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Lessons learned: What to expect from Shared Visions — New Pathways

New process is 'like night and day' compared with previous surveys

Expect a lot of interaction with unit staff — but no control over where surveyors go or who they talk to. That's what quality managers who participated in the pilot surveys for the Joint Commission on Accreditation of Healthcare Organizations' Shared Visions — New Pathways process are saying. "We have actually experienced it. So now we know what it feels like, looks like, and walks like," says **Helena Feather**, vice president of compliance and health information at Trident Health System in Charleston, SC.

A total of 24 organizations participated in the pilot test surveys, which were conducted from June to November 2003. "I have been involved in surveys for approximately 30 years, and this was like night and day. It is very, very interactive," she reports.

Overall, the new survey process is more customized, so the questions surveyors ask will differ depending on the facility, says **Debra Anthony Larson**, director of quality management at Mercy Hospital Grayling (MI), a 90-bed facility which was pilot surveyed in June 2003. "However, everything they surveyed had a patient safety focus, including medical record reviews, conversations with physicians and staff, and the leadership interview."

The new process scored points with unit staff, who felt that it was more patient-focused, Feather says.

Since surveys are customized, you can't do as much gearing up as you used to, says Larson, who treated the pilot as an unannounced survey. "I don't anticipate as much preparation as what I did previously. If you continue to focus on quality and patient safety on a daily basis, you really don't need to do a lot over and above. The staff did great. They did not feel intimidated and could readily answer the questions because it's what they do every day."

To prepare for your upcoming Joint Commission survey, consider the following lessons learned from the pilot survey process:

- **Don't be surprised if outlier patients are traced.**

Each surveyor did three or four traces per day, but to Larson's surprise, they often selected patients with an extended length of stay. "That was one

aspect of the survey that we didn't expect. For most organizations, patients with increased utilization of services tend to be your outliers. At the time, it felt as though they weren't looking at the patients that we routinely take care of," she says.

However, Larson acknowledges that outliers often are low-volume, high-risk patients, so selecting these patients to trace is consistent with the emphasis on patient safety. "That was something we learned from the pilot. Your top DRGs may be acute myocardial infarction and pneumonia, but those are not necessarily the patients they are going to trace."

In addition, the outliers were more amenable to being traced because they had multiple utilizations, so surveyors were able to assess processes in many units and across the continuum, she notes.

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Editorial Questions

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- **There is much less emphasis on document review**.

In past surveys, document review was always very time-consuming, and that burden has lessened considerably, Larson adds. "However, surveyors can always ask to review a specific policy, so you always need to remain up to date."

The traditional document review on the first morning of the first day has been eliminated, she says. "Prior to their visit, they did indicate to us specific policies they wanted to review, but they spent very little time reviewing policies throughout the survey. They would ask a question, and if we were able to give information and demonstrate compliance, they didn't delve further into policies and procedures."

The surveyors were looking for clear, concurrent documentation in patient records, Feather explains. "Everything needs to be on the chart by all the caregivers, so anyone can pick that record up and know what to do with that patient. They are only going to look at your retrospective, closed records if there is an issue, such as a chart missing a history and physical."

Surveyors wanted to see how staff went back and forth between paper and electronic records, and legibility was a significant issue, she says. "While tracing, if the surveyors picked up a medical record and were unable to read the order, the surveyor would hand it to a member of our staff. If the staff could read it, that was fine. If not, it was noted."

- **Surveys will zero in on your priority-focused areas.**

Surveyors identified communication, patient safety, and physical environment as priority-focused areas for Mercy Hospital Grayling. "This information was based on data gathered from our past surveys, our self-assessment, and our core measures," Larson points out.

She says that certain clinical groups identified were confusing at first, such as neurosurgery. "We are a small rural community hospital and don't provide that service here." However, surveyors explained that procedures such as ear, nose, and throat surgery fell under the DRG of neurology. "Once the surveyors explained to us how service groupings were selected, then it made sense," she adds.

During the opening conference, surveyors presented a one-page report identifying the clinical service areas of trauma, cardiology, general medicine, and general surgery as priorities, Feather says.

"The surveyors asked us if we would agree that those were our priority-focused areas. We know that those are priorities for us, so we acknowledged they were correct," she says.

The survey team will come in knowing what clinical service areas they are going to look at, adds Feather. "Priority-focused areas appear to be selected from areas you identify as not totally compliant, as they evaluate your periodic performance review [PPR]."

Likewise, Feather says, the patients selected for tracing involved areas that were identified as partially or not compliant in the PPR.

"They didn't tell us how they were selecting the patients, but it is clear that they were identifying themes from our PPR," she explains. "They selected more than one trauma patient and several cardiovascular patients, and that was the majority of what they looked at."

Helpful tool for prioritizing improvements

According to Larson, the PPR allows you to determine in advance if you are compliant, not compliant, or partially compliant. "The PPR was an extremely helpful tool to assist us in prioritizing improvements," she says, adding that the feedback received from surveyors also was useful. "In some cases, we found that we had evaluated our compliance harsher than the actual intent of that element of performance."

Similarly, Feather says her organization was "very hard on ourselves" when completing the PPR. "There were some areas that the Joint Commission thought we were compliant in, when we said we were only partially compliant," she notes.

- **Surveyors will visit some units more than once.**

Overall, surveyors selected about 15 patients to trace during the five-day survey, Feather says. "They went to every unit at least once and sometimes three or four times. They spent 1½ hours on one of the units."

Some units were visited multiple times by more than one surveyor, she adds. "A surveyor may go to the same department two or three times on one medical record, and then another surveyor may also go to that same department with the same or another tracer."

On one occasion, Feather was entering the special testing area with one surveyor and passed another surveyor who was leaving.

"The surveyors were looking at different medical records, and it just happened to be the same department," she says.

In addition, patient tracer rounds may bring surveyors to departments that normally aren't visited during surveys, such as the laboratory, which is accredited by the College of American Pathologists, Feather adds.

"Surveyors were tracing a patient who received several blood transfusions, so they stopped by the lab to talk to staff about their process of obtaining informed consent for blood and how the blood was transported to the OR," she recalls.

- **Staff may be confused about the lack of a survey score.**

Surprisingly, the absence of a survey score didn't sit well with staff, Feather says. "As I presented results back to our departments, it was hard for everybody to understand that we had no score, and we don't get anything we can brag about or share with staff.

"That will need to be explained more than once, that this is a continuous ongoing process in preparation for the unannounced surveys," she continues.

However, Larson says that not having a score may remove some of the pressure, especially since survey results will be published. "I think that knowing we don't have scores will diminish the anxiety associated with getting a bad score," she says.

- **Information gleaned from patient tracers will determine system tracers**.

The information surveyors discover during the patient tracer rounds will determine which system tracers will be conducted. At Larson's facility, these were medication management, infection control, and use of data.

"When we developed our agenda with Joint Commission, they identified a day and time that the surveyor would do the system tracers," says Larson. "However, we did not know specifically what system tracer would be conducted and only had a brief period of time to bring staff together for the interview."

The lack of advance notice made it difficult to have staff involved in the various aspects of care available to interact with surveyors, she notes.

- **Staff spent far more time with surveyors than in the past**.

Since surveyors always returned to units where the patient tracer originated, the staff at those units wound up spending a significant amount of time with the surveyor, Larson says. "That did take time away from patient care, so

this aspect was difficult and time-consuming for staff," she says. "However, staff did like having the opportunity to truly show off the care they provide."

The surveyors didn't expect staff to remember the particular patient they were tracing. Instead, they asked about the processes involved in caring for this *type* of patient, Larson says.

"Questions are directed at various standards and elements of performance, while always looking for environment of care, infection control, and patient safety issues," she says.

Surveyors mostly spoke with individual staff members one-on-one, except when they returned to the originating unit for a second time, Larson explains. "At that point, they had more of a multidisciplinary conversation when possible, and engaged the pharmacist, dietitian, social worker, nurse, and physician."

Staff had mixed reactions to the amount of feedback they received from the surveyors, says Feather. "Some told us that they didn't get the consultation they thought they would get from surveyors, while others said that specific surveyors did sit down with them and talk about their involvement with patient care."

According to Larson, surveyors frequently made recommendations and gave examples of how to meet the elements of performance.

"I have found they have been in an educative mode for some years now, and that was very evident during the pilot," she says.

But one thing everyone agreed on was that surveyors talked to more unit staff than ever. "I think everybody was surprised at just how much interaction there was, and how many people interacted with the surveyors in each area that they visited," Feather stresses.

"Before, surveyors weren't out and about, and staff already knew who was being hand-picked to talk to them," she says. "It's not that way anymore. The surveyors do the hand-picking."

[For more about the pilot surveys, contact:

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Cope with lack of control during new survey process

Surveyors don't want an entourage

Perhaps the hardest thing to get used to about the Joint Commission on Accreditation of Healthcare Organizations' new survey process is the lack of any set agenda, says **Helena Feather**, vice president of compliance and health information at Trident Health System in Charleston, SC. "Before, you knew that certain surveyors were assigned to specific interviews, and you knew exactly what date and time they would occur. This is very different. You do not know which surveyors will be going through what tracers."

Surveyors were continually "out and about" during the facility's five-day pilot survey, talking to staff about their role in improving patient care. "It is no longer the administrator's survey, nor the director's," says Feather. In fact, she says that at the opening session, the surveyors made a point of saying, "Now, when we go out on the floors, or the units, or departments, we're not going to see a whole crowd standing there waiting for us, are we?"

In addition to not having handlers, the survey team wasn't interested in seeing storyboards, Feather says. "For previous surveys, I had minutes, functional team books, notebooks, and all kinds of data available in the boardroom. This time, I had none of that," she says. "They wanted to know about the care provided to the patient, not wade through a storyboard presentation."

For the first few days of the pilot survey, the new process was trying for both the facility and the surveyors, Feather points out. "It was very confusing to start with, because it was so unlike any way they've ever surveyed before," she says. "We needed to see it in action for a while, and it took until Day 3 until it all jelled. After that, the process was very good. It's just a matter of getting used to something brand-new."

If you feel confused during the survey about what is being requested, you should ask for an explanation, Feather advises. "I wouldn't have a problem saying, 'The standards read this way. Please help me understand how what you are asking relates to the standard,'" she says.

Feather advises you to pay very close attention during your first survey day so you can grasp the process quickly. In addition, she recommends

talking to quality managers who have been through a pilot survey or early 2004 survey to determine the dynamics of the survey team and individual surveyors. "Learn as much as possible in advance about how they are going to survey, so you are ready for them to walk in the door."

In the end, you must allow the survey team to take the lead, Feather adds. "The surveyors will be the decision makers in terms of tracing patients, records, and processes through facilities. Sometimes they would just take off and lose you, which was a little bit unsettling. You don't have a lot of control."

Since you won't have any advance warning about where surveyors are headed, it will be a challenge to make sure key staff members and physicians are present, says **Debra Anthony Larson**, director of quality management at Mercy Hospital Grayling (MI).

"In the past, you knew the surveyors would be going to a certain unit at a certain time, so you could get all your staff together," she explains. "You don't have that opportunity now."

That means physician participation will be more difficult, she says, especially for physicians with office practices, since they won't know if one of their patients will be selected to be traced, or if so, which day it will occur.

"But even with it being hit or miss, the surveyors were able to interact with our physicians," Larson notes. "However, unlike in the past, it's more one-on-one instead of a group discussion."

Another difficulty arose since, as a small hospital, Mercy Hospital Grayling has only one social worker and spiritual care provider to interact with multiple surveyors, Larson says.

It is no longer possible to coordinate interviews so they aren't happening simultaneously, she explains. "If they happen to be ready to do a multidisciplinary conference, staff can't be in two places at one time," she says.

Despite the lack of control over scheduling, Feather points out that the patient tracers do give surveyors a better picture of your compliance, and the process is good preparation for the upcoming unannounced surveys, which will occur in 2006.

"So what if you don't have an agenda? You won't have one when they come in unannounced either," she says. ■

What JCAHO's new IC standards mean for you

The buck will stop at the administrator's desk

The Joint Commission on Accreditation of Healthcare Organizations has issued new infection control standards for 2005, emphasizing at a conference in Chicago that hospital executives — not quality managers or infection control practitioners — are going to have to take ultimate responsibility for enacting them.

"There are some people who, quickly scanning the revised standards, have concluded that they are really nothing more than old wine in new bottles," said **Dennis O'Leary**, MD, president of the Joint Commission. "However, if you are an accredited organization, that would be a really grave miscalculation. These standards bell the cat. They put leaders of health care organizations on notice and on point. If things go south for any reason . . . [there is] no opportunity or permission to defuse the responsibility."

In addition to the 2005 standards, some 400 attendees at the Joint Commission's infection control conference discussed a 2004 JCAHO patient safety goal of reducing nosocomial infections. The actions culminate the Joint Commission's aggressive new interest in infection control, which now has become a strategic cornerstone in its overall mission to improve patient safety.

"This may seem to some of you a little bit pushy on the part of the Joint Commission," O'Leary said. "But the infectious problems that we are likely to face, even in the near-term future, are really frightening. Human lives are actually at stake."

The 2005 standards reflect the input of an infection control expert panel that was formed last year. The standards focus on the development and implementation of plans to prevent and control infections, with organizations expected to:

- incorporate an infection control program as a major component of safety and performance improvement programs;
- perform an ongoing assessment to identify their risks for the acquisition and transmission of infectious agents;
- effectively use an epidemiological approach, which includes conducting surveillance, collecting data, and interpreting the data;
- effectively implement infection prevention and control processes;

- educate and collaborate with leaders across the organization to effectively participate in the design and implementation of the infection control program.

Anticipating a question that was to come up throughout the two-day meeting, O'Leary said at the opening session that hospitals must provide the resources to enact the standards.

"We even add a separate standard on assuring the adequate allocation of resources to support infection control," he emphasized. "We will be surveying that closely. Leaders are also responsible for ensuring adequate training. In the resource-tight times that we live in, education and training are the first to go. We will be looking carefully to ensure those are in place and deployed properly."

Perhaps the most important aspect of the 2005 guidelines is the requirement to conduct a risk assessment at least annually to determine the most important infection control focus areas.

"You need to know what your risks are," said **Robert Wise**, MD, JCAHO vice president for standards. "Shape a living program that adjusts and adapts over time. The identified risks actually drive the rest of the program. If you identify the wrong target, everything else is going to be wrong in your organization. That's why we ask for a formal analysis of this at least annually."

Surveillance remains a cornerstone principle, but the 2005 standards add a critical element of intervention, he added. "[We] expect that when issues arise — whether sentinel events or other findings — that something is going to happen," he said. "When our surveyors come on site they are going to be looking for data, action plans, and quantifiable results."

The most controversial new element comes not in the 2005 standards but in the JCAHO's two-part 2004 patient safety goal to reduce the risk of health care-acquired infections. The first aspect of that is to comply with the new hand hygiene guidelines by the Centers for Disease Control and Prevention

(Continued on page 11)

2005 JCAHO standards feature analysis, action

Some of the key aspects of the Joint Commission On Accreditation of Healthcare Organizations 2005 infection control standards are summarized here:

IC.1.10 – Risk of Health Care-Associated Infections are Minimized Through an Organizationwide Program
- All applicable components are integrated.
- Everyone in organization is knowledgeable.
- Infections are reported.
- Outbreaks are investigated.
- Written plan exists that includes:
  — goals of program;
  — prioritize risks;
  — strategies to handle risks;
  — evaluation of success.

IC.2.10 – Identify Risks of Acquisition and Transmission on an Ongoing Basis
- Risks are identified proactively and retrospectively.
- Formal review of analysis is held at least annually.
- Surveillance activities are targeted.

IC.3.10 — Based on Risk, Priorities and Goals are Set to Prevent Infections
- Priorities and goals are established.
- Hand hygiene is enhanced.
- Risk of transmission with procedures, equipment, and devices is minimized.

IC.4.10 — Strategies Implemented to Achieve Goals
- Relevant guidelines are incorporated.
- Risks associated with procedures, medical equipment, and devices are reduced.
- Applicable precautions are used.
- Screening and intervention of people in facility is practiced.

IC.5.10 — Evaluation of Effectiveness of Intervention and Redesign
- Program's goals are evaluated and revised.
- Emerging problems in health care community are addressed.
- Relevant guidelines are evaluated.

IC.7.10 — Program Managed Effectively
- Responsibility to manage program is assigned.
- Qualification is determined by program's needs.
- Individual(s) coordinate all parts of program.
- Individual(s) facilitate monitoring of effectiveness.

IC.8.10 — Representatives from Components Collaborate to Direct Implementation
- Leaders collaborate with IC program managers.
- They assess adequacy of resources.
- They assess outcomes of goals.
- They revise program to improve outcomes.

IC.9.10 Leaders Allocate Adequate Resources
- report of effectiveness to Patient Safety Program;
- sufficient staff (numbers, competence, skill mix);
- adequate information systems;
- adequate laboratory support;
- adequate equipment and supply. ■

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Do you offer a choice on home care services?

It's the law, but no one's looking yet

Discharge planners at some facilities apparently are either unaware of — or are ignoring — a federal requirement that hospitals offer patients a choice of home care providers and that they tell patients when there is a financial interest between the hospital and an agency to which the patient is being referred.

Despite clear provisions to that effect under the Balanced Budget Act (BBA) of 1997, several sources tell *Discharge Planning Advisor* that they are aware of hospitals that routinely refer patients to an affiliated home health agency for care, without either mentioning the other providers that are available or disclosing the connection between agency and hospital.

At the other end of the spectrum are hospitals that have a clear, proactive policy in place for ensuring that patients are aware of their home care options.

The good news for noncompliant hospitals is that repercussions aren't likely to be felt until at least sometime next year, which looks to be the soonest that any type of monitoring process could be in place.

"We had so many provisions [of BBA] to implement that it's taken a long time catching up with all of them," a spokesman from the Centers for Medicare & Medicaid Services (CMS) tells *DPA.* No further action has been taken following the publication of a proposed rule in the Nov. 22, 2002, *Federal Register*, he says. The comment period ended Jan. 21, 2003.

"A draft version of the final regulation is in the clearance process here," the spokesman adds, but he says the rule then will have to be cleared by the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB). It's not uncommon for just the OMB piece of the process to take 90 days, he explains.

The interest and concerns expressed by the home care industry in CMS's "Open Door Forums" provided the impetus for the rule-making process, the spokesman adds.

Once the rule is in place, he said, hospitals will be required to begin submitting data on their post-acute care referrals and will be monitored on their actions.

That day can't come soon enough for **Ann Bender**, MHA, RNC, CMC, owner, president, and CEO of Private Care Resources Inc. in Duncansville, PA. "[Discharge planners] need to realize there is a requirement there to offer options to the patient," she says.

Bender, whose company provides home care services, says she experienced the situation first-hand when her mother was hospitalized in 2002.

First, Bender says, she had to cancel arrangements that had been made to have home health care provided by the hospital-affiliated agency. Then, when she arrived to pick up her mother, she learned the equipment needed had been ordered from the durable medical equipment (DME) company connected with the hospital.

"I said, 'Who made the choice?' and the nurse said, 'We thought it would be convenient.'"

When the nurse didn't seem to understand the reason for her concern, Bender says, she decided to handle the matter after getting her mother

home. "I called the DME company and said, 'Come get your stuff,' and then I called the company I wanted."

Section 4321 of the BBA, *Nondiscrimination in Post-Hospital Referral to Home Health Agencies and Other Entities,* paragraph (a), *Notification of Availability of Home Health Agencies and Other Entities as Part of Discharge Planning Process,* has four requirements:

1. Hospital staff must provide patients referred for home health with a list of agencies available in the area where patients reside (Pub. No.105-33, Sec. 4321, 111 Stat. 394, 1997).
2. Agencies must formally request each hospital to list them as available for service delivery.
3. Hospitals may not specify or otherwise limit qualified agency providers.
4. Hospitals must tell a patient when there is a financial interest between the hospital and agency if the patient is referred to that agency.

In the case of the hospital she dealt with, says Bender, "I'm sure [the nurses handling the discharge] are not aware [of the federal requirement]. Their directive is, 'You refer to our own.'"

Patients leaving the hospital, meanwhile, often are not in the best frame of mind to take a proactive approach in arranging their care, she says, and may say something like, "Who do you think I should use? Just set it up."

In contrast to the hospital Bender describes, discharge planners at Mt. Ascutney Hospital and Health Center in Windsor, VT — and throughout that state — with the best intentions of following the BBA directive find themselves facing an unusual challenge.

The state of Vermont requires all home care services to be offered through local Visiting Nurse Agencies (VNA), with the aim of providing quality care to all levels of need, regardless of insurance status, explains **Cheryl Briere**, RN, CCM, director of case management at Mt. Ascutney. As a result, there is no choice for patients who require home care services.

"Every state may have different regulations" concerning home care, she points out.

Neighboring New Hampshire, where Briere worked for most of the past 10 years, "is totally different," she adds. "It allows for-profit nurse staffing agencies to compete with the VNA, giving patients several choices for home care services."

The particular difficulty Vermont discharge planners face, Briere says, stems from two things: "The patients being discharged are more complex than ever before, and due to staffing shortages, the VNA often is unable to offer as much care as might be requested."

As part of a quality improvement process, she adds, Mt. Ascutney case managers have been making follow-up telephone calls to patients within a few days of discharge to determine if home care services have been initiated.

"We have cases in which the patient does not receive services within the appropriate time," Briere notes. "If we order physical therapy three times a week, we get it two times a week."

Her department is wrapping up six months of data collection, she says, and will sit down with VNA representatives to identify problem areas and possible solutions.

Further complicating care delivery, she says, is the rural nature of the state. "It often takes two hours to get to somebody's house.

"If care is not available, and if there is no choice," Briere adds, "how do you advocate for the patient for the appropriate level of care?"

As for other post-acute services — such as intravenous infusion and chemotherapy or total parental nutrition — Mt. Ascutney case managers are able to offer some choice to patients, she says, although nursing services associated with these therapies still must be delivered by the local VNA.

"We say, 'Here are your choices,'" she notes, "and if the patient doesn't have a preference, we can offer suggestions, can say, 'We had great success with this company,' because there are those that provide better service for a particular item and still meet the criteria for patient choice."

To ensure its compliance with the BBA regulation, Briere says, Mt. Ascutney already has implemented a policy and procedure for post-acute care referrals. Patients are given a list of available vendors from which to select and are asked to sign a document saying they've been given that choice, she adds.

A small, rural "critical access" hospital with a rehabilitation unit as well as acute care beds, Mt. Ascutney finds itself on the other side of the referral equation, Briere points out, when an area hospital refers patients to its rehab unit.

"As a critical access hospital, we're allowed to have a total of 25 beds and no more than 15 acute care beds, so we can bring in rehab patients to fill in the difference," she explains. Because of the hospital's space constraints, Briere says, sometimes there is a backlog of referrals.

That puts her in the position of reminding the referring hospital's staff of the need to offer

patients other rehab choices or, if appropriate, home care, she notes.

At OSF Saint Anthony Medical Center in Rockford, IL, discharge planners offer the full range of post-acute care options to patients, explains **Joyce Nicklas,** RN, MBA, director of quality/care management.

"When staff go in to interview patients [regarding post-discharge care], we just give them the names of all we're aware of," she says. "We let them know there's a choice, and ask them if there is an area — like a mileage range — that would be their first choice. Then we give them the list of agencies that are in that radius."

The home care agencies are in alphabetical order, Nicklas notes, which means the hospital-affiliated agency, the name of which begins with "OSF," is far down the list. "We tell them up front it is affiliated with the hospital but that they have no obligation to use it."

To keep the process objective, Nicklas says, patients are asked what they are looking for in a home care provider, and are encouraged to check agency web sites and rankings given by the *Chicago Sun-Times* and other entities. "We also tell them to talk to their physician, so we're not imposing [our views]," she adds.

The process is so evenhanded, Nicklas says, that the affiliated agency — far from having the majority of hospital referrals — gives the feedback that it isn't receiving very many patients from that source. When hospitals fail to abide by the BBA rules, she suggests, it may have to do with the discipline that is handling the process, as well as with a lack of training.

Social workers — who coordinate referrals at Saint Anthony's — tend to be more in tune with such directives than are nurses, Nicklas notes.

"At some hospitals, what they call case management — and the training that goes into it — is so varied," she points out. "A general staff nurse or someone who has not worked on the case management side of things may not be aware that [the BBA directive] is out there." ■

Hospitals seeking SNF beds think creatively

As hospital discharge planners and case managers struggle to place patients with complex care needs in skilled nursing facility (SNF) beds amidst the challenges of the prospective payment system (PPS), many are keeping their heads above water with a mix of timely planning, community collaboration, and creative thinking.

That's the combination recommended by **Pat Orchard**, CCM, CHE, RN, MSHA, MEd, market development executive for a Philadelphia-based consulting company called Care Science. "When hospitals call, I tend to be the person who does the assessment of what's going on in terms of discharge planning and case management."

As a former nursing home administrator, she sees both sides of the problem: Hospitals must find places for increasing numbers of stable but medically complex patients. Nursing homes can't afford to keep their doors open if their patient mix is too heavily weighted toward these high-cost patients.

A big part of the dilemma is that nursing homes can say no, Orchard notes. "They can say, 'Sorry, I can't take that patient.' It's not like a hospital, where they have to take them."

New pharmaceuticals and advanced technology are adding to the logjam created by the PPS, Orchard points out. "There are expensive drugs the nursing homes can't possibly maintain with their reimbursement and equipment needs that are more expensive than they used to be."

If care requires an advanced bed system — for a burn victim, for a frail, elderly person, or for an obese patient — "most nursing homes don't keep those, and they have to be bought or rented," she says. "You can [afford to] put those in an acute setting; but in a nursing home setting, it may be cost-prohibitive."

Community collaboration is crucial in such instances, Orchard notes, and often includes a healthy measure of negotiation and relationship-building. Ideally, she says, nursing homes will agree to take higher-cost patients if they get a fair share of the less complex variety.

Sometimes, she adds, hospitals — and payers — find ways to make it easier for the nursing home to cover the cost of a complex patient. "There are patients who need IV antibiotics long term, and they are expensive. Many payers offer to work with the nursing home to continue to provide those through additional reimbursement above the daily rate."

In the Medicare realm, "the leeway is limited. It frequently depends on what the antibiotic is, but a physician who is more in tune [with financial concerns] may transition more quickly to another [less expensive] kind of antibiotic," notes Orchard.

In some cases, she adds, hospitals may send the necessary equipment to the nursing home along with the patient. Those kinds of solutions require that a discharge plan be created as early as possible, Orchard emphasizes.

"The sooner the plan is put together and you can discuss it, the quicker you can start resolving some of the issues," she says. "You may want to do some joint responsibilities. The providing facility may work with the sending facility to cover some of the expenses.

"For example," she adds, "the hospital may rent some equipment and keep sending it over [to the SNF] until the patient doesn't need it anymore." Or, Orchard says, as mentioned above, the hospital can collaborate with the physician and the nursing facility on covering the cost of antibiotics and other expensive medications.

"Many of the commercial payers work with the nursing home and providers to add more dollars," she says. A win-win situation can be created, notes Orchard, because the patient's benefits are not used up as quickly.

"The physician makes sure the patient gets the services needed while moving the patient to a lower level of care, which is beneficial for everybody, she says. "There is some flexibility, but it needs to be well-planned out and orchestrated with all parties. You can't do it on the day the patient is discharged."

That's the kind of cooperative approach taken at OSF Saint Anthony Medical Center in Rockford, IL, explains **Joyce Nicklas**, RN, MBA, director of quality/care management. She notes the problem in finding enough SNF beds is not the number of beds but the payer mix required by the nursing facility. "They're looking at how many more Medicare and Medicaid patients they can take. There might be beds out there, but because of their financial situation, they're not able to take all comers. So they stratify to get some kind of balance."

To facilitate patient placement, Nicklas says, she meets every other month with SNF administrators, as well as with representatives from hospices and other nursing homes. "We're just trying to work on some kind of collaboration," she adds, "[letting them know] we're not trying to get rid of patients, or you're being dumped on, but that there are a lot of common performance indicators, and how do we manage those collectively?"

To ensure care consistency, for example, the hospital and nursing home share forms containing information on patient treatment, Nicklas says. "If the patient is on a skin protocol [at the SNF], we bring that here with us. If they're doing a good job, we want to be able to keep that up. Then, we give [SNF personnel] a contact person here, so they understand what we teach our patients at discharge," she adds. "If the patient starts to deteriorate [back at the SNF], they have someone to call, to do some troubleshooting, so the patient is not sent directly back to the hospital."

Thanks to case management initiatives in the emergency department (ED), Nicklas says, SNF patients who are brought to the ED because their blood pressure dropped or their condition began to deteriorate — and in the past would have been admitted to the hospital — often can be treated and sent right back to the nursing facility.

"They might just need an IV dose of antibiotics and to get started on therapies," she notes. "Some are identified as needing palliative care, and there's nothing we can do for them here. We have Social Services go down and talk to the family, and they are sent back." ■

(Continued from page 6)

(CDC), explained **Richard Croteau**, MD, JCAHO executive director of strategic initiatives.

The Joint Commission will be looking for health care facilities to adopt all Category I (supported by the most clinical evidence) recommendations in the CDC hand hygiene guidelines, he said.

"As for the Category II recommendations, we will encourage those, but we won't be surveying and scoring those," he said. "What does that mean in a practical sense? Direct caregivers of high-risk patients can't wear artificial fingernails. That's Category I. They should trim their nails to less than a quarter inch, but that's Category II [and won't be enforced]."

Managers should consult their local fire marshals and safety regulations regarding the ongoing flap over the use and location of the alcohol-based hand rubs, he added. Noting that hand hygiene compliance usually is no better than 50% in any given study, some conference participants questioned whether the Joint Commission will be looking to spot and punish individual breaches. "We will be looking for patterns," Croteau said, noting that a behavioral change is required that will not occur quickly. It is similar to the Joint Commission's ongoing effort to reduce medication errors by getting clinicians to stop using medical abbreviations they were taught years ago, he noted.

"What we are looking for is improvement," he said. "Now we are going to be aggressive about [hand hygiene]. Don't get me wrong. This is serious, and it's gone on too long."

The second and more controversial part of the infection control 2004 patient safety goal is the Joint Commission's request to manage as sentinel events all unanticipated patient deaths or permanent loss of function associated with a health care-acquired infection.

"Joint Commission's position that deaths and disabilities associated with health care-acquired infections are sentinel events — that they require analysis and intervention into cases — has not gone down well with many health care organizations and practitioners," O'Leary told conference attendees. "They argue that the required root-cause analyses are a labor-intensive exercise in futility for a problem that was inherent in the delivery of care. The Joint Commission respectfully disagrees."

Still, when an audience member noted the difficulty in determining whether a patient's loss of function was "permanent," Croteau said there is no expectation of long-term follow-up.

"At the time of discharge, can you reasonably project a permanent serious injury?" he said. "That is your last, best opportunity to make that observation. We don't want to get into quibbling about whether something is permanent or not. If we could just strengthen the percentage of reports of these unanticipated deaths, we would have more than enough information that we can learn a lot from."

Ultimately, by learning more about infections and their prevention, the Joint Commission hopes to achieve an ambitious change to an overall culture of safety. Drawing comparisons with aerospace and nuclear agencies, Wise said the goal is a nonpunitive environment driven not so much by standards but by common expectations and a kind of peer pressure to do the right thing. In health care, that could mean some day, when nurses remind physicians to wash their hands, they will kindly thank them for drawing it to their attention, he offered by way of example. Unfortunately, the audience burst into laughter at the thought of that happening in health care reality.

"Believe it or not, that's what we're talking about — the type of environment where everybody has the same goals," Wise persisted. "This is a problem that is not going away. In fact, it may get worse. The commitment cannot be just for this year or as a problem of the month."

Indeed, the Joint Commission shows every sign of having locked onto infection control for the foreseeable future.

"The revised standards are officially effective Jan. 1, 2005," O'Leary warned. " I hope no one feels they can relax until that time. Infection control has been an element and focus of our 2003 random unannounced surveys. And we will be looking very close at infection control in our random unannounced infection control surveys next year as well." ■

What to do if physicians dispute your data

How to present data effectively

It's a frequent tactic of physicians: claiming that quality data are imperfect, invalid, or otherwise misleading. "When physicians are not acting on proven data, the quality manager has to stand up to the physicians and protect the integrity of the

data," says **Frederick P. Meyerhoefer**, MD, principal of the Canton, OH-based Meyerhoefer Organization, a consulting firm that specializes in compliance with Joint Commission on Accreditation of Healthcare Organizations standards.

"Physicians forget that they make decisions daily about their patients with clinical data that are frequently imperfect," he adds.

If you're not able to analyze and present data effectively, physicians continually will challenge its validity, Meyerhoefer warns. "This will bog down the system with nitpicking rather than performing the needed analysis for patterns and trends and opportunities to improve," he says.

Here are effective tactics to use when physicians challenge your data:

- **Give key physicians a heads-up before meetings**.

It's a good idea to brief committee chairs in advance about data you'll be presenting at a meeting, Meyerhoefer advises. "It is also usually a good tactic to identify influential physicians and make them aware of the data and their import."

This way, physicians are aware of the implications of the data and you'll avoid blindsiding them, he explains, adding that you also should consider briefing naysayer physicians in advance to head off potential obstacles, he suggests.

- **Convince physicians to act on good data**.

Physicians may be reluctant to take action even when the data are beyond reproach, Meyerhoefer says. In this case, you'll want to avoid a full-blown confrontation, but you must urge physicians to act on the data, he advises.

For example, if data reveal that certain physicians are failing to discharge myocardial infarction patients on beta-blockers, intervention by the department chair and specific monitoring of the physicians might be called for. Or you might need to push physicians to implement a corrective action for the use of unapproved abbreviations and illegible handwriting monitoring.

If there is a physician with data with significant deviation from his or her peers, the presentation of that fact frequently is the only incentive needed to change behavior, Meyerhoefer notes. "No physician wants to be the sore thumb," he says.

You'll need to instruct physicians on moving to the next "drill down," even when data indicate that a goal has been reached, Meyerhoefer says. For example, if a goal for 90% compliance has been reached, physicians need to look intensively at the noncompliant 10% of the data to identify correctable factors. "The quality manager must be the goad to move ahead for further quality improvement in patient care and decrease the 10% variance," he says.

- **Be proactive if physicians lack confidence.**

"Physicians are very data-driven," says **Tania V. Bridgeman**, PhD, RN, director of clinical pathway development at University of California — Irvine. "If they get flawed data one time, it is a very long recovery period before they are comfortable again," she says.

For example, a physician might ask for data on a certain procedure, but the wrong ICD-9 code is queried. "Once they see something like that, their confidence level drops. So all your homework must be done with no bases left uncovered — they will find them."

If a physician feels that poor-quality data have been received from one of your team members, your instinct might be to downplay the individual in question to avoid conflict, but this is a mistake, Bridgeman says. Instead, she recommends bringing the person to individual meetings to regain confidence.

"If a physician doesn't believe in the integrity of data from finance or another hospitalwide clinical database because they've been burned in the past, I bring those key people in," she says. "You don't put them in the background — you place them out front."

For example, the facility's spine surgeon felt he had received some flawed data from the decision-support analyst, so Bridgeman brought that person to a meeting with the physician so she could address the problem directly.

"Every time I went to meet with him, she became an integral part of the meeting. I didn't go away; I continued to return with this person to the same physician over and over again," she says. "It gradually built up the confidence level."

Bridgeman attributes this to having "relentless follow-through. If I said we were coming back with data in two weeks, we went back in two weeks and I gave the floor to the person they had some trepidation about," she says.

- **Identify physician champions**.

Enlist the help of individuals who strive for clinical excellence and are not afraid to address issues with other physicians, Bridgeman says. When she developed a clinical algorithm for abdominal pain, she sensed resistance from the entire emergency department (ED).

"They didn't want to follow a predetermined algorithm and also be asked to access an electronic order set that would activate the pathway,"

she recalls. "I took the physician champion with me. What I wasn't able to address as a nurse, he was able to address. Ultimately, the ED chief joined forces with the champion."

If problems occur with resistant physicians, the champion can help with that problem as well, Bridgeman says. "If you find that people are slacking off from using the pathway, then the champion would come in behind you and help with the reeducation process to achieve compliance," she says.

She says that the "physician champion" strategy has made quality projects a success several times at her facility. For example, it was determined that pneumonia patients admitted through the ED sometimes were having blood cultures drawn after antibiotics were administered, instead of beforehand. "This null and voids the blood culture," Bridgeman explains.

She used the facility's clinical documentation system to pull the records of 35 pneumonia patients and discovered that the problem was occurring 27% of the time.

The cause was due to a communication breakdown in the transfer between the ED and the inpatient nursing unit, says Bridgeman. "There was an assumption that antibiotics had not been given, when they actually had been given in the ED," she explains.

As a result, a systemwide educational process was implemented, with the champion physician and the chief of the department of medicine going to grand rounds to educate the residents. "We also educated all nursing units again on the importance of this," Bridgeman says.

Similarly, physician buy-in was integral when a quality issue arose regarding blood transfusions. "When we found the benchmark for blood transfusions was approximately 30% and we were at 60%, we initiated an action plan for an in-depth look at what was going on," she says. "The re-transfusion of autologous blood is pervasive across the United States."

In this case, Bridgeman worked with the physician champion to get the chief of the department of orthopedics and chief of pathology on board. A performance team met and determined that the facility's intraoperative cell saver required a pump technician to operate, who wasn't always available. "So we purchased a smaller machine that transfused both on the OR and the PAR [post-anesthesia recovery], and continued to transfuse on the unit," she says. The equipment collects up to 1,000 cc blood, which is cleansed and re-transfused. The autologous rate of transfusions are now dropping, in accordance with the national benchmark**.**

- **Ask physicians for input**.

Don't hesitate to ask physicians directly for their help, Bridgeman advises. "A plea for assistance enhances their credibility and thus elicits their support," she says.

Physician leaders typically have access to databases and a network of colleagues to consult with, and in turn, will offer the information to you, she says. When you appeal for physician input, emphasize that your facility is comparing unfavorably with others, Bridgeman suggests. For example, say, "Look at where we stand against other university medical centers — we've got to change this."

"You have to tell them, 'I am really in trouble and can't get to the bottom of this. I need your help and expertise,'" says Bridgeman. "All of a sudden, they feel part of the process because you are asking for their help."

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THE QUALITY - CO$T CONNECTION

Get more out of your FMEAs

The five stages of FMEA implementation

By **Patrice Spath**, RHIT
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Health care organizations have been improving processes for years. Recently, however, the Joint Commission on Accreditation of Healthcare Organizations mandated that organizations use a

proactive risk assessment technique — failure mode and effect analysis (FMEA) — to improve the safety of patient care activities. Unfortunately, many organizations are failing to fully realize the benefits of the FMEA process. This proactive risk assessment technique can be a powerful process improvement tool, yet often it is perceived as something that must be done to meet an accreditation requirement. FMEAs can and should be a key element in a health care organization's performance improvement strategy. Understanding the differences between those organizations that use and do not use FMEAs correctly can help you become one of those who experience the immense patient safety improvement benefits that FMEAs can bring.

FMEA Barriers to Success

Barrier	Consequence
The FMEA is implemented as a JCAHO compliance initiative rather than as an organizationwide performance improvement strategy.	Performance does not improve with each FMEA.
There is no value proposition for the FMEA.	The organization does not see the connection between its quality and patient safety strategies and the FMEA.
A "systems" view that integrates people, process, technology, organization, and performance is lacking in FMEA work.	Inefficient efforts are made to develop and leverage FMEAs.
The sponsorship of FMEAs by senior management and physician leaders is variable and/or weak.	FMEA team authority, goals, and resources are limited.
A "find-and-fix" mindset prevails over a "learn-and-prevent" mindset.	FMEAs are generated and used after a near miss when the greatest potential for error prevention has diminished.
People think management sees documentation of unresolved process inadequacies as a sign of individual failures.	People's willingness to uncover potential failure modes is reduced.

Organizations normally can be categorized in one of five implementation stages. Organizations that achieve measurable patient safety benefits operate in stages four or five. Unfortunately, many health care organizations still are in stages one through three, with most in stage one.

• **Stage one.** Typically, the organization in stage one uses FMEAs because it has to meet a requirement imposed by an external oversight group or accreditation body. Physicians and/or staff members conduct the FMEA right before the deadline for completion. Often, the wrong people perform the FMEA. The quality management department ends up analyzing the process and/or authoring the required documents rather than making the FMEA team members responsible for completing each step.

Management does not understand the value of an FMEA, and there may be a lot of confusion and disagreement on how to complete each step and fill out the FMEA form. Debate occurs when team members attempt to prioritize the potential failures in the process. Because accurate feedback systems often don't exist to base the priority ratings on, people make uneducated and sometimes inaccurate guesses about the probability and effect of failures. The team uses these best guesses to assign a criticality score to each potential failure. If too many high-priority failures requiring actions are identified, the team may adjust the ratings to bring the score below the action trigger level. Obviously, this can disrupt the entire FMEA process and make it meaningless.

At stage one, the organization fulfills its FMEA requirement but the value of each FMEA is greatly diminished. Many potential patient safety problems remain unsolved. The individuals performing the FMEAs believe they are doing them correctly because the organization's leaders are accepting them. Eventually, people begin to see the FMEA process not as a valuable patient safety improvement tool but just as something that has to be done to meet requirements.

• **Stage two.** Management ensures that the individuals who will perform and use the FMEA data are trained in the proper technique. They realize that the people performing the FMEAs must be experts in the process. Rather than being confused by the FMEA terminology, people realize they have used proactive risk-assessment techniques before but never called it FMEA. Although people have proactively improved processes

before, they have not done it in a rigorous way using a systematic FMEA methodology. Thus, the full benefits of process improvement activities were not achieved.

In stage two, everyone involved gains an understanding of what high-priority failures are and why it is important to find and prevent them. Management also realizes that it doesn't have systems in place that will give the team the data needed to accurately determine the failure probability and effect ratings. Using the limited objective data they have, the FMEA team members know they will have to use their knowledge of the process to arrive at the ratings. Due to the lack of an objective basis, the team members don't waste a lot of time arguing about the criticality ratings of potential process failures.

People who are involved in FMEAs come to believe in the power of this technique for improving the safety of patient care processes. Unfortunately, these same people may doubt whether management will provide the time and resources necessary to complete a comprehensive FMEA and successfully implement action plans.

• **Stage three.** The organization begins to use FMEAs correctly for targeted high-risk patient care processes. Early on, there is excitement that the FMEAs will result in significant safety improvement, but as people begin the undertaking, worry starts to set in as the team uncovers and documents the complexity of the process being analyzed.

Everyone knew the complexity existed but had never seen it documented before. FMEA projects grow from the two to three short team meetings that used to be normal to longer sessions involving more people. The organization must overcome its fear of the increased length and complexity of a comprehensive proactive risk assessment if FMEAs are to be successful. FMEA risk-assessment projects should be a key element in the health care organization's quality planning process; they must be planned for and adequately funded and staffed.

As more FMEAs are completed, many problems will be uncovered that must be solved if the organization is to make patient care as safe as it can be. There may not be enough resources to solve all of these problems and still meet the project completion deadlines. Knowing this, people begin to proclaim that FMEAs take too much time without enough return on the investment. They begin to wonder if all of the hard

CE *questions*

1. Which is recommended to prepare for the Shared Visions — New Pathways survey process?
   A. Expect surveyor questions to be identical for all facilities.
   B. Anticipate that patients selected for tracers always will be from the most common diagnoses.
   C. Prepare for extensive document review.
   D. Educate staff to prepare for increased interaction with surveyors.
2. Which accurately describes the new Joint Commission survey process?
   A. Surveyors are assigned to specific interviews.
   B. You won't have advance notice about which units surveyors will be visiting.
   C. Units only are visited a single time by the survey team.
   D. Physicians are given advance notice if one of their patients is going to be traced.
3. According to Robert Wise, MD, how often should the risk-assessment component of the 2005 JCAHO infection control standards be subjected to formal analysis?
   A. every three years
   B. as often as determined by the IC practitioner
   C. every six months
   D. at least annually
4. Which is recommended to obtain physician support for quality improvement projects?
   A. If a physician lacks confidence in one of your team members, avoid bringing that individual to meetings.
   B. When presenting data at meetings, avoid briefing physicians in advance.
   C. Ask physicians for help if problems arise with compliance.
   D. Don't inform physicians if your facility compares unfavorably to others.

Answer Key: 1. D; 2. B; 3. D; 4. C

COMING IN FUTURE MONTHS

- Behind-the-scenes reports from the first surveys of 2004
- Update on the most common causes of sentinel events
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work was a waste of time. What good is it to know what is wrong with a process and not be able to correct it? Life was a lot easier when all the problems were not documented. If organizations don't overcome this obstacle, they may slip back into stage one.

• **Stage four.** Management realizes the length of an FMEA project cannot be predetermined. The complexity of the process being analyzed determines the length. Management makes it clear to those involved in the FMEA that all of the problems uncovered in the project can't be solved at once. Management will have to make objective decisions as to what to work on now and what must be delayed. Once the initial FMEA is done, management creates a long-term plan to improve the process further. This plan is shared with everyone involved in the initial FMEA so they understand that management is not ignoring important concerns.

• **Stage five.** The organization has implemented several proactive risk-assessment projects and action plans to answer the majority of high-priority failures identified in the FMEAs. Systems now exist to provide data to more accurately set failure criticality ratings. Due to the accuracy of the new criticality ratings, people are able to predict process failures better and implement focused corrective actions. Now actions required for improvement can be prioritized better.

Before significant process changes are made, the FMEAs are reviewed. If a process change must be made, staff review the FMEA to determine the impact the change will have on safety. When an undesirable patient care event occurs, the appropriate physicians and/or staff members consult the FMEAs. If the FMEA inadequately addressed the failure, changes are made to ensure that all possible steps have been taken to prevent a similar problem in the future. The organization uses the FMEAs as internal training tools because they contain important knowledge about the safety of high-risk patient care processes.

The FMEA process can be a powerful tool for improving patient safety when properly used. As with any tool, before it can be used well, it must be understood. Organizations that want to gain full benefit from FMEAs must confront and overcome the common barriers summarized **in the box on p. 14**. Otherwise, undesirable consequences will occur. Once organizations fully understand and commit to the FMEA process, people will be pleasantly surprised with the patient safety improvements that result. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

• Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.

• Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.

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