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More core measure data for 2008: Don't neglect your internally defined priorities

Resources are 'increasingly limited'

With data collection requirements continuing to increase, you'll need to be sure that internally identified priorities aren't falling by the wayside.

As of Jan. 1, 2008, hospitals accredited by The Joint Commission will be required to collect and submit data for an additional core measure set. The current requirement is for the collection and submission of three core measure sets, or a combination of core and noncore measures.

Several quality professionals interviewed by *Hospital Peer Review* reported having to reduce measurement of internally identified areas in order to comply with public reporting requirements.

At Mission Hospitals in Asheville, NC, independent service line analysis has been limited at times in favor of national quality targets, says **Tom Knoebber**, director of quality and performance improvement. "We continue to operate under a service line model with a centralized PI [performance improvement] department," says Knoebber. "Agendas tend to be set by areas targeted by national goals, so prioritization has been done for us."

The Joint Commission's requirements, as well as many others, definitely do tax data collection resources at York, PA-based Wellspan Health's two hospitals, says **Sandra Abnett**, director of quality.

"We are currently involved in other nationally known collaboratives, which also expect data collection on clinical measures," says Abnett. "We want to participate in the mandatory and non-mandatory requirements, but it does put a strain on the workforce in our hospitals."

Both required and internally defined improvement initiatives are considered and prioritized by the organization's management team, says Abnett. "We have about 300 clinical indicators that our departments collect information on, and a few dozen internally defined, which don't relate to a reporting requirement," she says. These include dialysis anemia management, whether patient contact is initiated within 10 minutes of arrival in the emergency department, lost laboratory specimens, and safety training for pediatric trauma patients and families.

At Sisters of Mercy Health System in St. Louis, more than 200 measures are being reported to various entities, with different scorecards used for The Joint Commission, the Hospital Quality Alliance, and the health sys-

tem's own initiatives.

"We understand and support the need to measure what's important — and that includes national measures such as the Joint Commission's," says **Sue Sinclair**, director of quality management. "But the focus on national reporting hasn't stopped us from identifying and measuring our own Mercy-specific activities."

Having the local resources and technology available to support data collection — for both required and system-specific measures — is an ongoing challenge for all health care providers, Sinclair acknowledges. "That doesn't mean it's not important and we shouldn't be doing it. In fact, it's only going to continue to expand because our consumers are now demanding these measures," she says. "So whether it's part of an accreditation requirement or in response to the expectations of our patients, we are going to have to figure it out, because it's not going away."

Measurement is an important component of quality and performance improvement, Sinclair adds. "We know we can't improve if we don't measure. We have no doubt that measurement supports quality and safety," she says. "That's why we are committed to doing it." The organization recently implemented changes to medication administration processes as a result of internal measures that were not required as part of a public reporting effort.

Because The Joint Commission's measures are now aligned with those required by the Centers for Medicare & Medicaid Services (CMS), some organizations are able to comply with the new requirements by drawing from data already being collected.

"We are looking at the fourth set to come from something we are already doing for CMS, so it won't be as burdensome," says **Jan Brewer**, PhD, RN, director of quality improvement at Mission Hospital in Mission Viejo, CA. "We are happy that CMS has joined forces with The Joint Commission to make it easier for us to comply."

Quality and clinical managers at Mission are currently determining which set of data is the "best match" for the indicators the hospital is reporting.

"In this way, the impact to the workload and use of the data should be lessened," says Brewer. "Still, this is another data mouth to feed. As always, the match will not be quite perfect and the data load may take a bit more effort. But we are hopeful that the additional workload will be minimized, and will be in concert with quality activities we are already doing."

That some measures are aligned is certainly good news, but it's equally true that data collection requirements are making it challenging to find resources for internally identified areas. "It is very difficult keeping up with the many priorities, and not just The Joint Commission's. There are any number of benchmarking projects that are competing for our time," says **Pat Wardell**, vice president of quality management and patient safety officer at St. Jude Medical Center in Fullerton, CA. "It keeps us all very busy, and in some respects does make it difficult for us to get

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things accomplished."

Quality managers at St. Jude are doing their best to balance internal priorities with external regulatory and voluntary indicators and projects, says Wardell. "We review these to see if the internal and external indictors align. If they do, and if the definitions are the same, we are in luck," she says. "If not, we have to continue to assess who we have collecting and analyzing the data."

Based on the assessment, focus might be shifted for an individual to be able to accommodate the need, whether short or long term. "It is not realistic to believe we can just add staff for every project, so we continue to assess work loads and adjust accordingly," says Wardell.

Strategies to identify improvement areas

When addressing internally identified areas in need of improvement, consider the following strategies:

• Provide broader oversight of opportunities.

Mission Hospitals recently expanded the responsibilities of its centralized PI department, to provide a broader oversight of system quality assurance (QA) and PI opportunities. "The global 'QA' identification still resides within the PI department, but the role of investigation and verification is sent to the service line for them to respond to," says Knoebber. "Within PI, we have developed a macro calendar to review throughout the year." Specific data sources include HealthGrades, patient safety indicators, the Hospital Quality Alliance and CMS reports, and internal "Top 10" reports based on APR-DRG data on length of stay, mortality rates, and readmissions. "This was traditionally a QA activity that we have assigned to the service lines," says Knoebber.

These are then reported through a newly developed centralized physician leadership team, to prioritize and balance all the issues within the service area. In some cases, the team "re-prioritizes" opportunities within the service line, or special teams may be created.

Recently, the new HealthGrades reports were reviewed by one team, showing that the organization had one-star performance in three areas. "We have found flaws with HealthGrades in the past, and since this is public data we are obligated to at least validate and develop a response," says Knoebber. "The various vendors manipulating public data are more of a problem than CMS or The Joint Commission. Their motives are to sell reports."

In this case, the three areas were assigned to the various service lines and after replicating the methodology internally, the organization is working on case review. "In many cases we find the issue is in exclusion criteria according to their definition," says Knoebber.

For example, for abdominal aortic aneurysm bypass surgery, the vendor might exclude all patients with a length of stay less than one day, but at Mission Hospitals many patients are treated and released within 24 hours. "Only the very critical patients stay past 24 hours, thereby leaving us with a smaller denominator to divide our deaths into, showing us to have a high mortality rate when, in fact, we send the healthy ones home," says Knoebber. The organization worked with HealthGrades to modify the definition so the hospital's score was not misleading.

In other cases, there is mainly a need for education and bringing a fresh objectivity to the problem. "The concept of harmonization has been positive in most areas, since these are based on high-risk and high-volume procedures," says Knoebber. "But this only adds to the pressure to investigate and respond to all areas, whether they are opportunities or not. Resources are an increasing problem."

• Integrate staff requests with existing requirements.

Physicians may come forward with "pet projects" that don't fit into your organization's priorities. "They may want me to review 100 charts for them and we will take it to the quality leadership committee. If they say it has importance, we find the resources somehow," says Brewer. "But if they say it doesn't fit with our strategic needs, either internally or externally, then we have to put it on the back burner."

However, sometimes staff requests can fit in with other requirements. When an emergency physician came forward with a request to look at sepsis, Brewer found a way to integrate it with Joint Commission requirements and also, the hospital's participation in an Institute for Healthcare Improvement (IHI) project.

"I took his need, and our need to comply with The Joint Commission, and the work of our IHI impact team, and wrapped it up in one nice package so we could move forward on this," says Brewer. "Sometimes I feel like a traffic cop, trying to get all the traffic that is similar moving in the same direction."

Quality professionals will need to do more of this kind of strategic thinking to ensure that internal priorities are met, such as aligning Joint

Commission requirements for an annual failure mode and effects analysis with IHI requirements, says Brewer. The goal is to "work smarter, not harder" by aligning various data collection needs, both internal and external, she says. "We are looking at things we are concerned about, that are not to the point where it would be a reaction to something that is wrong, but a preventive type of project, so we can use it to serve both The Joint Commission's requirements as well as our own internal requirements," says Brewer.

• Have units do their own data collection and analysis.

A quality manager at Mission Hospital set up a computerized system to allow unit staff to do their own independent PI projects. Staff run their own data to determine whether an issue is significant, and may then present their findings to the quality leadership committee.

"We've got all kinds of independent PI projects going on all over the hospital because we have this computer capability," says Brewer. "They can gather, analyze, and report their own data and that has helped a lot. When staff come to us, we tell them, 'We can't do this for you, but we will set it up so you can.'"

For example, a nursing unit started out with a pilot project to improve communication during handoffs, and the SBAR (situation, background, assessment, recommendations) process was implemented hospitalwide as a result. The unit's project also helped the hospital to comply with The Joint Commission's National Patient Safety Goal on improving handoff communication.

Data collection burdens are forcing quality to move out of a "silo" approach to a "network" approach, says Brewer, adding that your PI or quality department can act as a central hub. "If we know what is going on, we can connect people and integrate all the different projects," she says. "There are just not enough people and not enough hours in the day. But if something is really important, we'll find a way."

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Hospital hit by tornado shares lessons learned

Peer review files may have been destroyed

Disaster preparedness has been a priority for most hospitals for years, including readiness for the possibility of internal disasters such as hurricanes and terrorism. Sumter Regional Hospital recently was put to the test when their hospital was hit by a tornado which struck Americus, GA, after 9 p.m. March 1.

There were few serious injuries among patients, visitors, or staff. However, one side of the hospital building collapsed, part of the roof was lost, many windows were blown out, and there was flooding. Seventy-five cars in the parking lot toppled on each other.

"I was notified by a family member who also works at the hospital that the hospital had been hit by a tornado," says **Angel Lamb**, director of the medical staff department. "Cell phone reception was very poor that night, so it took a little over an hour for me to find out."

After all the patients had been brought down from the floors and were being relocated to other surrounding hospitals, quality professionals began trying to retrieve their records. Lamb and other quality staff were able to enter the building on the first day after the disaster, escorted by construction workers. They wore hard hats and boots for protection, and managed to haul out cartfuls of files. After the second day, however, they were no longer allowed inside because mold and mildew presented an infection control risk.

"There was a lot of water in the hallway outside our department, but we were relieved to find that the water had not reached our filing cabinets that were located on the backside of our office,"

says Lamb.

Staff from several departments helped move the credentialing records from the filing cabinets to another area of the hospital, put the records in paper boxes, and wrapped them in biohazard bags to protect them from moisture. "We were able to retrieve all of our active staff files intact and move them to safer ground," says Lamb.

However, it's possible that all of the organization's archived files were completely destroyed. At press time, technicians were working to retrieve databases from the hospital's servers, which suffered water damage. A company is working to retrieve paper medical records to see if those can be salvaged.

"We kept an Excel spreadsheet of everything that had been sent with the doctors' names, specialties, and the dates that they had been affiliated with us. If that database is retrievable we will have that to pull from," says Lamb. "Otherwise, we will have no way to verify previous affiliations."

For credentialing files, only the past two reappointments are kept in the current files, with the older data purged into a separate file. "The current files are what we were able to retrieve, but the purged active staff files are still in the hospital," says Lamb.

The practitioners who are no longer on staff have been archived. "Those archived files for the past five years are still in the hospital and we do not know the condition of those files at this time," says Lamb. "Anything past five years is kept in another building, which was blown away, so those were destroyed."

If the database can be salvaged, dates of privileges will be able to be verified, but otherwise, the hospital will be unable to verify these, says Lamb. "I guess we will just have a letter in the file that states our records were destroyed by a tornado," she says. "If hospitals have closed and there is no way to get verification from that hospital, usually if you can document the situation in the credentialing file, The Joint Commission will accept that." Quality professionals worked closely with surrounding hospitals to get their medical staff members set up with temporary privileges there, adds Lamb.

Diane Mixon, RN, MSN, CMSRN, Sumter's director of quality and peer review, has one practical tip for quality professionals. "Metal cabinets may not be the prettiest things, but they were the only ones that kept files in fairly good shape," she says. "We got all of the peer review files out and they weren't damaged, but the files in open or wooden cabinets absorbed moisture."

Mixon says that she is hopeful that the server can be salvaged, meaning that the historical data will be able to be retrieved as well. "Anything you can back up and store on a server, you need to do that in a timely manner," she recommends. "There were some files I was working on that may be lost."

As for The Joint Commission's core measure requirements, the Georgia Medical Care Foundation has put in a request to the Centers for Medicare & Medicaid Services for the hospital to be given a reprieve from submitting data due March 15 and for the three following quarters.

"They are trying to intervene on our behalf, because we don't even know if we will have actual files from which to abstract data for a while," says Mixon. Although the hospital began implementing electronic medical records recently, records at present remain only partially electronic. A lot of core measure data, such as for pneumonia and the surgical care improvement project, continue to involve paper records such as ED records and anesthesia records during surgery. "Also, we are not fully operational and currently are only admitting patients for observation," she says. "Quality measure data are based on inpatient data, so it may be a while before we have records to abstract."

The hospital was last surveyed by The Joint Commission in 2005 and expects that during their next survey, the disaster will be a major focus. "I'm sure that the surveyors will be very interested in how we handled this, how our disaster plan worked, and what we have done to better preserve patient safety," says Mixon. ■

Patients may define medical errors differently than you

Make it easy for patients to report safety concerns

If a nurse failed to respond to a patient's call light in a timely manner with no harm resulting, would you consider this a "medical error?" Probably not, but the patient might.

Hospital patients define medical errors much more broadly than the traditional clinical definitions of medical errors, says a new study of more than 1,600 patients at 12 Midwestern hospitals. For example, patients believe that errors include communication problems, lack of responsiveness, and falls.

The study shows the importance of explaining exactly what is meant by the term "medical error" if patients are to be effectively engaged in programs to prevent them, say the researchers. They recommend tailoring educational programs to address the fears and concerns of each patient, so patients can play a more active role in error prevention.

The study also found that error-related concerns alone, even if not linked to an actual error, are enough to significantly affect a patient's perception of their entire experience.

There is no question that patient satisfaction is an important element in the overall determination of quality, says **Patti Muller-Smith,** RN, EdD, CPHQ, a Shawnee, OK-based consultant working with hospitals on performance improvement and regulatory compliance. However, it's a mistake to expand the definition of a reportable incident to include the patient's perception, she cautions.

"This has the potential to compromise data reporting," says Muller-Smith. "It may also cloud the focus on making changes that will affect patient safety and improve patient medical outcomes."

Patient perspectives are so variable that the data cannot be considered valid from a statistical standpoint, Muller-Smith explains. "That is not to infer that it is not important. But quality professionals may lose focus if the scope of data gathered has perception and not factual data," she says.

Most patient satisfaction surveys and questionnaires already address the patient's perception of responsiveness to their needs. The issue you must consider is whether there is effective communication among caregivers that would impact a patient's overall sense of satisfaction with the care they received, says Muller-Smith.

"Many patients are frightened when they enter a hospital or have to seek care in an emergency department," she says. "There is a low level of trust in the health care system as a whole. A lot of media attention has been given to dramatic medical errors that have occurred, which continues to feed this distrust."

Although medical errors do occur, the media has blown things out of proportion with sensational headlines, says **Patrice Spath**, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "Every day, thousands of patients are cared for in hospitals and very few of these patients experience a true medical error," says Spath.

But because of media coverage of catastrophic medical mistakes, many patients and their family members come in expecting errors to occur — thus, any deviation of what they consider to be the norm is thought to be an error. "We need to know if our patients feel unsafe and the reason behind these feelings. Then hospitals can educate patients on what to expect during their stay," says Spath.

Hospitals can use their existing customer satisfaction and feedback mechanisms to find out if patients feel unsafe and why, says Spath. For instance, some hospitals have added individuals from the community to hospital patient safety groups so that the voice of the consumer can be heard. "Health care is very complex. We need to make sure our patients feel safe during what can be a confusing and frightening experience," says Spath. "We must understand what makes them feel unsafe and address those concerns. Then hospitals can design strategies that address the root cause of these fears."

What is a medical error?

Quality professionals agree that there is little to be accomplished from attempting to clarify what constitutes a "medical error" with patients. "I doubt if we'll be able to educate patients as to the meaning of 'medical error.' We can't even seem to agree on the meaning!" says Spath.

What patients view as an "error" may actually be a miscommunication, inadequate pain control or failure to improve as quickly as they thought they would, and these things are not typically reportable incidents, says Spath.

Trying to correct what patients perceive as a medical error would be difficult at best, if not impossible, until public trust in the health care system is restored, says Muller-Smith. Restoring trust most likely will come from reducing actual medical errors and providing patients with more frequent information about what is being done for them, she says.

The study found that patients who received care in small and rural hospitals reported the fewest types of concerns, regardless of the severity of illness. "It is interesting to note that there is less concern about medical errors in hospitals where the patient is much more likely to know their caregivers better. They believe that they will receive good care because they know them," says Muller-Smith.

In large, busy, urban settings patients often have different caregivers each day so there is little time to form a relationship. Communication is probably the single most important aspect of

(Continued on p. 47)

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Administrators fall short of full recognition of CM duties

Staffing models often out of date

Until a hospital's executive administrators truly acknowledge that case management is part of the cost of doing business, it's likely that those charged with performing that task will continue to struggle with daunting workloads and inadequate staffing, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

"It's like people who want to run a department store but don't want to buy clothing or racks or cash registers," she adds. "Then the ones who need those things are in the position of saying, 'What is our return on investment?'"

Although there is some movement toward recognizing case management as part of a health care organization's basic structure, Zander says, it often fails to include a full acceptance and understanding of all the necessary case management functions — utilization review (UR), discharge planning, access, and care coordination. **(See related story, p. 63.)**

With increasingly complex cases and more and more uninsured patients, traditional case management staffing models have become obsolete, suggests **Kate Tenney**, RN, manager for case management at Sutter General Hospital in Sacramento, CA.

"In the old days, with the original case management staffing models," she adds, "you took the overall census and determined which patients would need utilization review, which would need discharge planning and some coding documentation, and then calculate staffing based on, for example, UR takes 20 minutes and discharge planning maybe 45 minutes."

With current patient acuity levels, however, those time studies are no longer accurate, Tenney says. "I have case managers who have large caseloads of homeless, uninsured, young patients with multiple diagnoses.

"It used to be that if a patient was 45 years old, he didn't require anything but UR," she says. "Now that 45-year-old has hypertension, diabetes, is a smoker, and has peripheral vascular disease."

In addition, that patient might be a drug user with wounds that are infected because he lives on the street, Tenney adds. "Since he has no insurance and is homeless, there is no place in the community he can go. Skilled nursing facilities are not geared to the young."

The picture doesn't even have to be that bad for the case to be a challenge, notes **Barbara Leach**, RN, director of case management for Sacramento Yolo Sutter Health.

"Say the person is a skilled worker, works for a mom-and-pop operation [and so doesn't have insurance] and barely pays the rent," she says. "We have a 57-year-old who has lived [in the hospital] more often than not because [he needs post-acute care] and there isn't anywhere else for him to go."

Adding to the pressure is the faster turnarounds that have been expected since the advent of the hospitalist program, Leach points out. "If there is a test in the morning, [hospitalists] are expecting to do something by that after-

noon."

In the past, case managers would open a case in the morning, spend 30 minutes on it, and not touch that case again for 24 hours, adds Tenney. Now, the hospitalist handling the case might come back to it during the day — multiple times — necessitating more involvement by the case manager.

Not only is medical care more complicated, there are more accompanying questions that need to be asked, Zander says, citing a hospital case on which she recently consulted.

"The patient had a burst aneurysm and was pretty much out of it, and had a bad skin breakdown from being in a nursing home," she explains. "The hospital staff was upset because there was no DNR order. The patient, who now was having an infectious process, had already been in the hospital eight days, but nobody had talked to her husband about any of this."

The man didn't come in at a time when it was convenient for a member of the staff to talk with him, and the patient was still sick enough to need utilization review, Zander says. "Nobody was talking about 'the middle part' of care. We can save her life, but does her husband actually even know how her body looks under the sheets, how deep the wounds are? You don't come back from that."

In this instance, the hospital involved didn't have case management, she notes, so there was no one saying to the husband, "If [the patient] goes into a code, what do you want to do?

"The case manager is the catalyst for asking the right questions," Zander says.

New staffing models in order?

Despite these increasing demands on the case manager's time and expertise and the demonstrated need for someone whose job is to ask those kinds of questions, Tenney says most hospital budgets are dependent on that initial staffing model.

A reevaluation of staffing ratios is obviously in order, Leach says, but the fact that models vary a great deal among hospitals complicates the issue.

"Some hospitals do not have what we call an integrated model," she adds. "At Sutter, our case managers do UR, discharge planning, and a fair amount of care coordination. In other hospitals, those are all distinct roles, which makes it hard to compare models and staffing."

At some hospitals, notes Tenney, social workers do a great deal of discharge planning, and at others they don't do any part of it.

Leach says she has done some "work sampling," whereby one identifies categories of work that are expected to occur and then observes staff to see what category they are performing at particular intervals.

"You can say you spend 30% of your time doing this, and 60% doing this," she explains, but work sampling can reveal that those percentages are way off. In an "80-20 world," where the most intense work takes up 20% of one's time, Leach adds, "20% feels like more. You always write down the things that drive you insane."

To help relieve the staffing crunch, she says, Sutter Health has added "nurse extenders" to help relieve the staffing crunch, she says.

The drawback there, however, is that most of the increased demands on case managers require nursing expertise, Leach notes. "The nurse extender can't assess the results of a critical test or resolve a complicated family dynamic or determine what level of care the patient needs."

At Sutter Health, explains Tenney, these nurse extenders are known as case management specialists. They act as assistants to the case managers and do provide invaluable help, she says.

"The job description requires some college education and some background in medical care," Tenney says. "[Case management specialists] are responsible for the entire placement process once the case manager has identified what is needed."

A certain percentage of time in the staffing model is calculated for placement, she notes. "The nurse extender can pull that [function] out of the nursing model, and the case manager can handle twice as many patients that will need placements because of the nurse extender positions."

At Sutter General, four specialists do 800 placements a year, Tenney says. "The other piece [they perform] is that once the case manager has determined that a patient will go to an SNF, the specialist will meet with the family, coordinate the actual transfer including transportation, communicate with the SNF, and copy charts.

"So basically, the specialist will make all the arrangements and follow through and then back it up with documentation," she adds. "So a case manager can hand off the rest of the case to that person. It's one thing to have a clerical person

who can make copies, but to have a person you can hand a case to is a huge help for case managers."

While the nurse extender helps with a piece of the case manager's work, what Leach refers to as "how long it took to Xerox something" has been eliminated from the case manager's schedule. "It took away that down time, that time to think.

"Because we've moved hospitals into a 24-7 operation," Tenney adds, "case managers are constantly trying to maneuver patients and keep up with documentation."

Under normal circumstances, managers would go to the hospital's administrative team and say more case managers are needed because of the acuity of the patients, she says, "but in the current environment, that's not an option anymore."

Instead, the focus at Sutter General is to bring down the number of full-time equivalents per discharge, Tenney continues, because it's higher than at other facilities in the community.

To make the most of the staffing that is available, she says, "we concentrate on making the case managers as efficient as possible. We try to train them not to take on other people's jobs."

The tendency, Tenney explains, is for case managers to do a lot of things that are not part of the case management role, such as helping nurses and physical therapists with their tasks, because it facilitates discharge.

"For instance, the physician writes that the patient can go home as soon as his labs are normal," she says. "The case manager will go to the nurse and say, 'The labs are normal. Is the physician going to discharge?'"

The nurse, Tenney adds, will respond, "I don't know. I didn't know the labs were normal." Under normal circumstances, she says, the case manager will then call the physician and go back to the nurse and say, "Here are your orders for discharge."

Other staff members may not be as aware of time and length of stay, as well as other patient issues, as case managers, Tenney notes, which can lead to another potential drain on case management resources.

"Traditionally, on any hospital unit, the case manager was the center of information if someone didn't know what was going on," she says. Being that resource for a unit is very time consuming, Tenney adds, and not realistic in today's environment.

"Ask yourself," she advises case managers, "Can you afford to take every phone call of every nurse and physician that comes by to talk to you? Time is such an issue. That [pattern] may have to change."

Another lesson case managers may need to learn, Leach points out, is when to give up — at least for the time being.

In many instances, she says, case managers will concentrate on a very difficult case, in which the living conditions, the age and attitude of the patient, and perhaps the lack of family involvement make it extremely unlikely that the patient can be readied for discharge.

"When staff tell me about a situation like this," Leach says, "I tell them, 'Put this down. Work on it again tomorrow. It wouldn't get done today anyway, and you need to move on to the five other patients you haven't seen at all. Make sure you don't [negatively] impact cases you can make a difference on.'"

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It takes *all* CM functions to provide necessary care

Care coordination 'least recognized'

Many top hospital decision makers still fail to recognize that case management is a core function of patient care, not an optional service that needs to prove return on investment, says **Karen Zander**, RN, MS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA.

Even those who do acknowledge that case management is part of the basic structure of a hospital may not see all of its components as crucial, says Zander.

Hospitals have accepted that utilization review (UR) has "tightened up" so that it is no longer just about having good contracts with payers, but must be practiced on a daily basis and must be done mostly by nurses, she says. "Case managers have to implement the contracts. UR has gone from a blanket, 'We'll get paid, just send this off' to having to explain why

we deserve to be paid for this day for this patient."

"If we say, 'This is what we need for UR,' [administrators] wouldn't balk at that, but the functions keep evolving and growing," Zander adds. "If we start with one staff [member], they say, 'OK, we understand,' but then we keep throwing more responsibilities on that staff [member] and the complexity of cases [keeps increasing]."

Having an electronic medical record makes the job of UR easier, she notes. "The problem is that no one has a complete electronic record, so you have to look at the computer for some information, the paper chart for the rest, and then you have to track down the physicians to see who's covering for whom."

The next most acknowledged case management function is discharge planning, Zander continues. "People know that patients can't live in the hospital for the rest of their lives, so they have an intuitive understanding that discharge planning has to happen.

"They also know that length of stay and getting paid are connected, so there is even more recognition of the importance of discharge planning, and there is a target attached," she says.

"In fact, there are several targets attached," Zander adds. "The more the quality targets rise, the harder the job. It's not just finding a place for the patient to stay, but, [asking], 'Have we done the right thing to prevent readmissions, are we doing the right work in the hospital, and are we sending the person to the right level of care?'"

There are long-term acute care hospitals, but they don't usually take Medicare, she notes, "so you might have a patient who can use that, but has the wrong payer."

The Center for Case Management estimates that 45% of a hospital's medical-surgical patients should be going somewhere besides home at discharge "and we think that [percentage] is low," Zander says. "The recovery phase of [hospital] care got amputated with DRGs.

"What we mean by 'somewhere,'" she adds, "is somewhere where there is nursing oversight and actual nursing care, such as long-term acute care, hospice care, home care. Even one home visit we count."

In actuality, Zander says, most hospitals are at 20% and, with readmission rates on the increase, "will have to ramp up."

The **access** function is the third, less acknowledged, component, she says, "although it has always been a foundation of case management. It is about getting patients connected with health care services, especially the front end of the care.

"That includes getting patients into and through the emergency department; getting them a bed if needed; acquisition of a primary care physician, appointments, transportation, and other resources," Zander adds. "Liaison staff to community agencies are also working in the access function."

The fourth function of case management, care coordination — "the middle of the care" — is the least recognized, she says. "It's about team leadership, treatment planning, and quality, not just what the physicians are doing, but what all the other services are doing in regard to basic care, like pain management and mobility and patient education.

"Are they getting confused? Are they dehydrated? What is their pulse oxygen? Are we mobilizing them correctly? Do they understand how to take care of themselves?"

If caregivers aren't paying attention to those questions, Zander points out, "four days can turn into 40 days. It slips into that very fast if you don't manage those things.

"We have a little poem at the [Center for Case Management]," she notes. "UR is accountability for the *pay,* care coordination is accountability for the *day,* discharge planning is accountability for the *stay,* social work is accountability for the *way,* and access is accountability for today."

If a hospital's executive team doesn't understand all the necessary functions, and how case management will serve those, and if there are no real targets in place to show where a hospital wants to get, Zander says, whatever staffing was allocated at a case management department's inception is likely to remain.

"If social workers did discharge planning and nurses did utilization review [originally], then you are stuck with that unless the hospital sees the access and care coordination issues," she adds. "Unless [administration] sees the scope of what you have to achieve, you get into a fall-back position instead of an aggressive one."

(Editor's note: Look for a case management staffing model developed by Karen Zander for the Center for Case Management in the next Discharge Planning Advisor.) ■

(Continued from p. 42)

reducing the patient's anxiety level, says Muller-Smith. "From a practical standpoint, this should be a major focus of making the patient feel safe and secure," she says.

Data from existing reportable incident criteria and patient satisfaction surveys should be used as indicators of overall quality, says Muller-Smith. "The goal is to provide an environment where the patient is safe and also feels safe," she says.

Analysis of sentinel events reported to The Joint Commission has demonstrated that communication leads to a variety of process failures that impact patient care, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC. For example, a patient about to undergo a radiology test with contrast has no awareness whether contrast will affect the patency of the peripherally inserted central catheter line — the patient just undergoes the experience of line insertion again.

Many attempts to understand the patient perspective are under way, including The Joint Commission's National Patient Safety Goal requiring encouragement of patients' active involvement in their own care as a patient safety strategy, and development of the Centers for Medicare & Medicaid Services HCAHPS survey instrument — the first national attempt to standardize patient satisfaction with care, in order to make "apples to apples" comparisons.

"Ask many questions, stay tuned to what patients are complaining about, and tie what you learn back into staff education," advises Swain. "When monitoring communication with patients, set your expectation to see staff using that information."

Consider implementing the following strategies to address patient perceptions about safety:

• Assess patient concerns about medical errors in real-time.

"You don't want to do this retrospectively. You want to be going around asking patients, 'Is there anything that has made you feel unsafe today?'" says **Geri Amori**, PhD, health care consultant with Shelburne, VT-based Risk Management and Patient Safety Institute. "That could be done by nurses, patient advocates or quality professionals. But there should be a place where it is reported daily."

• Give patients a simple way to report concerns.

There needs to be a quick and easy way for patients to report anything they believe is an error, says Amori.

Instead of educating patients about what is considered an "error," encourage them to tell you whenever they think an error has occurred and what they believe that error is, Amori advises. "We need to emphasize to patients that we want to know about anything they experience or see that they believe shouldn't have happened," she says. "If we create limitations about what we want reported, we could lose important information."

The patient's concern might not technically be considered an error, but might reveal communication or other patient safety issues that need to be addressed, Amori explains.

It is important that patients and family members have a mechanism for voicing immediate concerns, but this should not be done through the hospital's incident reporting system, says Spath. Instead, hospitals should make it very clear to patients and family members that any concern should be immediately brought to the attention of their caregiver.

"If the situation is not resolved to the patient or family member's satisfaction, they need to know how to contact the hospital's patient advocate or someone in a similar position," says Spath. For example, some hospitals encourage anxious patients or family members to call a special phone number to activate a rapid response team.

• Incorporate patient attitudes into safety programs.

Include these two questions on your patient satisfaction surveys, recommends Amori: Do you believe any errors occurred during your stay? What do you believe they were and may we contact you for more information?

Swain recommends these interventions, done by your hospital's guest relations department or senior management:

• Hold focus groups with parents of pediatric patients with stays exceeding four days, especially those coupled with an admission from the ED, since this group of patients was identified by researchers as having the most safety concerns. "Communication processes should be enhanced when talking to patients, since patients often feel they are 'talked over' or are being 'talked about,'" adds Swain.

• Train nurses in "scripting" to explain to patients why they are using patient safety techniques, such as patient identification, over and over at every patient encounter.

Patients may wrongly believe that the reason staff continually ask for their name is because they aren't communicating well. "If staff were proactive and said, 'It is important for your safety that we all double check who you are, so we will all be asking you your name and date of birth,' patients would expect

this intervention and begin to participate, rather than think staff do not communicate," says Swain.

Similarly, since it takes about 20 seconds to use hand hygiene, during that time the staff could be telling the patient about the reason for cleaning their hands between patients and procedures. "That inclusion activity costs nothing, makes the patient part of the facility's safety program, and opens communication for patients to talk to staff about many related concerns," says Swain.

Reference

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ACCREDITATION
Field Report

Best practices found in survey at KY hospital

Surveyors impressed with handoff processes

After the Agency for Healthcare Research and Quality (AHRQ)'s Hospital Survey on Patient Safety Culture was completed by staff at Our Lady of the Way Hospital in Martin, KY, results revealed that improvements were needed for communication during handoffs.

Rapid cycle improvement processes were implemented, beginning with a single unit that served as a pilot, focusing on handoffs from the ED to the medical/surgical unit for patients being admitted. "We put some processes in place for direct communication between the ED nurse and the receiving nurse on the inpatient unit," says **Billie Turner**, the organization's vice president of clinical operations and chief nursing officer. "They do their communication via phone and this is done in front of the patient."

A template is used by both nurses to make sure that the ED nurse is giving all the information that the team feels is important, and that the receiving nurse is filling in all the blanks. To measure the results of the new process, quality managers used the hospital's patient satisfaction survey, which asks patients how nurses work as a team.

"We were using that as a metric to measure how we were doing with this, because we give the report in front of the patient," says Turner. "We did see some big improvements in our patient satisfaction that we attributed to this process."

After the initial pilot went smoothly, the handoff process was implemented in all hospital departments, as well as the organization's six rural clinics where patients are admitted from. "The process is done the same way there," says Turner. "The nurse at the clinic calls the inpatient unit and gives the report." The same process is used for patients going to diagnostic testing from the inpatient unit, and patients going to surgery or returning from surgery.

During a February 2007 Joint Commission survey, the surveyor gave high marks to the handoff process. "He particularly liked the fact that we had expanded it through all the other areas, including diagnostic testing," Turner says. "He was pleased that we have a consistent process. Whether patients are coming from a clinic, surgery or the ED, everybody uses the same format to give and receive report."

Here are other areas The Joint Commission surveyors were impressed with:

- **The medication reconciliation process.**

"He said it was a best practice they were planning to share with other organizations," says Turner. "Our handoff process played a big role in that, actually. Our pharmacy is very involved in our process, and we feel that has been a big benefit for us."

The process starts at admission, wherever the patient is admitted, and is used throughout the organization. A list of the patient's medications is obtained and sent with them to the inpatient unit. "If for some reason the list doesn't come with them, then it is done on that unit," says Turner. "That list is reviewed by the physician and serves as an order sheet as to whether or not the medications will be continued."

Wallet-sized medication cards are given to patients to carry and present each time they come to the ED or clinic, and upon discharge from the hospital, the patient is given a printout of their medications. "We encourage them to bring that back in with them when they come," says Turner.

• Nursing admission assessment for inpatient units and care planning.

"He liked this process because the way we have it set up, it actually triggers things that go into the care plan," says Turner. "Our care plan is very multidisciplinary and he was able to see all of the discipline's input into the care plan."

• Education assessment.

"If you look at The Joint Commission standards, in the elements of performance it's very specific as to what you have to have," says Turner. "We listed it all on a single sheet and we check it off. The surveyor said it made it really easy for him to find it."

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THE QUALITY - CO$T CONNECTION

Fault trees uncover complex causes

Understand what the date are telling you

By Patrice Spath, RHIT
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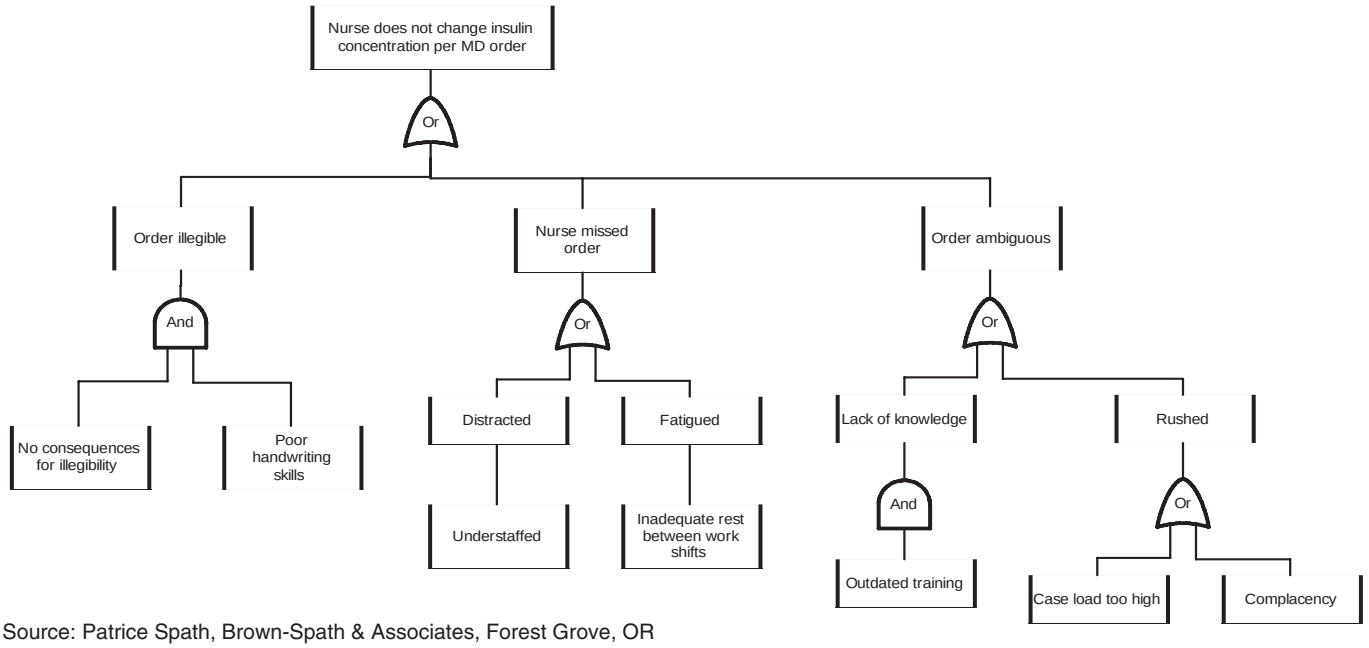
Root cause analysis (RCA) is a technique used during an incident investigation to find the fundamental system deficiencies that caused the event. It is also a tool used during a failure model and effects analysis (FMEA) to determine the most likely causes of process failures so that corrective actions can be taken before an adverse event actually occurs. There are many ways of discerning root causes — the most common being a series of "why" questions that may eventually

Completed Fault Tree Diagram



Source: Patrice Spath, Brown-Spath & Associates, Forest Grove, OR

lead to the discovery of fundamental causes.

Even when RCAs or FMEAs are performed flawlessly, it can be difficult to recognize the inter-relationship between causal factors and root causes. Often the fundamental system deficiencies are not single point failures but rather a combination of factors. For example, a data entry error in the computerized medication ordering system may not by itself result in a adverse drug event.

But when this error is combined with other mistakes, such as failure of the double-check system in pharmacy, the likelihood of an adverse drug event goes up. When looking for root causes, whether after an occurrence of a significant adverse event or for failure prevention purposes during a FMEA, it is important to understand the various relationships within the complex systems of health care delivery. If these relationships are not considered, the actions taken to improve patient safety will be less effective.

A tool used in other industries to evaluate complex system relationships is fault tree analysis (FTA). This analysis would be useful in health care to identify the fundamental root causes of unsafe situations, which often result from a complex interaction of multiple failures. FTA is useful for several purposes:

• Identifying all causes of a undesirable event or process failure mode.

• Understanding the interrelationships between multiple causes.

• Determining the most effective areas for action.

To conduct an FTA, a fault tree diagram is developed. A fault tree is a graphical method for systematically listing various sequential or parallel events or combinations of faults that must occur for a particular undesired event to occur. The fault tree diagram is then analyzed to identify where several things must fail together to cause another failure or where only one of a number of possible problems need to occur to cause a significant process failure. Once the relationship between failures in the process is clear, appropriate corrective actions can be taken.

Fault tree analysis can be integrated with a root cause analysis by creating a diagram for each significant contributing cause that contributed to the event. It can also be integrated with FMEA by developing a diagram for each high-risk failure. Construction of the fault tree involves working downward from the top event (the contributing

CE *questions*

13. Which is recommended to ensure that internally identified priorities are not neglected?
A. Avoid overlapping data collection required by The Joint Commission and other organizations.
B. Don't contact vendors to modify definitions for exclusion criteria, even if your organization's ratings are misleading.
C. Never allow individual units to perform their own data collection.
D. Integrate staff requests for collection of quality data with existing requirements.

14. Which did a study find regarding patient perception of medical errors?
A. Patients define medical errors much more broadly than traditional clinical definitions.
B. Patients believe that errors must result in physical harm to the patient.
C. Error-related concerns typically do not affect patient satisfaction.
D. More safety concerns were reported by patients in smaller rural hospitals.

15. Which is recommended to involve patients in safety programs?
A. Assess patient concerns retrospectively, not in real-time.
B. Devote significant resources to educating patients about the definition of medical errors.
C. Change your incident reporting process to include patient perceptions such as communication problems.
D. Have nurses explain why they are using patient safety techniques.

16. Which is recommended by quality professionals at Sumter Regional Hospital for storage of credentialing files?
A. Use only wooden file cabinets.
B. Store files on floor.
C. Back up information electronically in a timely manner.
D. Use paper or electronic records for storage, but not both.

Answer Key: 13. D; 14. A; 15. D; 16. C.

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

cause or failure) asking, what could cause this event to occur? This question continues to be asked until the end of your universe is reached — the point at which your organization can no longer control the causes. At this point, you've found the root causes. Once the diagram is completed, it serves as the basis for developing appropriate actions to reduce the risk of critical failures and safety hazards.

Suppose, for example, your organization conducts an FMEA on the process of insulin infusion therapy. One of the potential high-risk failures is that the nurse doesn't change the patient's insulin concentration as ordered by the physician. This failure mode becomes the top event in the fault tree diagram.

To build the diagram for this failure mode, the FMEA team brainstorms the "whys" to the top event — why would the nurse not change the patient's insulin concentration? There could be several immediate causes that would create this problem:

- order is illegible;
- order is ambiguous;
- order is missed.

One of the unique characteristics of FTA is the ability to examine the relationship between immediate causes and root causes. This is done by determining if the causes, as identified by the FMEA team, happen independently or if two or more must happen together to cause the top event to occur. The relationship between causes is illustrated on the fault tree through the use of special symbols called "gates." The OR gate is used when causes are independent of one another. The AND gate is used when two or more causes must occur together to create the previous failure.

In this example, the FMEA team determines that any of the three immediate causes — order illegible, order ambiguous, or order missed — could by themselves produce a situation in which the nurse might not change the patient's insulin therapy concentration. Thus, the OR gate is used to connect these immediate causes to the top event on the fault tree. These causes are illustrated on the first row beneath the top event on the fault tree diagram.

The FMEA team continues to build the diagram by identifying the immediate or contributing causes and finally the root causes that exist or co-exist to create the failure depicted as the top event. The "why" questioning ends when the

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- 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.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ Your biggest challenges for compliance with the 2008 NPSGs
- ■ Update on The Joint Commission's conflict management standards
- ■ Proven ways to involve patients in safety initiatives
- ■ What to measure when monitoring disruptive behavior
- ■ Novel ways to encourage staff to report safety concerns

team gets to a point where the causes are out of the organization's control (e.g., patient variables) or when the team runs into a dead end when asked, "What would cause this to occur?" An example of a completed fault tree diagram for the event — nurse doesn't change the insulin concentration — is shown on **p. 49**.

Once the fault tree diagram is completed, analysis and action planning begins. In this example, it is apparent that illegible orders result from a combination of two root causes: poor handwriting skills and lack of accountability.

The team identified handwriting practices and accountability as being dependent; meaning that one cause cannot be fixed without also addressing the other cause. Notice in the diagram that an AND gate was used to connect these two root causes to the immediate cause — order illegible. There are several independent root causes (as depicted by the OR gates in the diagram). For example, understaffing is an independent root cause of missed orders as well as staff not having adequate rest time between work shifts. For action planning purposes, this means that understaffing can be dealt with independent of the rest time concerns. However, changes in staffing practices could only reduce the likelihood of missed orders. The issue of adequate rest time between work shifts would also need to be addressed if the goal were to eliminate missed orders.

Using fault tree analysis during an RCA or FMEA can help the team identify the inter-relationships between various complex factors. By clearly recognizing the risk points in a process, the team can determine where action plans should be directed to achieve maximum benefits. ■

Correction

Question 12 in the March issue should be replaced with this question:

Which of the following strategies did M.D. Anderson Cancer Center use to increase the number of safety reports submitted to the Close Call Reporting System?

A. Changing terminology regarding nurses' identification of possible errors from "near miss" or "close call" to "good catch."
B. Using an end-of-shift safety report to help nurses identify patient safety concerns that ocurred during the shift.
C. Promoting incentives.
D. All of the above.

The answer is D.