple of protocols as a study to determine the benefits of routine preoperative testing for various surgeries. There is a serious lack of research in this area, and more good studies would be great."

For more information on this topic, contact Elisabeth Kato, MD, MRQ, Medical Officer, Agency for Healthcare Research and Quality, Rockville, MD. Telephone: (301) 427-1104. ■

PSOs tout benefits of membership

They claim delay shouldn't deter hospitals

When the Centers for Medicare & Medicaid Services (CMS) announced in March that there would be no mandate for hospitals to join patient safety organizations (PSOs) until January 2017, at the earliest, rather than January 2015, many probably breathed a sigh of relief. After all, while many hospitals had jumped on the PSO bandwagon in the wake of the 1999 Institute of Medicine report, *To Err is Human*, others had dragged their feet, thinking it was more work — akin to what they were already doing so much of: feeding bits of data into an organization, often paying for the privilege of it, and not getting anything out of it that they weren't getting from somewhere else in another format.

But that's not at all what PSOs are about, says **Rory Jaffe**, MD, executive director at the California Hospital Patient Safety Organization (CHPSO), and after several years as voluntary organizations, some with thousands of hospitals participating, the benefits of having a great deal of data available on troublesome issues is just becoming apparent.

Jaffe says that at a recent PSO meeting held by the Agency for Healthcare Research and Quality, CMS spoke of the final rule (http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf), saying it came about largely because of a possible shortage of hospitals and providers who could participate in the health insurance exchanges if they were also required to participate in PSOs as early as 2015. But in the comments in the *Federal Register*, he notes, there were many who disputed that, and objected to the length of the delay, if not to the delay itself.

"We think a delay is fine if they are clear about the intent and what happens after that," Jaffe says. "A lot of people had been confused about the mandate the way the law was written. But this will allow for hospitals to join, and to have much broader participation in healthcare exchanges. That's what they are doing everything they can to facilitate."

What he believes is noteworthy and worth underlining to those on the fence is that Congress has twice chimed in to say that participating in a quality organization is so important that they are going to make a law about it — first in 2005, and then with the Affordable Care Act. "Congress has expressed its will, and regardless of the delays, this is something that with a virtually unanimous vote has become the law of the land."

Few hospitals would meet the exceptions that will be granted in 2017 when the delay expires, Jaffe says — hospitals in states with really robust reporting systems such as Pennsylvania, for instance. If you aren't in one of those, then you should really be thinking about joining a PSO if you haven't already, he adds.

Benefits can accrue quickly

"There are a lot of benefits that accrue really quickly," he says. "I can't overstate it enough. With the confidentiality and privilege protections that we have, you can share information with other organizations, and learn things with a degree of transparency and without fear of legal repercussions that will have a great impact on your safety and quality."

ECRI, a Plymouth Meeting, PA-based PSO with more than 1,000 hospital members, has been touting the benefits of joining since 2008, says **Amy Goldberg-Alberts**, MBA, FASHRM, CPHRM, program director for patient safety, risk, and quality. "We have published three deep-dive reports — on medication safety, health IT, and most recently on lab safety," she says. The latter one took information gathered from participating hospitals and was able to find that errors *in* the lab aren't just *of* the lab, but often are systems-related problems. They were able to discern these patterns because they had data from a large number of organizations that were participating in an open, collaborative, sharing environment.

"You can't think in isolation anymore," Jaffe says. "And the great thing is, you don't have to. For years, think of the things you have been itching to share with your peers but couldn't. Now you have a way to share the burden with a peer in another organization or ask a question. PSOs are the tool that can facilitate that. Can you imagine other industries not sharing information on problems in the manner healthcare has NOT shared information?"

He brings up the airline industry and pon-

ders what might happen if one airline had a problem with a wing or another part but didn't share that information with another airline. It's unthinkable, says Jaffe, but that's the way the healthcare industry has worked when it comes to errors, mistakes, near misses, and problems. At least until now.

"We are really helping organizations understand the social technical system, evaluate issues, and bring them to the attention of people designing systems and equipment so that we won't have to wait for a crash to learn from these things," Jaffe notes.

Solace in sharing

One recent issue CHPSO uncovered related to the way information was displayed on a PACS imaging system. The PSO started researching and found that there was an organization with a near miss related to the PACS system display of information, too. So they called other PSOs and found that there were other instances of harm and near misses. This kind of data will be put together and provided to the manufacturers so that the problem can be addressed. Again, without the data collection and collaboration of the PSO members and of the PSOs with each other, this might not have happened until there had been much more harm.

There is also solace in sharing, says Jaffe. "We had an event recently where a patient died, and one of the feelings that was most prevalent among the people involved was that they wanted to be sure this didn't happen anywhere else. They needed to share the information. The PSO is the intermediary that can make that happen."

One of the big fears is that PSO participation will be difficult, but Jaffe says most of them make it easy. "Once you are hooked up to most PSOs, it's minimal work," Jaffe says.

Healthcare needs a common way of looking at events, a culture of reporting and learning, and a legal protection for patient safety and quality information, he says. "That's the purpose of a PSO. It's everything that quality and safety advocates have been asking for, and it's here now."

CHPSO has 300 members, and like ECRI, has capacity for more. "A mandate isn't going to do anything for us, though. We have to demonstrate our value, and I think we are starting to do that. We are seeing the information we gather pay off, even to the point of influencing design of systems and equipment."

Goldberg-Alberts notes that another benefit for hospitals is that PSOs aren't just for inpatient facilities. Indeed, other healthcare organizations also take part, such as physician practices, long-term care facilities, home care, and ambulatory surgical centers. As care coordination matters more and more, having the kind of data that relates not just to one kind of facility, but to patient care across the continuum will be another asset to organizations that become early joiners of PSOs.

"I don't think you should put this off," she says. "Look around at the PSOs in your area. Evaluate your options, and consider your next step."

For more information on this topic, contact:

- *Rory Jaffe, MD, Executive Director, California Hospital Patient Safety Organization. Sacramento, CA. Telephone: (916) 552-2600.*
- *Amy Goldberg-Alberts, MBA, FASHRM, CPHRM, Program Director for Patient Safety, Risk, and Quality, ECRI, Plymouth Meeting, PA. Telephone: (610) 825-6000.* ■

Eligibility criteria revised for ambulatory

Effective July 1 if seeking TJC reaccreditation

The Joint Commission (TJC) has revised eligibility criteria for its ambulatory care program, including criteria for organizations seeking reaccreditation and organizations seeking accreditation for the first time.

These revisions take effect July 1, 2014, for ambulatory customers seeking reaccreditation and are effective immediately for organizations seeking ambulatory care accreditation for the first time.

For more details, see the April 2014 issue of *The Joint Commission Perspectives*. Web: http://bit.ly/1lzRSTB.

The revised eligibility criteria also will be published in the spring 2014 E-dition update and the "2014 Update 1" to The Joint Commission's *Comprehensive Accreditation Manual for Ambulatory Care*. ■

HHS releases security risk assessment tool

The Department of Health and Human Services has made available a security risk assessment tool tailored to the needs of health care providers in small or medium-sized offices.

According to an HHS news release, the tool "is designed to help practices conduct a risk assessment in a thorough, organized fashion at their own pace by allowing them to assess the information security risks in their organizations under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule."

The HHS Office of the National Coordinator for Health Information Technology (ONC) and the Office for Civil Rights (OCR) collaborated on the tool and, according to the news release, ONC is soliciting feedback from users and plans to update and improve the tool.

The Windows version of the tool is available at http://www.healthit.gov/providers-professionals/security-risk-assessment. There's also an iPad version, which can be found in the Apple App store. ■

COMING IN FUTURE MONTHS

- Creating mentors in quality improvement
- How to work effectively with hospitalists
- The ICD-10 delay and what it means for you
- Are readmission rates getting better?

CNE QUESTIONS

1. According to Leah Binder, what fraction of employees had a high deductible health plan in 2012?
   a. 1/3
   b. 1/4
   c. 1/5
   d. 1/6

2. PSOs were created by a law passed in what year?
   a. 2005
   b. 2008
   c. 1999
   d. 2010

3. How much time do the Barnes-Jewish nurses say you'll spend filling out paperwork after a patient has a fall?
   a. 90 minutes
   b. 120 minutes
   c. 180 minutes
   d. 240 minutes

4. One of the newer elements on the ECRI top 10 safety concerns list is:
   a. falls
   b. pressure ulcers
   c. retained foreign objects
   d. drug shortages

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. ■