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September 2014: Vol. 39, No. 9
Pages 97-108

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Financial Disclosure:
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AHC Media

Using Always Events to drive quality improvement

Focusing on the positive

Serious reportable events — the words can send a shiver up the spine of a quality professional, and any healthcare professionals who are present when such events occur.

In stark contrast are Always Events, which the Institute for Healthcare Improvement defines on its website as "aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time."

"Patients can experience Always Events," says **Martha Hayward**, the lead for public and patient experience at the Institute for Healthcare Improvement (IHI) in Cambridge, MA. "They are positive. And the thing is, where we fail to meet quality and safety goals usually has to do with patient experience. If we eliminate harm and increase safety and fail to focus on patient experience, we are missing the most important thing: how those initiatives translate to patients."

For years, Always Events were the baby of the Picker Institute, which, until it closed at the end of 2012, offered matching grants to organizations that came up with ideas for great Always Event projects. After its closure, the grants ended but the mission continued, bequeathed to IHI.

To qualify, an Always Event must be something important to patients, says Hayward. "You have to start not how we as a system perceive what should happen, but how patients do. We have to go to patients and ask them, not as perfunctory participants, but as guides."

The second requirement for an Always Event is that it has to be evidence-based — something that is known to make a difference in outcomes or safety or how patients feel about their care. Third, it has to be measurable and sustainable, and lastly, low cost. What they find, Hayward notes, is that most Always Events — 98% — relate to issues of communication, which can usually be implemented with a minimum of financial input. "Communication seems to be where we fail patients and families dramatically."

Hayward's own story is an example of why this kind of work is important. She was a cancer patient, admitted to a hospital at 7 a.m. one morning seven years ago for a bilateral mastectomy. She and her husband came in and, as they put on her wristband, she was asked what she was in for. She choked out the words, not knowing that it was just the first of 12

times she would be asked between then and the operating room what she was in for. The last time, as she lay on the gurney, gowned and ready for surgery, her husband "freaked out" and started yelling at the staff, wanting to know why they were asking his wife this question, why they did not seem to know.

Of course, the reason was safety. "But it cut my confidence and led to me having a racing heart as I went into surgery," she says. "If someone had said at the start that safety was the number-one concern and that everyone would be asking me why I was there, I would have felt completely different. I would have felt cared for."

Because they tend to be cheap fixes, Hayward says, Always Events are attractive to the bottom line and the folks who are watching costs. And because they are meaningful to patients, they are very attractive to frontline staff — they can see the impact of their implementation quickly. "It gives meaning to the work they are required to do," she says.

Accumulating evidence

Even for those who might be skeptics, there is increasing evidence that this is part of good care. "There is a lot of evidence about patient engagement in general, and about specific Always Events, we are accumulating evidence," she says. "The field of person-centered care is exploding. It reduces readmissions, costs, improves outcomes — we know this from the literature. And implementing Always Events can drive culture change. If you have a system that is frustrated with patients who aren't engaged, you can take this to leadership as a way to engage them."

The next two articles (see pages 99 and 100) include examples of Always Events that made a difference to patients, providers, and facilities — bringing benefits to all involved.

The IHI website has a starter kit on Always Events at http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx. It includes outlines of requirements, as well as of some of the successful events that have been tried in the past.

"Always Events translate patient experience into events," Hayward explains. "We are moving from knowing what patients want to behaviors that meet those desires. I do not want to feel like a number. I want to be known. How do we translate that into an event? What does that look like? It means the patient will always be asked how they like to be addressed and then be referred to in that manner. Always."

For more information on this topic, contact: Martha Hayward, Lead, Public and Patient Engagement, Institute for Healthcare Improvement, Cambridge, MA. Email: mhayward@ihi.org. ■

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.

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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.)

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Partner With Me aids dementia inpatients

Reduced anxiety, better compliance reported

People who have cognitive problems often face difficulties when they are hospitalized. They are in different surroundings, with different schedules, different caregivers. Symptoms of cognitive problems can become more pronounced, agitation worse. They may become violent where before they were not. They may refuse medications or eat poorly. Often, they will not be discharged to home, but will have to go to a long-term care facility.

It was something that bothered **Cynthia Barton**, RN, MSN, GNP, a nurse practitioner at the University of California, San Francisco hospital's Memory and Aging Center. "Patients — and their families — just aren't prepared for that. They are more likely to not go home, they have more functional and cognitive difficulties post-hospitalization than pre," she says. "And if we were uncovering cognitive difficulties for the first time — or if they were getting markedly worse with the hospitalization — the families are so devastated. But we could have predicted this."

She and her colleagues wondered what they could do to prepare them for the potential that hospitalization may change the course of their or their loved one's disease progression. They also wondered if they could make the hospitalization easier for the patient, the family, and also for providers who might not have extensive experience with dementia patients — there aren't many orthopedic or other wards specifically for older people with cognitive problems.

Barton figured there were three things to consider. First, to prepare the family for what might change and how they can help. Second, to get information from the patient and family that can help make the hospitalization easier — information such as the bedtime routine, medication-taking tricks, what the patient prefers to be called — and share that with the staff. And lastly, to prepare the staff for patients with dementia and other cognitive problems and how they might respond differently than other patients.

Patients and families are given a prehospitalization checklist of items that can help make hospitalization easier (http://memory.ucsf.edu/sites/all/files/download/Pre-admitPWMfinal.pdf), a paper schedule for visitation with space for names and contact information (http://memory.ucsf.edu/sites/all/files/download/PWMHospSchedfinal.pdf), and a care plan (http://memory.ucsf.edu/sites/all/files/download/PWMchart.pdf).

Volunteers

"We also wanted to develop a specialized cadre of volunteers so that extra work wasn't put on the nursing staff," Barton says. "That was the linchpin of this." The volunteers are there seven days a week. Many were family members of Alzheimer's patients, those considering nursing or medicine as a career, retired staff, or Alzheimer's lab workers; some spoke Spanish and Chinese, which was particularly helpful in the community being served. "The recruiting was amazing."

Training was done by the Northern California chapter of the Alzheimer's Association, which used the Dementia Friendly Hospital's Program created by the St. Louis chapter (http://www.alz.org/stl/in_my_community_62183.asp) — Barton notes they did not use the modules on diagnosis and medication, as they weren't pertinent. "We focused on communication strategies and interactions with people." Staff on the pilot units also received that training. Volunteers also had one-on-one training with the project coordinator.

Volunteers interview the family members and transfer the information to a large laminated sheet that is over the patient's bed. (For a sample of the questionnaire, see http://memory.ucsf.edu/sites/all/files/download/PWMQuest.pdf.) That provides key information to anyone who walks into the room — the patient's preferred name, how to get the patient to take her meds, what helps her sleep. Barton has one example of a patient who was refusing her medication over and over. When they finally had the chance to ask a family member — five days later — what might work, they found that just saying, "bottoms up!" would get the pill down the hatch without a hitch. Having that information available at a glance can keep a situation calm, which can make a huge difference to patient, family, and provider.

A video on preparing for hospitalization that the original grant funded (https://www.you-

tube.com/watch?v=ONK9oDVOUaw) plays on the hospital channel regularly, and it is being presented to all the outpatient clinics at UCSF, too, Barton says. It is shown to preoperative patients, as well, and plays in the emergency department.

Previous literature has shown that this kind of thing works, but there is no hard data on this particular program yet. The initial program enrolled just 37 patients, Barton says. They do have positive comments from patients and families. But she would like for it to be used in enough patients to see if there are fewer readmissions and shorter hospitalizations. Right now, a medical center in San Francisco is considering the program, as is a facility in St. Louis. "I know this is seen as a benefit by families and nursing," she says. For now, that's enough. They are working to translate the video to Chinese, though, and that would be for a fuller research project.

Not all aspects of the project were workable. They wanted the cheat sheet above the patient bed to be something that could travel with the patient from place to place, so if the patient had to go for a test to another department, the information would go with him, says Barton. They tried putting a little sticker shaped like a brain to indicate that this person has cognitive difficulties, and paper copy of the cheat sheet from above the bed in the chart, "but not everyone knew what that was. Now that we have an entire electronic record, maybe we could build something into the system."

Barton says that partnering with patient and family is something that should always happen, as should tailoring care to the cognitive ability of the patient. But it does not yet. "This makes it so much easier for nurses and patients. If we had known to say 'bottoms up' days earlier, think how much stress that would have avoided. For everyone."

Barton gave a speech on the Partner With Me Program that can be seen at https://www.youtube.com/watch?v=jumMIu7s_q0. The program's forms, links, and guides, many of which are linked above, are all available at http://memory.ucsf.edu/caregiving/hospitalization.

For more information on this topic contact Cynthia Barton, RN, MSN, GNP, Nurse Practitioner, UC San Francisco Memory and Aging Center, San Francisco, CA. Email: cbarton@memory.ucsf.edu ■

Program eases family burden in tough time

Waiting is the hardest part

Patient- and family-centered care is at the heart of the University of Pittsburgh Medical Center (UPMC), says **Deborah Maurer**, RN, MBA, administrator, University of Pittsburgh Medical Center Transplant Services. As part of that emphasis, medical students would shadow patients who were called to come in for transplant. It did not matter the time of night or day of the week — when the call came, a student shadowed them. "They were considered objective observers."

Maurer knows that UPMC, as a large academic medical center, can be scary — particularly at night, alone, on a long wait during a dangerous surgery on a loved one. One of the students spent his shadow time helping guide a woman through the maze to find coffee and an ATM. He sat with her during the long wait through her husband's surgery. At the end of it, Maurer, says, she told that student he had been her guardian angel. During the debriefing, some 20 or 30 shadow experiences later, that story and image stuck and the Guardian Angels program was born.

Maurer says they created a job description for someone to be a companion and help family members with "logistical maneuvering" through the facility. They are paid $3 per hour to be on call and $10 per hour when they come in. They are students and are there for a year or two. Usually, there are about a dozen at any one time, she says. There have been 40 since the inception. The low number was three, the high 15. Summers are usually the hardest to keep staffed because often students will have other jobs to go to.

As part of their orientation, angels have to shadow a transplant team as they evaluate patients, shadow social workers as they work with patients and their families, learn about organ allocation, and take a tour of the operating room where transplants take place. They also must master a list of common locations in the hospital: ATMs, coffee spots and vending machines, elevators, cafeterias, and entrances. The last event is handled like a scavenger hunt.

While the initial funding came from the Picker

Institute in 2011, when that ended, UPMC found other grants to fund it, and patients and family members have also been generous in giving to the Guardian Angels program once they have experienced it, Maurer notes.

Since 2012, there has been a five-question survey provided to users, and Maurer says there has never been a single negative comment on one. The value the 300 users have placed on just having someone with them — to converse, to play cards, to wait with them — is immense.

The cardiac surgery program at UPMC is looking at a similar model, and other transplant programs have been in touch about starting up angels programs of their own. While acknowledging her bias, Maurer thinks it is best suited to a transplant program or some other program that involves very long surgeries and a lot of waiting. "There are unique aspects to what we do here. They may come in a half a day in advance for testing. And sometimes, things do not work out."

But the support they give with way-finding is certainly something that can be replicated in other programs. As for the compensation, because of the on-call aspect, it seemed important to pay them. "The struggle with odd hours of being available would make it difficult for us to find enough people who would be reliable volunteers," she says. Happily, it has been easy to fund.

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ACS NSQIP conference outlines quality gains

Texting, a simple walk among the successes

At the American College of Surgeons annual quality conference in New York in July, surgeons outlined some of the gains that data from the National Surgical Quality Improvement Program (NSQIP) database has helped them achieve. Among the headlines were a way to cut the risk of blood clots in surgical patients who are placed in isolation, creating a new bundle to cut surgical-site infections, and how texting patients to remind them of pre-operative showering protocols can help avoid infections later.

The project to decrease venous thromboembolism (VTE) came out of Carilion Clinic at Roanoke (VA) Memorial Hospital. VTE impacts more than half a million patients a year (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6122a1.htm), according to the Centers for Disease Control and Prevention (CDC).

To **Sandy Fogel**, MD, FACS, the data from NSQIP indicated that patients who were in isolation were much more likely to develop a clot than others — almost six times as likely if they had general surgery or vascular operations or were trauma patients, and 3.5 times as likely if they had some specialty procedure.

Fogel also noticed that while VTE rates were very low in 2008, around 2010, they started to rise significantly. He and his team went looking for a reason. They found one in a hospitalwide focus on reducing Methicillin-resistant *Staphylococcus aureus* (MRSA). Patients who tested positive were being put in isolation. The MRSA rates went down. But those patients were also being much more left alone, less likely to do the walking and lung exercises that can help prevent dangerous blood clots, he says.

"It was one of those cases of unintended consequences," he explains, noting that VTE rates are now falling, and MRSA rates haven't rebounded. "This is a case of 'holy cow!' We had no idea why this was happening. We asked all sorts of questions about why the VTE rates were changing. We looked at nine months of data, and it turned out we had a new infectious disease doc who was responsible for the war on MRSA. That was the difference. We duplicated the findings with other patients, with trauma patients. But it all came down to asking the right questions."

As a result, they created a special place for patients in isolation to walk around, and hired specially trained aides whose job it was to get those patients up and about and to do the required lung exercises. They also have a specific nurse specialist who provides reports on those patients, and the patients and their families get education on reducing the risk of clots and the importance of ambulation post-surgery.

"Patients in isolation have fewer contacts with providers," he says. "We already knew they were more prone to depression and general complica-

tion rates. This is the first time we demonstrated that they had a higher risk of VTE, too."

If you have to have contact isolation precautions, you can't let that stop patients from walking. "Prophylaxis against clots is not enough," he says. "They have to walk. We also found that the longer time they were without their meds, the higher their risk. So if the nurses were taking longer to get to them — because they were in isolation — and they missed a dose, their risk went up."

Another piece of data gleaned: Most of these patients — 80% of them, says Fogel — were asymptomatic for MRSA. They were carriers, not septic or sick. And one new piece of data not yet published: Patients who have a second operation are at a nine times greater risk for a clot. "We know that one of the risks of VTE is missing a dose of prophylaxis, but we have them skip it before going into the OR. We aren't treating them. We should probably keep them on anticoagulants through their operations. But that may be a hard sell for some surgeons."

Patient satisfaction scores are usually lower for patients in isolation. Fogel thinks the change in procedure, which helps alleviate the loneliness and ensures that these patients have something productive to do, might improve those scores. If they do, the results may find their way into a paper.

Currently, partial results have been published in *The American Surgeon,*[1] and full results will be submitted in the future.

New bundle, new results

Barbara Drake, RN, the quality and patient safety coordinator at Vancouver General Hospital in British Columbia, would like to think it is possible to get to zero surgical-site infections (SSI).

She knows there will always be cases that are hard to control — patients who can't help but play with their dressings, or show their wounds to their friends. But her experience in driving down infection rates by 77% makes her very hopeful.

Using a best practice bundle that Drake and her QI team created with input from frontline staff by going through evidence-based measures that had already worked and adapting them to their own needs, they took a cardiac SSI rate of 7% — about twice that of other hospitals their size that participate in NSQIP — down to 1.6%, 0.4% beyond the initial goal, Drake says.

Gathering a team of frontline staff, they found some specific areas that were suggested as best practices by the literature, but were being missed at the hospital. Among them were using weight-based dosing of prophylactic antibiotics and giving a second dose if a surgery lasted more than the half-life of the medication — usually three or four hours; creating a better, standardized kind of wound care using different types of dressings that were kept on for longer; and warming patients back up to normal body temperature after they came off of bypass, she says.

While some of the ideas came from the Canadian Patient Safety Institute's Safer Health Care Now program (http://www.saferhealthcarenow.ca/EN/Pages/default.aspx), others came from the American College of Surgeons or other elements of the team's literature search.

They ended up creating an acronym for the entire bundle — CLEAN — that helped to encapsulate the main components, both old and new, Drake says:

- C: Clean hands before touching the dressing, chlorhexidine wipes applied to the body before surgery, clippers used for hair removal instead of shaving, and nasal decolonization (disinfecting the nostrils with ultraviolet light) performed.
- L: Leave the dressing on for 72 hours postoperatively, and leave the pink chlorhexidine disinfectant on the skin for six hours after the operation.
- E: Engage patients and staff on best practices for SSI prevention.
- A: Appropriately use antibiotics.
- N: Normothermia (normal body temperature), normal blood glucose (sugar), nutritious meals, and no smoking for patients.

Drake, who expects the findings to be published this fall, says one of the unexpected benefits of the program is that this multidisciplinary team approach to the problem was such a success that she believes it will be easier to introduce other changes in the future. "Before, the teams were not as mixed up as now. They did not always include the frontline staff. But when you think about how many departments touch a patient, it is so important that they all be included in efforts to improve care."

While initially this effort has been directed at cardiac patients alone and in one facility, she believes it will expand — both to other hospitals and within Vancouver General itself. Indeed,

bits and pieces of CLEAN are already filtering throughout the facility. The hand-washing and chlorhexidine, the nasal decolonisation, and clippers for hair removal — those are already in use. Orthopedics was already using the 72-hour dressing, which is one reason the cardiac team adopted it. The redosing of antibiotics was also already a practice for other surgical departments.

With the success of the SSI reduction program, Drake says she and her colleagues have been talking about the possibility of "getting to zero." Part of that is patient engagement and finding ways to update and engage staff so that CLEAN is front and center in their mind.

"I think the reality is we will always have someone who is diabetic or a high BMI," Drake says. "But when we do have one, we research why now, to see if there are factors that are not in the bundle — or not yet in the bundle that might have an impact."

Of current interest is the issue of bathing after surgery, she notes. That seems to be a common thread with some of the infections that have occurred despite the use of the bundle. She's also thinking of ways to keep the number of infections in front of staff — maybe build a little friendly competition between units, or have them invested in a "this many days since our last infection" run. Add a little more patient education to the mix and who knows, that zero may be attainable, even sustainable.

A good reason to stay connected

People are loath to let go of their phones these days, and that fact is helping one facility ensure patients are taking their pre-operative showers before coming to the hospital for elective surgeries.

At the Medical College of Wisconsin in Milwaukee, patients are required to take two consecutive showers using chlorhexidine gluconate (CHG) before they come in for their surgery. But, says **Charles E. Edmiston, Jr.**, PhD, CIC, FSIS, FIDSA, FSHEA, a professor of surgery and director of the surgical microbiology research lab at the college, based upon some preliminary investigations, "we had discovered that not all patients were actually completing the task. I also have heard this concern raised by my colleagues at other institutions around the country."

He decided to see if texting, emails, or voicemail messages might be a way to get patients to comply with the directive. "There was some data in the literature that patient electronic alerts were an effective strategy, enhancing compliance to other health care tasks such as taking prescribed medications in a timely fashion." There is also data that flu vaccination rates increase with such protocols.

For Edmiston's study — published in the *Journal of the American College of Surgeons*[2] — the vast majority (80%) opted to receive a text message, while 5% wanted to get a voicemail.

Current literature is mixed on how effective showering is at reducing surgical-site infections, but Edmiston and his colleagues are firmly in the camp that done properly, according to a strict protocol, it could have a positive impact on reducing adverse events like infections: "Our team felt that this was an opportunity to empower the surgical patient by emphasizing the importance of this task and allowing them to be an active participate in this risk-reduction process."

The patients who participated in the study were either prompted to shower two or three times with the chlorhexidine solution, or not prompted to shower. The results showed much higher concentrations of the chlorhexidine on the skins of the patients who got the prompts than those who did not, suggesting that the prompts worked to remind them to adhere to the protocol they were given when they were making plans for their elective surgery.

Edmiston says they did not know what the results would show — although they had some idea that text messaging could work. The concept is not unique, he notes, but "it is the first time that it was used to improve compliance to an important preadmission risk-reduction strategy for surgical patients."

He thinks that along with preadmission showering, texting or other messaging strategies can also be used for other preadmission tasks for patients, such as encouraging them to bring all their medications with them to the hospital, or reminding them about scheduling requirements. It also could be used to remind them they can't eat within 12 hours of their surgery.

"This technology could also be used to link patients to instructional materials related to pre- and postoperative requirements," says Edmiston.

It might also work post-surgery, he continues, for inquiring about pain or even taking a picture of the surgical site, he adds, noting that

in a separate but related endeavor, one of the laparoscopic surgeons at the Medical College of Wisconsin — Matthew Goldblatt, MD, FACS — has a developed a "virtual follow-up clinic" where, for example, patients send smartphone photos of their postoperative surgical site for clinical evaluation with follow-up phone consultation, allowing the patient to respond to other physician or nursing queries.

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Judging handoffs: Video study validates tool

Now you can tell if you're doing it right

A short study in the July issue of the *Journal of Hospital Medicine*[1] may change handoffs forever. For the first time, a tool created to judge the quality of how one physician passes the baton to another has been validated as effective.

Author **Vineet Arora**, MD, a hospitalist and associate professor of medicine at the University of Chicago Hospital, notes that there have been other tools used to judge handoffs, but this one — a mini-clinical examination exercise (CEX) — has been written about in the literature before, including by Arora and her colleagues.[2] Some have created their own evaluation tools, too. But by taking one that was already out there and evaluating its validity, she says, Arora and her co-authors hoped to be able to someday create training materials that could be relied upon to deliver a particular set of skills.

A grant from the Agency for Healthcare Research and Quality (AHRQ) five years ago helped them to create this specific tool, which borrowed from best practices already in the literature. In 2011, they tested it. What was just published was an effort to ensure it was an objective measure. They filmed handoffs of various quality and showed them in random order to faculty from Yale and the University of Chicago. For the most part, the tool worked, and was able to help faculty draw valid conclusions about the quality of the handoffs they witnessed.

Now that they know this mini-CEX works, should it be used by everyone all the time? It is currently in use in a slightly different format at the University of Chicago hospital for hospitalists and residents. It is being tested as-is in different environments, such as the pediatric intensive care unit.

Given that there is a mandate by The Joint Commission and other groups to have a standard approach to handoffs, it seems like a good idea to be able to validate that what you do is hitting the mark, she says. "You can have a handoff standard, but if you aren't measuring in some way, how do you know where you need to get better?"

Doing the observation work and rating, however, is very labor intensive. Someone in an organization will have to decide how often this kind of information should be collected, but Arora agrees that it should be done. "You can't do every handoff every day," she says. "But you can do spot checks. That's how I imagine it will be going forward. For a few days or a week, each unit will see how it is going."

She says there is some level of pushback from some physicians. But she notes that there is science you can show to those who do not like the idea of objective rating. "Those who self-rate are much more likely to rate themselves as better than they really are. That's why we need to train

people on what a satisfactory handoff looks like, or a superior one looks like."

Having videos of them to show as a training exercise will help ensure that people provide valid ratings, regardless of whether you use the mini-CEX tool she used or something else. "They give you a much better idea of the good, the bad, and the ugly."

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Joint replacement registry bears early fruit

Surprises in data point to unknown safety issues

There has long been a hole in the data collected on joint replacements: Patient-reported outcomes over an extended period of time were missing. In late 2012, the Agency for Healthcare Research and Quality (AHRQ) gave a $12 million grant to create the Function and Outcomes Research for Comparative Effectiveness in Total Joint Replacement (FORCE-TJR) to attempt to plug that hole, and it is already showing signs that the money is being well spent.

Already, surprises in the data are leading orthopedists to rethink the way they consider risk and provide ammunition against those who think they are overzealous in pushing for surgery.

There had been several independent joint-related data repositories before FORCE-TJR, says **David Ayers**, MD, a co-lead of the program and chairman of the department of orthopedics at the University of Massachusetts Medical School in Worcester. Other countries have successfully adopted a single portal registry that naysayers said could not work in the U.S. But so far, 20,000 patients and 150 surgeons have enrolled and submitted data to the program. Thirty of those surgeons have come in post-grant.

Along with information already collected related to cost, readmissions, and complications, this includes information on function and pain, both before and after surgery, he says. That patient experience has been missing. "This is very meaningful data."

Among the big "aha" moments, says Ayers, is that more than half of joint replacement surgeries are now in people who are younger than 65. "That is the most rapidly growing segment having elective joint replacement," he says. "The assumption has been that these are young, active people who want to remain active. What we have found, though, is that there are some who fit that, but the majority do not. They are obese and they have significant medical comorbidities and significant pain as well as functional limitations."

This group mimics the over-65 age group, but they are more obese and have more comorbidities. "They may have been active once, but data shows that by the time they have joint replacement surgery, they are severely limited by arthritis and are more obese," he says. "But they have all the benefit as the seniors over 65. That they are younger equals out the obesity/comorbidity issues. They have similar adverse event profiles as older patients."

So these younger patients who might not have been on the radar for adverse events due to their age need to be because of their weight and other factors such as diabetes, he says.

Ayers says another item of surprise from the data is that there is a near exponential rise in knee surgery — more than a million a year — fuelled by advanced arthritis, not because orthopedists or patients are changing their decision-making about when to have surgery. A look at the pain and function profile of these patients, compared to studies from 10 and 25 years ago, shows there has been "no liberalizations. We are not recommending surgery at an earlier stage. These are people who are very disabled, physically limited, and in significant pain."

The Centers for Medicare & Medicaid Services (CMS) has been publishing readmission and complication rates for every hospital that does more than 25 joint replacements per year, says Ayers. They risk-adjust based purely on administrative data from Medicare. FORCE-TJR used its data to see if there is a way to use its clinical information to improve the risk-adjustment methodology for patients and providers.

"This was a collaborative project we did with the American Association of Hip and Knee Surgeons," he says. "What we found is that by adding clinical information we can significantly improve the prediction of CMS readmission data and improve their risk adjustment based on five areas."

They are:

- BMI: that it is not just above or below 40, as CMS has. Less than 40 but still high is also important, notes **Patricia Franklin**, MD, MPH, MBA, the other co-lead of FORCE-TJR and the director of clinical research for orthopedics and physical rehabilitation at the medical school. "It is not just the most obese who are a risk, but across the continuum."
- Pre-surgical function.
- Whether the patient is a smoker.
- The total burden of musculoskeletal disease: Ayers notes that knowing if there is arthritis in one knee is not enough. If the patient has arthritis in the other knee, the hips, the low back, that will also impact the risk of complication or readmission. "It is important to the physical function after surgery, and if you have more disease burden, it makes sense that you will have a greater likelihood of complication."
- Synergistic effect of medical comorbidities: It is not just whether you have three other comorbidities that add three more "points" of risk. They add more than that. The cumulative effect of diabetes, renal disease, and cardiac disease is more together than if you looked at each individually.

That this information is available could be a boon, says Ayers. A facility that does total joint replacements should take the CMS administrative data that it uses for risk adjustment and add those five factors to help determine which patients are most at risk. Then develop programs to ameliorate that risk.

"This is really exciting. This allows us to figure out the best practice over different pathways — anesthesia, pre-op, surgery, post-op," he says.

The registry provides quarterly executive summaries and reports on consistent risk factors for complications, as well as patient-reported outcomes, Franklin says.

"Do they have more comorbidities, are they older or heavier. These are compared to national norms for risk factors and outcomes," she says. Participants also receive a preoperative profile that includes information on severity of pain and functional disability both at the center in question and nationally. Outcomes such as readmission rates are also part of the information provided, and this has proved particularly illuminating.

Franklin notes that while many people will travel a distance to go to a good joint replacement facility, if they are having pain, shortness of breath, or other complications, they often go to a different hospital, and the original facility may not get that information. Indeed, 25% of the time, that happens. "We get the true number because we ask patients did they go to the hospital and which one."

Other data includes 90-day all-cause complications, and 6- and 12-month patient reported outcomes, for the participant and national comparison numbers.

Cost of participation depends on how much information the organization wants, says Ayers, as well as the assistance needed in terms of computer program set up.

"It is comparable to NSQIP and the programs by thoracic surgeons in terms of costs and involvement," he says. "What is new is that there has never been an option like this to be part of a quality improvement methodology for joint replacements."

Franklin also notes that FORCE-TJR is certified by CMS to submit as quality data for PQRS.

For more information on this topic, contact:

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Videos help providers check injection practices

The Centers for Disease Control and Prevention (CDC) continues to investigate outbreaks as a result of unsafe injection practices. These mistakes and knowledge gaps put healthcare providers and patients at risk. The CDC's One & Only Campaign created two short videos to help make healthcare safer, one injection at a time:

• ***Check Your Steps! Make Every Injection Safe*** for healthcare providers, 3 minutes and 45 seconds;

• ***Managing Patient Safety, One Injection at a Time*** for healthcare managers, 2 minutes and 33 seconds.

Created by the Safe Injection Practices Coalition, these videos detail critical information to help providers and facility managers double check their injection safety knowledge and help keep patients safe from unnecessary harm. To access the videos, go to https://www.youtube.com/user/OneandOnlyCampaign. For more on the One and Only Campaign, go to Facebook (One & Only Campaign) or Twitter: @InjectionSafety. ■

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CNE QUESTIONS

1. Which of these is NOT an element of an Always Event
   a. Communication-related
   b. Measurable
   c. Meaningful to patient
   d. Low cost

2. Partner with Me goals are to:
   a. To help keep dementia patients from readmission
   b. To help prepare patients, family and staff for the special needs of dementia patients
   c. To help staff avoid conflict with dementia patients
   d. To reduce the use of restraints with dementia patients

3. The Transplant Guardian Angels help families by
   a. Explaining transplants to them
   b. Getting surgical updates for them
   c. Providing companionship to families during long waits
   d. Being on call for the patient

4. FORCE-TJR has recently found that most joint replacement patients are now
   a. Obese
   b. Under 65
   c. Have at least three comorbidities
   d. Uninsured

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. ■

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