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NOVEMBER 2014 Vol. 39, No. 11; p. 121-132

INSIDE

AHC Media

How many procedures makes competency?

How is your recredentialing dealing with the new numbers game?

It's an intuitive truth that makes sense to just about anyone who hears it: If you are having a procedure done, you want to go to someone who has a lot of experience doing that procedure. Now, that truth is being included in ratings by organizations like The Leapfrog Group, as well as in the suggested requirements of specialty organizations. Earlier this year, the American College of Surgeons finalized requirements for pediatric surgery and the various levels of competency required by hospitals and staff to handle specific cases (https://www.facs.org/media/press-releases/jacs/pediatric0314).

For many hospitals, having surgeons or other physicians who do procedures complete a certain number in order to demonstrate continued competence has been a part of recredentialing for a while, says **Kathy Matzka**, CPMSM, CPSC, a consultant from Lebanon, IL, who specializes in credentialing and staffing issues in healthcare.

> "IT'S EASY IN A BIG CITY TO SAY THAT A SURGEON HAS TO DO A HUNDRED BIG PROCEDURES, BUT IN A RURAL AREA, HOW DO YOU SET THAT NUMBER?"

Many hospitals have included a numerical standard as part of core privileging for about 20 years, she says. The problem is that templates of documents have been shared around, and the numbers have been passed about as if they were delivered from on high, rather than developed through a considerable discussion among the staff at a

Financial Disclosure: Editor Lisa Hubbell, Executive Editor Russ Underwood, Associate Managing Editor Jill Drachenberg, and nurse planner Nancy Schanz 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.

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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.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST registration number R128870672.

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

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $469
Outside U.S.A.: Add $30 per year. Total prepaid in U.S. funds.

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ACCREDITATION: 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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particular hospital, she says. And there are other facilities that have simply left the number issue blank and inserted language like "must do enough for the medical staff to make a reasonable decision about continuing privileges."

"It's easy in a big city to say that a surgeon has to do a hundred big procedures, but in a rural area, how do you set a number?" she asks.

And if you do set a number, you have to live by what you write down on paper, complete with consequences for not meeting the threshold.

That doesn't mean that if a physician has done 29 procedures she can't operate in your hospital if the number is set at 30, Matzka says; it means you have to put in place policies and procedures that will allow her to otherwise prove her competence, such as having a certain number of surgeries proctored by someone who is credentialed and who works in that specialty. If there is no one at your facility who can do that, then you bring in someone from outside to do so, she says.

There is also something called transference of skills, where the skills used in one procedure might be similar enough to another to constitute equivalence and thus the numeric threshold can be met in that way, Matzka notes. "Maybe you didn't do 30, but you did 20 and a bunch of something else that uses the same skills set." In this case, too, a thoughtful consideration by staff familiar with the kind of work done by the physician in question is vital in order to protect all parties — hospital, physician, and patient. It is done on a case-by-case basis, and when and how it is accomplished has to be included in the bylaws of the hospital under the section denoting how you recredential physicians.

While some organizations that rate physicians and hospitals are taking note of numbers, Matzka says she doubts that the Centers for Medicare & Medicaid Services — from which all accreditation requirements by organizations like The Joint Commission flow — will ever do that. "They say only that the medical staff has to assess the ability to do tasks and procedures. The Joint Commission had a FAQ at one time about core privileges that said it would be inappropriate to re-grant privileges for something that someone hasn't done in two years. But that sentence was removed." What is important to The Joint Commission and other accreditors is that you evaluate your physicians and their ability to continue to perform well on a regular basis — every two years for surgical staff, she says.

The specifics are left to each facility, Matzka says, although some data are common in just about every hospital's review of surgeons: surgical case review, the appropriate use of blood, appropriate use of medications, return-to-surgery rates, rates of patients sent to the intensive care unit. Each department will have indicators it evaluates. Orthopedics may want to look at the appropriateness of total joint replacements, while obstetrics may be interested in C-section and VBAC rates.

She says that while it's easy to assume that the bigger hospitals in metropolitan areas do it best, that's not necessarily true. "I've worked with some critical access facilities that do a fantastic job, while some really large hospitals just don't. In some ways, the bigger

you are, the harder it is to get a handle on what everyone is doing. If you have 1,000 physicians, it's harder to know what's going on. In a small rural hospital, everyone knows how everyone is doing. It may not look as good on paper, but they often have a much better knowledge of what is going on in their facilities and how their physicians are performing than a large hospital with all the data and computer analysis in the world at their disposal."

Matzka says for those small hospitals where numbers may be harder to achieve, or meaningless, the best option is to get peer recommendations for recredentialing: "The direct knowledge of the people involved when you have a small medical staff and the president is evaluating can be just as edifying as numbers. They have an intimate knowledge of the kinds of procedures and most likely if they are going well or not."

Department chairmen, medical staff evaluations, nurse input — in a small facility, you have people doing a wide array of procedures they might not do if they were in a larger facility, she says. A general surgeon may be doing colonoscopies whereas in a bigger city that would be a gastroenterologist's job. Get a good indication of what the physician in question is doing and whether it's being done well. Look at incident reports, Matzka says, as well as complaints. Along with the traditional data, they should give you a good idea of someone's competence. If you don't have someone available who understands the specialty — you have just the one cardiologist or neurologist — bring someone in from outside to judge his or her work and do a chart review.

Small hospitals shouldn't take their requirements to recredential physicians any less seriously than a large hospital that has dozens of specialists available to them, even if finding a doctor lacking could leave them without their one cardiologist, says **Paul Hofmann**, DrPH, president of the Hofmann Healthcare Group, a consulting firm based in Moraga, CA.

One issue he thinks could help smaller hospitals avoid problems is to avoid the clarion call of expanded service lines. Not every hospital has to have all the bells and whistles, he says, and there may not be the volume of potential patients to justify an expansion. If you end up trying to expand into a previously unknown realm, you may find it more difficult to ensure that a physician is doing all the right things for all the right reasons.

If you haven't looked at your recredentialing policies in a while, pull them out and have a look. Set the doctors the task of discussing any numbers included in your requirements. Look at what some of the specialty societies are saying, but understand that they offer only opinions, and they can differ, Matzka says. "Different training programs will say different things. Take all of those into consideration, but in the end, your medical staff has to determine what they can live with. They are just guidelines, not requirements."

When the medical staff come up with a number, Matzka says, they should look at the numbers for every staff member and see if it would have an impact on any of them. "I have seen it happen where they fill out some form they find online that says these are the requirements, and it says 100 major procedures in the last year. They adopt it blindly without knowing what the norm at that facility is."

When they have the number and the average production for the doctors, they need to come up with a strategy for what to do with those physicians who don't meet the number, Matzka says. If your physicians think 50 procedures is a good number, and three of your physicians are at 49, is there an argument for lowering the threshold? What about the people who are somewhat, but not significantly below it? What are the requirements they have to meet to continue practicing? Is there another way they can demonstrate competence? "If you put it in writing, you have to live with it," she says. "It may be that when you have something like that, you do a focused professional evaluation or you may look for transference of skill. Make sure it's something you can live with."

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Refocusing your readmissions reduction strategies

AHRQ says dig into Medicaid while it's still an option

Cue the shark music. Because just when you thought you were getting a handle on reducing readmissions for your Medicare population, the Agency for Healthcare Research and Quality (AHRQ) has another task for you: Look at your Medicaid readmissions, because you may find that those patients are bouncing back in at least the same quantity as your older patients. And if you aren't being penalized for those readmissions now, there may be a time coming when you will, says the lead author of a new toolkit commissioned by the agency to help get you through the project.

Released in August, the *Hospital Guide to Reducing Medicaid Readmissions*, available at http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html, was created to help organizations "unpack the differences" between the Medicaid and Medicare populations, says lead author **Amy Boutwell**, MD, MPP, a practicing physician, Harvard Medical School instructor, and consultant who guides organizations through the morass of health reform. She says even the best organizations who want to make sure they look at readmissions in a way that pays no attention to payer but focuses on keeping patients from bouncing back are still using guidebooks, evidence, articles, and information that was created specifically for Medicare patients. That just won't work for many, if not most, members of the Medicaid population. "They are looking for patients with congestive heart failure, or pneumonia, the diseases of frailty," Boutwell says, "We still need to know those high-risk conditions, but they may not be the high-risk conditions for your Medicaid patients. In fact, very few organizations are aware of what their Medicaid population's readmissions risks are."

In an ideal world, we wouldn't stratify based on payer, and maybe in a few years, that's where healthcare will arrive, she continues. "We would screen for readmission risk for every patient," she says, noting that a few facilities are already diving headlong into this effort. "But my experience working with thousands of hospitals is that unless there is an incentive to do so — or a disincentive in the case of a penalty — then they won't do it."

Medicare stopped paying for unplanned readmissions. Some third-party payers are following suit. And now, Medicaid is jumping on board. Just two months ago, Illinois announced more than $16 million in penalties against hospitals for unplanned Medicaid readmissions, and Boutwell says there are "a handful" of other states considering similar options. New York state has created a waiver program designed to reduce Medicaid readmissions. Focus is increasingly on this vulnerable population.

"This kind of effort has, up to now, been defined by financial incentive and forcing people to put extra focus there because of that," Boutwell says. "And it's shameful that it takes that."

Some people think that because Medicaid patients are treated at a financial loss makes changing behavior low on the priority list. "We're losing money on them; how can they penalize us when they don't pay us enough?" is the thought process. "What's a percentage of a negative number?" But Boutwell says that's like saying your boat is sinking, so why not punch another hole in the bottom? Every time a patient who is a drain on resources comes into the hospital, he or she is costing money. If they come in once and you make them well and they don't come back, it's a win. If you don't make them well enough and they bounce back, you lose money twice. Added to that in the future may be a cash penalty that will speak louder than anything up until now has, she says.

The toolkit Boutwell and her peers wrote doesn't include pregnant women or pediatrics because the dynamics are different for those patients and there is just too little literature to figure it out. Besides, you want pregnant women to come back in for delivery. And sick children? They don't act like other sick patients.

The book includes worksheets to figure out your case mix and the number of readmissions for each payer — something Boutwell says she doubts many people know. She says it might be very surprising just how many of the unplanned readmissions come from Medicaid patients. Medicaid patients between 45 and 64 have a 24% readmission rate; Medicaid heart failure patients have a 30% readmission rate, compared to Medicare patients, who have a 25% readmission rate.

The emphasis is on young Medicaid patients — "a third of older

adults are dual eligible patients, so the existing Medicare readmissions reduction efforts will apply to them," she says. "But what are the issues for these younger patients? It tends to be the health and social issues that lead to the very diseases we see in older patients. We don't see the heart failure, but we see substance abuse, stomach problems, bleeding ulcers, and pancreatitis. We don't need the dementia and functional status screening tools we use for older patients, and if we use them on this group, we are missing the highest-risk Medicaid patients, most of whom are more likely to bounce back than an older Medicare patient."

Boutwell acknowledges that this will take added work, but she says the toolkit was designed to complement what you are already doing. "We made this so that it is easy to integrate with what you are already doing in the spectrum of readmission reduction efforts. We are simply making the argument that you should expand them to include Medicaid and providing tools that may make it a little easier."

The tools even include estimated time involved at the top of each, so you can more easily budget for each step. Some take a couple of hours. Others are simply there to help providers remember that there is another population out there. For example, a readmission risk factor list is included and can be posted in workrooms, discussed at meetings or seminar sessions, or even handed out as laminated cheat-cards to key staff.

With healthcare reform, you will likely see a large influx of Medicaid patients through your doors. They will be unfamiliar with the healthcare system. They will have infections, sickle cell disease, HIV — things that your previous experience with readmissions reduction programs didn't deal with, says Boutwell. They will have lower literacy levels and perhaps difficulty with the English language. All this and more will make them a potential drain on resources. More importantly, it will make them harder to heal.

"Nurses in hospitals are running around looking for the older patient with heart failure to try to make sure they do everything so that patient doesn't come back," Boutwell says. "That violates every principle of quality improvement. We should be doing something for patients across the board to make sure none of them come back unexpectedly."

For more information on this topic, contact Amy Boutwell, MD, MPP, Co-Founder, Collaborative Healthcare Strategies, Boston, MA. Email: amy@collaborativehealthcarestrategies.com ■

Update on CMS offer on appeals

One hospital crunches the numbers

When the Centers for Medicare & Medicaid Services announced that it would offer 68% payment for organizations that would drop their appeals with a deadline of acceptance of November 2, many wondered who might accept the terms. Granted, there would be a hunk of money in hand now, and no lengthy appeals process to go through — a process with no guarantee of success. But there are principles, too, right?

Hospital Peer Review asked one hospital what it is thinking about in making a decision.

Linda Jo Spencer, the Hospital Compliance and Privacy Officer at Middlesex Hospital in Middletown, CT, outlined six things the hospital is looking at in determining what to do:

- Success rate of historic appeals.
- Interest rate of denied cases.
- Impact on the reduction of inpatient days on the cost report.
- Bad debt.
- Costs associated with the appeal process.
- Cash flow.

The hospital has more than 400 cases in the appeal process and has been "historically successful at overturning these denied cases at the Administrative Law Judge (ALJ) level," Spencer says. The offer is simply an attempt to reduce the backlog at the administrative law judge level, since it could take as long as four years just to hear all of the cases that Middlesex alone has in the queue.

She continues, "If the hospital pursued this settlement offer by CMS, the hospital would be agreeing to a 32% reduction in reimbursement and will forfeit the interest that has accrued on the denied claims which could be as much as 133% of the favorable claim. In addition, since these claims will continue to be in 'denied' claim status by CMS and will not be counted as inpatient days on the hospital cost report, it will impact the graduate medical education calculations."

Further, after the Administrative

Agreement is signed, the hospital cannot pursue any co-pays and deductibles that haven't been collected on these claims or characterize them as bad debt, she says. "In this calculation, costs associated with the appeal process are being reviewed — such as staff and physician time for compiling medical records, responding to the appeals, writing appeals, and attending ALJ hearings. Also, the effect of cash-flow delays in the appeal process versus taking the settlement now is an important factor."

She concludes, "The decision to appeal or settle is being carefully considered." No word at press time as to what that decision is.

For more information on this topic, contact Linda Jo Spencer, Hospital Compliance and Privacy Officer, Middlesex Hospital, Middletown, CT. Email: lindajo.spencer@midhosp.org. ■

All aboard for a new face in QI

Engineers have a different perspective in IDing, solving problems

They speak a different language, and the lore in society is they are completely otherworldly, but engineers may be the missing tool in you quality toolbox, the thing that makes you see a problem in a novel way, approach its solution differently.

Six years ago, Spartanburg (SC) Regional Hospital implemented Lean-Six Sigma management, and created three engineer positions as a part of it, says **Heather Bendyk**, MBA, corporate director and master black belt of quality services for the 588-bed hospital and the health system of which it is a part.

The rationale was simple: Healthcare is far behind other industries in the science of quality. "We talk about quality in terms of regulatory compliance, but that should be a minimum. We should be talking about designing the best workflows, so that compliance is always met." The ultimate goal, then, is a high-reliability organization, with little to no variability in work.

That's where the engineers come in: with an expertise in designing workflows, seeing bottlenecks, and acting as the plunger to push the clogs out and reroute them in a better way. "They are looking at efficiency all the time," she says.

Bendyk herself is a former engineer and knows it can be a tough transition — she took medical terminology and acronym courses, as well as an anatomy and physiology class to help learn the terminology. Because she knows how long it can take to get up to speed when you come from outside healthcare, she highly recommends finding someone in your organization and training him or her into the role. They don't have to have a clinical background — they can learn what they need, as she did.

One thing she values in engineers is their ingrained habit of solving problems by going to the source. "In other industries, if they have an issue, they go to the floor and talk to the operator. In healthcare, that means that when I have a problem, I go to the floor and talk to the front-line staff. What do they do? How do they take care of the patient? Why are they doing something in a particular order? What are the problems they see? That front-line staff isn't often engaged in conversation, but no one can tell you more."

"There are a lot of people who would argue that engineers come up with terrible solutions," says **Alan Card**, PhD, MPH, CPH, CPHQ, president and CEO of Evidence-Based Health Solutions, a research and consulting firm based in Notre Dame, IN, that works in healthcare risk management and patient safety. "But they shouldn't be coming up with the solutions; rather, they should be facilitating the process, breaking it down into components, and doing the things that they do so very well."

Card, who did his doctorate with engineers to learn about patient safety through their eyes, says the structured approach they use to determine if a solution is valid is of particular interest. "What we used to do in healthcare when there was a patient safety problem was the blame and shame approach. A lot of tools and techniques we have used to move away from that — like failure mode analysis — are from engineering. But most of the people using them are not engineers. They leave off at risk assessment. They stop with tools that were not designed specifically for healthcare."

Card developed an active risk control kit for testing, which draws from those very risk management tools that engineers value so

much (the tool is available free at activeriskcontrol.com).

Card says that since healthcare is a system, and it has been designed, it follows it can be redesigned to be more safe. "We don't think of it like that, though. If we sit down to look at a problem, typically, no one has spent any protected time thinking about the processes and systems they work in. They don't see how what they are doing fits in with what others are doing and how the patients perceive it."

Engineers do. And while it's possible to have someone in quality trained to think that way, it's unlikely. Most quality staff are clinically trained. "They use the tools of the engineer, like root cause analysis, which has been used for 20 years, but we haven't budged the pandemic of harm in a decade and a half," Card says.

One reason, he says, is that the tools help us understand, but they don't help us understand the solutions that we create in response to the problems. If people aren't trained in the techniques that spawned the tools, we will keep coming back to "person-focused solutions, like signage, alerts, training, rather than system-focused ones."

Engineers would be great process facilitators to foster the kind of thinking that can move beyond the "short-sighted solutions that we have come up with so far," Card says.

While he understands the idea of getting an engineer into the department — and applauds organizations like Spartanburg for taking a leap of faith and embracing the benefits of embedding engineers in quality — he also thinks there is value to having an outsider's perspective. "If you bring an engineer in and say, 'Solve this,' you'll get rubbish. But if you ask one to help you think something through, you'll get some great help. They need to know how healthcare works. They don't need to know the clinical stuff, although that should be in the room. They need to understand how nurses and physicians work, how the departments fit together, and how they interact together. Beyond that, they don't need to be too much of an insider."

He sees all the quality department ads looking for nurses. And if it's a small quality department, of course, that's what you need to do your chart review. But if you are a large organization and have room for something else, you could do worse than hire an engineer, Card says. "We are missing a lot by focusing on only the domain-area expertise and not the process expertise."

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Stand-alone obs unit success

Pennsylvania system saves a million by making key changes

Observation status has been under the radar for a while, and with the two-midnight rule in full force, getting patients to the right place on a ward or discharged appropriately has taken on new urgency. Excela Health in Greensburg, PA, took observation wait times of as long as 30 hours and cut them by a third on average, saving the system a million dollars in the first year alone.

"We were losing money, spending more the longer they stayed," says **Eric Kreinbrook**, RN, MSN, currently the patient information manager, but then the clinical nurse coordinator for the observation unit. "We had 44% of our times in the unit greater than 23 hours, and 23% were greater than 36 at one of the hospitals." That hospital was Latrobe, the site of what would become a big and ultimately successful experiment.

The quality improvement team decided to tackle the problem by bringing together every single person who touched the patient to meet with nursing, administration, and the chief medical officer. The team included housekeeping, emergency department staff, radiology — anyone who ever came into contact with an observation patient attended meetings at one point or another, says Kreinbrook. Eventually, a core group of main stakeholders formed around the key issues, but people were brought in as needed to talk about issues as they arose.

"We figured out pretty quickly

that the biggest problem was that no one had ownership of observation status. Nurses paid attention to patients who were the sickest. So we created a stand-alone observation unit at Latrobe Hospital, where nurses were trained specifically for observations patients. Those patients were their patients," he says.

The unit is an open unit, meaning anyone in the hospital can admit to the observation unit, while many facilities have a closed unit, to which only ED physicians can admit.

The new unit was originally housed within the ED itself, but because both that department and the obs unit had a greater need of beds than the two units had in the single space, they opted to move out of the ED and house the obs unit elsewhere in the hospital.

It took two months to plan the observation unit opening, and it went pretty smoothly, although Kreinbrook says having an open unit is stressful: It can be hard to track down physicians. "If there is a 16-hour discharge goal, then for patients who are over 18 hours, we call the physician and ask for the discharge plan. But when there are so many physicians in the mix, it can be harder to get ahold of the right one."

At 18 hours, every patient has a time out. There is a tracking form for each patient clipboard, with the discharge goal, stress test results, and 18-hour proactive discharge steps. At the time out, if there is no discharge plan on the clipboard, the physician is contacted, and if the doctor is unavailable, that is escalated to the assistant or chief medical officer. "We also set it up with cardiology that they have an hour to call in results to us after stress tests."

For any testing, observation is third in line, after emergent and stat testing. A HIPAA-compliant white board that includes the patient room number, nurse, testing, patient initials and the discharge goal is visible to everyone. This helps keep everyone on track, Kreinbrook says. "We also have the physicians put the discharges in a planned state, stating that if the testing comes back negative, the patient will be discharged to follow up with his or her primary care physician. All of that is done up front."

There is dedicated case management, so that the patient is put in the right unit from the start. Patients are not put in the observation unit unless that's where they should be, nor are they admitted unless they should be. "We have a 13% conversion rate, which has been very consistent, and that's because our patients are in the right place from the start," he says.

The observation training of nurses was a key factor in the success, he says. "There is a difference we could see when people were off or we had nurses fill in from other units. They didn't explain to the patient what observation was for, that the goal is to get you home in less than a day. That mindset of not giving you everything that inpatients get because you are not an inpatient, that we want you to go to sleep, and then have a stress test first thing in the morning and then go home — they didn't get that."

Physicians who have patients over 23 hours in observation get letters from the chief medical officer asking them to explain why. They also have a letter put in their recredentialing file. If there was a full admission recommended and they put the patient in observation, they also have a letter put in their file. On the flip side, Kreinbrook says physicians are rewarded for doing a good job with praise and recognition.

The hospital isn't a good place to be, he says. "[Patients] are exposed to germs, they spend time in bed and lose strength. Being out of the hospital fast is healthier for them. We want to get them back to their life."

More of the patient base was younger than one might think — ruling out acute things — and Kreinbrook says helping give those patients quick peace of mind, rather than having them linger for hours wondering, is good in too many ways to count: patient health, provider morale, wasted resources saved, mom's not worrying. The list goes on.

"I think this is essential," he says of the observation unit changes they made. "If you come to that unit, you are on the clock. We even had different color chart packs for them. We were green. If you see the green chart in radiology, you knew, it was on the clock. This patient skipped the line. If you were housekeeping, you knew, if the bed was empty, you cleaned it."

There are weekly meetings on Fridays where every case over 23 hours was reviewed, then eventually, any case over 20 hours.

At the meetings, when the longer cases were discussed, the core team members tracked problems for trends, and if a particular department was an issue, that department was called, and problems were solved. "Minor failures are all okay. We ask how we can make something better. We reach for the greater goal."

For more information on this topic, contact Eric Kreinbrook, RN, BSN, Patient Information Manager, Excela Health, Greensburg, PA. ekreinbrook@ExcelaHealth.org. ■

ECRI lauds health system for untethering patients

Telemetry not always appropriate, experts say

Monitoring patients' hearts with telemetry seems innocuous enough. It's not invasive, and it's an extra pair of eyes keeping track of a key vital function. So what's the problem? Apparently, telemetry can be an outright danger to some patients, tangling them up in cords and changing their center of gravity. And it can set off false alarms at a time when alarm fatigue is something that The Joint Commission has warned about.

So when Christiana Care developed a protocol for taking just about everyone off except those people who really needed the monitoring, ECRI took notice and gave them an award for technology and patient safety.

Andrew Doorey, MD, FACC, a member of the safety committee at the Christiana Care Health System in Newark, DE, believed that cardiac telemetry was "seriously overused" despite some surprisingly strict guidelines. They state that for the most part, outside intensive care, no one should be on telemetry for more than 48 hours. "If you come in with a heart attack, they recommend 48 hours, so imagine what the recommendations are for pneumonia or something less serious," he says. "But the fact is that most people are on heart monitors for their entire stay, until discharge."

They had made several attempts to change procedure by revising policies, educating physicians, and getting nurses to automatically discontinue telemetry after a certain time frame. "They all failed," he says. "And this seems to have been the case universally across the country."

The guideline at the hospital was for a limit of 72 hours, then for an automatic discontinuation. But that didn't happen. Part of the reason was that no one wanted to be the physician whose patient wasn't being monitored when everyone else's was. Nurses didn't want to be the ones responsible for disconnecting patients. No one wanted to be responsible.

Then there was the day that the telemetry control center, off campus in a building across the street, lost communication with the hospital. Very quickly, the 377 patients being monitored had to be whittled down to a much smaller number because there weren't 377 portable machines to monitor those patients. "The nurses had to figure out who needed those portable monitors," he says. "It was after hours, there weren't any docs around, they didn't know who to put on the devices. It's a complex decision, and I think even 50 cardiologists would have been hard pressed to figure it out."

A few days later, this was presented to Doorey and his committee. "The chairman asked how can we figure out who needs the monitors. I said almost none of them." And thus Doorey was volunteered to run the project.

The device may be innocuous, but being on it can cause real harm. "We got the 2004 American Heart Association guidelines, which gives ranges of duration," he says. "We made up a list of mainly cardiac diagnoses. They were blank about surgery so we asked the surgeons. They wanted the patients off as soon as possible so they would be up and walking. Simple surgeries, 24 hours, complex 48. We wanted the physicians to have autonomy, so they could always order telemetry, but that was under 'other,' and it was for 24 hours."

Doorey sold the plan to the nurses, as well, worried that they would be averse. They hated telemetry. It wasn't the safety net he thought they'd see it as. It gets caught up in other leads, patients trip, fall, they can't get comfortable. Smaller women who hang the box around their neck can have their center of gravity altered enough to make them a fall risk. They can't give medications to a single patient without interruptions from central monitoring.

Indeed, a study they did for the project of every alarm and every nurse analyzed thousands of alarms and found 99% were loose leads, low battery levels, or patients wandering out of coverage range. "Garbage calls," Doorey says. "Only a tiny percentage were important. And when we added up the time, it was 117 hours per day that the nurses spent dealing with telemetry alarms."

Everyone was coached and counselled in grand rounds and section meetings. "The old system was no one's responsibility. No one ever wanted to stick their neck out or be the only one doing things differently," he says. Now, there is a checklist that the nurses fill out after 12 and 24 hours that is imported into the electronic health system. Telemetry is automatically discontinued at that time. The final question is, "Is there any reason you think this shouldn't be

disconnected?" Doorey says that's the "hair on the back of your neck" question — the thing that you can't explain but makes you sure a patient should still be on telemetry.

Most alarms that ring in a hospital are physiologic — like telemetry. By showing that they could reduce the average telemetry census by 70% without any change in code blue, mortality, rapid intervention team, or other data, simply by applying national guidelines, Doorey thinks he and his team have made a real dent in reducing alarm fatigue. There is also less money spent chasing false diagnoses — there are artifacts that look like arrhythmias, but are just an electrical anomaly. He knows of one man who even had a defibrillator implanted that he didn't need because of such an anomaly.

There may be other benefits, too.

There was one patient Doorey likes to recall, who was in the hospital for a week. The 87-year-old was on telemetry the entire time. When the family came to take her home, they took her off her heart monitor and the family balked. "If she needed to be on it all that time, she still needs it!" they cried. "The nurse told them she hadn't really needed it," Doorey says. It's the kind of explanation that makes people distrust medicine. And it's a good reason to revamp telemetry practices. ■

Hospitals can track, compare needlesticks

Surveillance also tracks other injuries

A hundred hospitals have joined a new system to track needlesticks and other healthcare injuries, the first such national surveillance since 2007.

The Occupational Health Safety Network (OHSN) enables hospitals to compare their needlestick rates with other, similar hospitals, using an online reporting system that is updated monthly. The system, launched a year ago by the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention, also tracks slips, trips and falls, patient handing injuries, and workplace violence.

Slips, trips and falls surpass the other injuries in both number and rate, making them the most common hazard for hospital employees. The OHSN reporting enables hospitals to see where the injuries are occurring and to compare their data with other hospitals nationally, regionally, and of a similar size.

For years, hospitals have faced mandates to report hospital-acquired infections and other patient safety measures. OHSN is voluntary but it represents the most significant tracking of employee health and safety to date.

It is important to have that counterbalance, emphasizing overall safety in hospitals, says **Ahmed Gomaa**, MD, ScD, MSPH, project officer for OHSN. "We believe you cannot achieve patient safety without worker safety," he says.

Previous needlestick tracking systems provided important information about what types of devices led to injuries and which tasks were most hazardous. But most of those systems have been discontinued.

California ceased its surveillance program in 2005, and the CDC's NaSH system (National Surveillance System for Healthcare Workers) ended in 2007. EPINet, a University of Virginia project that collected information from South Carolina and hospitals in some Eastern and Pacific Northwest states, ended in 2012. By state law, Massachusetts requires its hospitals to report sharps injuries each year.

CDC planned to include sharps injuries in its National Healthcare Safety Network (NHSN), but it has focused exclusively on patient safety.

OHSN hopes to fill that gap. The system will collect information on the device used, the task involved, where and when the injury occurred — similar to the previous tracking systems. The denominators will include fulltime employees, bed size, and monthly patient admissions. "There is a big need for a surveillance system [in sharps safety]," Gomaa says.

Users of OHSN can download comparison reports at any time and can submit data through existing occupational health software programs.

Reporting helps boost support for worker safety — both nationally and within hospitals, says **Bobbi Jo Hurst**, MBA, BSN, COHN-S, manager of employee and student health and safety at Lancaster (PA) General Health. Lancaster is a member of the Voluntary Protection Program (VPP), a safety recognition program of the U.S. Occupational Safety and Health Administration,

and was one of the first hospitals to report data to OHSN.

"All executives want to know how you're doing and what your benchmarking is," she says. "The more information that your leadership sees, the more support you gain."

Slips, trips and falls are hospitalwide

OHSN is constantly adding hospitals, so the database is growing.

The data come from hospitals of varying size: 48 small (<200 beds), 38 medium (200-499 beds) and 16 large (>500 beds).

They span the country, with 55 in the Midwest, 33 in the South, 6 in the Northeast and 5 in the West.

As of June 2014, the network reported the following preliminary data:

• Injuries from slips, trips and falls (3,401) outnumbered patient handling injuries (3,053). There were 1,577 incidents of workplace violence involving nurses and nursing assistants among the 100 hospitals.

• Slips, trips and falls also had the highest incidence rate as measured per 10,000 worker-months (0.52), per 100 licensed bed-months (0.18), and per 1,000 admissions (3.2).

• Many slips, trips and falls occur outside of patient care areas. Patient handling was the No. 1 injury in patient care areas.

• Patient handling injuries also were the most common OSHA-recordable event.

• Most injuries were among employees between 45 and 64 years of age (7,041), followed by 30- to 44-year-olds (6,069) and 18- to 29-year-olds (3,436). ■

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CNE QUESTIONS

1. **How many Medicaid patients between 45 and 64 return to the hospital for unplanned readmissions?**
   a. 5%
   b. 25%
   c. 30%
   d. 24%

2. **What do engineers bring to the table that quality departments usually lack?**
   a. knowledge of workflow
   b. Risk analysis tools
   c. Ability to learn lingo quickly
   d. Knowledge of medical systems

3. **What is NOT one of the six things that Middlesex hospital is considering in its calculations related to the CMS appeals offer?**
   a. Historic appeals success rate
   b. Outstanding co-pays
   c. Cash flow
   d. Interest rate of denied cases

4. **According to data from the Occupational Health Safety Network, as of June 2014, what was the most common cause of injury in hospital employees?**
   A. Needlesticks
   B. Slips, trips and falls
   C. Patient handling
   D. Workplace violence

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Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Hospital Peer Review	0 1 4 9 _ 2 6 3 2	10/1/14
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta
Fulton County, GA 30326-1180

Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
AHC Media LLC, David Fournier, President and CEO
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

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AHC Media LLC	950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

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PS Form **3526,** October 1999 *(See Instructions on Reverse)*

13. Publication Title: Hospital Peer Review			14. Issue Date for Circulation Data Below: September 2014	
15.		Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a.		Total Number of Copies *(Net press run)*	152	126
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	119	104
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	12	6
c.		Total Paid and/or Requested Circulation *[Sum of 15b. (1), (2),(3),and (4)]*	131	110
d. Free Distribution by Mail *(Samples, complimentary, and other free)*	(1)	Outside-County as Stated on Form 3541	6	5
	(2)	In-County as Stated on Form 3541	0	0
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e.		Free Distribution Outside the Mail *(Carriers or other means)*	7	5
f.		Total Free Distribution *(Sum of 15d. and 15e.)*	13	10
g.		Total Distribution *(Sum of 15c. and 15f)*	144	120
h.		Copies not Distributed	8	6
i.		Total *(Sum of 15g. and h.)*	152	126
j.		Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*	91%	92%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2014 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: *David R. Fournier* Publisher & CEO — Date: 09/10/2014

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