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The push is growing for physician involvement in quality: Act now

Problem is a 'profound challenge'

(Editor's Note: This is a two-part series on physician involvement in quality initiatives. This month, we cover effective ways to involve physicians. Next month, we will give strategies to address resistance from physicians to evidence-based care.)

The new medical staff and upcoming leadership standards from The Joint Commission and the recent Centers for Medicare & Medicaid Services (CMS) ruling stopping reimbursement for certain preventable conditions have something in common: All are strong incentives to involve physicians in quality initiatives.

There is no question, though, that hospitals are struggling with this. Only one-third of respondents to a survey conducted by the Tampa, FL-based American College of Physician Executives reported that physicians were "very supportive" of patient safety projects. **(You can access the complete survey results and related articles at www.acpe.org/quality.)**

"This is a profound challenge for most health care institutions," says **Alice Gosfield**, a Philadelphia-based attorney and consultant specializing in quality improvement.

Physicians are so beleaguered by the multiple demands on them, that to engage them in quality improvement requires engaging with them on their business case for quality, says Gosfield.

"Physicians care about quality profoundly, but not always in the terms in which hospitals seek their involvement," she says.

Seek to understand physicians' perspectives, and engage them in ways that will respond to their needs, advises Gosfield. "Then, they can be real partners and collaborators around quality and not mere 'customers.'"

There often is a disconnect between physicians and hospital administrators, adds **Donald L. Mellman**, MD, MPH, MBA, FACHE, a Tampa, FL-based consultant specializing in health care quality. "Non-physician leaders speak a different language than physicians. The chief medical officer should be a translator for both sides and try to get them to work together," he says. "The most important thing, in my experience, is alignment of incentives."

It's not unusual for hospital administrators to subvert the peer review process for physicians who are high-volume admitters, to make it more favorable for those physicians because they bring in a lot of money to the

hospital, notes Mellman.

When quality professionals see things such as this occurring, or see that there is poor quality and nothing is done about it, it's "a horrible thing because they really care, and these are the people who are often not listened to," says Mellman.

To prevent this disconnect, the medical executive committee should be responsible for quality, but this is not happening in most community hospitals, says Mellman. "Ideally, the director of quality improvement should report to the chief medical officer, with a zero tolerance for disruptive behavior, which adversely impacts quality," he says.

Quality professionals should be 100% supported by the person they report to, who must be 100% supported by the CEO of the hospital, who must be 100% supported by the board, says Mellman. "And everybody should have a zero tolerance for poor quality and poor patient safety," he says.

Physician champion is key

"In our experience, it's essential to have a physician champion," says **Thomas Rosenthal**, MD, chief medical officer at University of California at Los Angeles Medical Center. "When you've got a physician champion, you've got a fighting chance to make it happen. That holds true for both academic centers and community hospitals."

Since you are asking physicians to change the way they do things, having peer leadership is essential, says Rosenthal. When physicians are given data that don't agree with their own experience, or that make them look bad, the first thing they tend to do is challenge the data.

"And that is one of the roles of the champion — to step in and say, 'I don't look so good either, but I am not challenging this, and I believe it's correct for these reasons,'" says Rosenthal.

In turn, the quality professional should give data and literature to the champion so that together they can craft a change plan, advises Rosenthal. Dramatic improvements can be made if physicians actually buy in to the reason for the change, he adds. For example, UCLA was able to dramatically reduce central-line infections in its intensive care units (ICUs) because physicians bought in to the practice changes.

"One of our infectious disease doctors has taken the lead and works with the physician and nursing directors in each of the ICUs," says Rosenthal. The infection control department provides monthly review data, so that physicians can track their infection rates and compliance with benchmarks.

Rosenthal attributes the success to a general agreement among physicians that there was a problem, and that it could be improved by making specific changes. "And further, that it was not going to destroy their practice or be disruptive to them," he says. "You need to have some cognizance that if you are going to ask the practicing physicians to change, it can't be terribly disruptive to them."

Your physician champion may not always be who you expect. "The champion may not be the person who is the titular head," says Rosenthal.

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"It may be the thought leader or the youngest person, or someone who is willing to own it from a moral point of view and truly believes the data."

When a goal of improving compliance with giving antibiotics within one hour of surgery was set, the matter became a practical one — who was actually available in the OR to give the medications. The anesthesiologists were there doing their preoperative workup during that time, so they were approached. "We got our anesthesiologists to agree to be an aggressive part of this thing and they made it happen," says Rosenthal.

Previously, when anesthesiologists were asked to perform an assessment required right before surgery, they refused, saying it was the surgeon's job. "I thought for sure they would say the same thing about the antibiotics, but they didn't," says Rosenthal. "They stepped up and said we believe that this is a good thing for us to be doing, and were willing to be engaged in the actual dispensing of the medicine." As a result, the hospital is now in the top fifth percentile for that measurement.

At Columbus (OH) Regional Hospital, physician champions co-lead interdisciplinary teams and work alongside clinical nurse specialists, says **Katherine J. Wallace**, RHIA, CPHQ, director of medical quality management. "The organization is committed to using their time wisely. Their involvement is kept to an as-needed basis," she says.

The clinical nurse specialists provide the most current research, and work with the physician champion to design processes to implement that evidence. "The most effective way to engage physicians is to respect their time and to implement identified plans so that they see the benefit that their involvement brings," says Wallace. In the hospital's most recent physician opinion survey, "efforts to continuously improve quality" was better than the 90th percentile, she reports.

Quality professionals also are members of the interdisciplinary team, providing data and tools to facilitate meetings. "Physician champions can certainly help defend data, if necessary," says Wallace. "Their role is also to defend the evidence-based practice to other physicians. We have found that physicians are naturally curious about their performance compared to others."

Physicians are provided with blinded data by physician so they can see their performance compared to other physicians' performances. "This generates a lot of questions, and even requests for medical record numbers so that the physician can follow up on their own cases," she says.

At Homestead (FL) Hospital, quality professionals approach individual physicians to ask if they would be willing to be the physician champion for a particular area, says **Jill White**, director of performance improvement. "They work closely with our performance improvement staff, as well as hospital staff and other physicians, on identifying opportunities and piloting strategies for improvement."

If you're looking for a champion, identify a physician you believe would be a good fit and then move forward, advises White. At Homestead, hospital staff do most of the legwork in actual data collection, but the physician champion reviews the data and becomes the spokesperson in communicating to the medical and hospital staff about these projects. "In this way, they feel ownership of the problem and solutions," says White.

Quality dashboards are presented at all medical staff meetings, says White. "Physicians want to do a good job. Sometimes just sharing information and opportunities creates momentum and results improve," she says.

Become a clinical insider

It's often easier for "insiders" to obtain buy-in from physicians, notes Rosenthal — for example, a nurse in UCLA's surgery department is part of the quality management team. "She has credibility with the chair of the department so when she speaks and says, 'Guys, we need to do this,' they listen."

If you don't have a clinical background, align yourself with physician and nurse leaders at your organization, he advises. "Take up a modest amount of time on the agenda with crisp, focused data," he says. Tell physicians, 'If you don't like the way I'm presenting data at meetings, guide me in how I can give you better information for you to make the changes you need,'" he recommends.

If quality professionals are perceived as "outside the group" it is an uphill battle to get anything accomplished, says Rosenthal. He points to the hospital's recent initiative to reduce ICU infection rates. "If we had somebody from the quality management department who was simply assigned this, and was viewed as an outside person, it would have been much harder," he says.

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You'll need performance data for all practitioners

Collecting data for complex practitioner groups

The Joint Commission's new 2007 medical staff standards require you to collect performance data for all practitioners. For most practitioners, this will be a simple and straightforward matter, but for others, it could prove to be a daunting challenge. Here are several examples:

Low-volume practitioners

"Obviously, you will have a limited set of data for low-volume people," says **John Herringer**, The Joint Commission's associate director of standards interpretation and lead interpreter of medical staff standards.

Depending on what the data show, they may or may not be useful, adds Herringer. "Just because somebody did two procedures and both patients died, doesn't mean there is a problem. They could have had multiple comorbidities and the physician was managing the case as best he or she could," he says.

Conversely, if the two procedures go well, it doesn't mean he's got a good track record either — the data could be meaningless because there was an insignificant number, says Herringer.

At Swedish Medical Center in Seattle, the solution for low-volume practitioners has been to separate membership from privileges, says **Nancy J. Auer**, MD, FACEP, chief medical officer. "We are in the process of changing our bylaws, so that low-volume providers who want to be active can achieve that status by active service on committees, attending Swedish-sponsored CME, being in a group that has a certified quality improvement program recognized by Swedish, or maintaining a certain number of patient contacts," she says.

Privileges will be based on education and experience for initial appointment, and maintaining activities to retain privileges, says Auer.

Psychiatrists

These physicians don't do a lot of procedures, and a lot of their work is confidential. "You won't be sitting in the room making a value judgment about how well he is interacting with the patient," says Herringer. In addition, the detail of the documentation in the charts could be limited or protected under state confidentiality laws.

If the patient is discharged, that indicates his or her condition improved from admission so that is a good outcome, notes Herringer. "Obviously if they do electroconvulsive therapy, then you will have procedures and outcomes data," he says. "You can also monitor their prescribing patterns. But in terms of interpersonal skills, it's a hard thing to do because you can't see it."

Physician's assistants and advanced practice registered nurses who are dependent practitioners

This is another problematic group, since much of their activity is coded under their supervising physician. "If they are independent and can bill under their name, you can code under their name. Otherwise, this group is going to be difficult," says Herringer.

If you have an automated medical record and the practitioner uses a password or computer sequence of keys to authenticate their signature, it might be possible for you to work with your information technology (IT) department and run a report of every patient record in which they documented something. "It would be labor intensive to do a chart audit, but at least you could find out the 50 patients they were involved with, and that would be a starting point," he suggests. "When every single thing on a hard copy record or that is automated is coded under their supervisor, it is very hard to figure out which cases they were involved with.

"I am a very firm believer that there is much more data being collected in an organization than is ever funneled back to the medical staff," says Herringer. He recommends sitting down with the medical staff, your IT department, performance improvement, infection control, and your billing department to identify all the data that are cur-

rently being collected.

Then the next questions to answer are: Are the data being funneled to the medical staff? If they aren't, can they be? How long will it take for this to happen?

"Don't try to reinvent the wheel, because there is probably a lot more being collected than the medical staff ever see," says Herringer. For instance, every time a Medicare patient is seen, a DRG bill has to go out with a primary diagnosis and additional codes for comorbidities.

"If somebody develops an infection and they have to stay, it will at least give you information on the volume of the procedures, the activities, the admissions, and the volume of the comorbidities that you are coding," says Herringer. You can start to identify a large amount of data from all of the billing codes and analyze them.

"If you see one practitioner has a tremendous amount of infection or large numbers of returns to the OR, you might want to look at him to see if there were problems with the initial surgery or problems that weren't anticipated," he adds.

The next question to answer is: Who is currently looking at the data and how often, and do you need to change that? A department might look at data every month, but they need to have data for everybody, stresses Herringer. "You can't just keep meeting every month and then two years later say, 'Hey, we have no data for this guy,'" he says. "It may be that you have no data because he hasn't been there, but it also may be that you are not capturing it in the correct manner. You need to keep some sort of file that identifies who you do and don't have data for."

At this point, The Joint Commission is not requiring specific time frames for looking at data, but if you are only looking at them every 12 months, that would be considered periodic and not ongoing, says Herringer.

"The idea is to look at data as they become available so you can take action earlier," he says.

However, frequency is not the only thing to consider — data must also be useful and valid. For example, even if you look at monthly data for low-volume or sporadic practitioners, it might be meaningless data.

"You can look at them every month, but you might have to aggregate three months to get any significant number to look at, or re-look at them when you get at least 10 or 20 procedures, because it doesn't mean anything to look at one or two," says Herringer.

For some specialized procedures that might only be done two or three times a year, you might not look at them very often, since you really need to look at more than one at a time.

How to collect data

As for how to collect data, Herringer advises using the four methodologies listed at MS 4.40, which include chart review, direct observation, monitor diagnosis and treatment techniques, and discussions with other individuals involved in the care of the patient.

"So you can use any of those approaches," says Herringer. "The interviews are going to give you information about their interpersonal and communication skills. Systems-based practice in very simplistic terms is: Are they are a good team player?"

The practitioner needs to understand that health care is delivered through a variety of systems, including information management, scheduling, medication management, and diagnostic testing. They must be cognizant of how they relate to all of these other systems.

"Are they completing their H&Ps in a timely manner? Is the update on the chart when you have the patient in the OR, or are you trying to track them down saying, 'Wait a minute, we don't have your H&P, where is it?'" asks Herringer. "Is an order for a [CT] scan going down to X-ray with no indication of what you are supposed to look for?"

The idea of the physician as running the health care team is outdated — the physician is a member of the team and needs to provide information in a timely manner so that other people can do their jobs, says Herringer.

Discussions with team members can give you important information about how well the physician is practicing within all of the other systems. "It's a very hard thing to proactively go out there and look for. You tend to end up back-dooring it by looking at complaints, or problems with charting," says Herringer. "Discussions with other team members will give you that information."

Ask team members: Are orders complete? Are updates done? Does the physician give you the indication for a diagnostic procedure? "You can get a lot of information by asking people," says Herringer. "You don't have to wait for the problem to arise."

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Proven solutions for two low-compliance areas

Areas deal with pneumonia, CHF patients

The Joint Commission's 2007 report "Improving America's Hospitals: A Report on Quality and Safety" had some good news — hospitals are achieving 90% or better on about half the quality measures tracked since 2002.

But there are two measures with less than 65% compliance: providing pneumococcal vaccination to patients admitted with pneumonia, and providing discharge instructions to patients admitted with congestive heart failure (CHF).

Both measures are complex because they require buy-in and participation from nurses and physicians, says **Becky Heinsohn,** director of hospital quality improvement for TMF in Austin, TX.

Hospitals that mandate concurrent review, with a designated individual responsible for following up with physicians and staff to ensure all measures are addressed, are more likely to perform well. "When nursing management and staff are held accountable for these measures in their performance evaluations or through incentives, financial or otherwise, compliance improves," she says. "In addition, when patients are involved in their own care, performance improves."

"There are always barriers to quality improvement," says **Nancy Jane C. Friedley,** MD, CMD, medical director for the Easton, MD-based Delmarva Foundation, a Medicare quality improvement organization.

To be successful, the hospital needs to have an "administrator champion" and the necessary infrastructure, and a "staff champion" who is dedicated to the project and will help maintain the gains that are made. For CHF, this is usually a physician, and usually a nurse or case manager for pneumococcal vaccine.

"Since cost is often a barrier, the hospital system must be willing to spend the resources to effectively implement quality improvement," says Friedley. Your IT system might need to be upgraded to give real-time feedback, or staff may need to be freed up to work on the project.

From the patient's perspective, barriers to implementing core measures may include fear of side effects of a medication or vaccination, cost of the intervention after discharge, or failure with previous interventions, especially those requiring lifestyle modifications.

Barriers to implementation from staff include uncertainty about whether the interventions are effective or safe, notes Friedley. For example, many physicians are still reluctant to give beta-blockers to CHF patients even though data show a decreased mortality for patients given beta-blockers. Likewise, some nurses are unsure about giving a pneumococcal vaccination to a patient who is admitted with an infection or a patient who may have already been immunized. "Time constraints are another obvious barrier, since staff have many interests competing for their time and energy," she says.

Obstacles for discharge instructions

In order to meet the requirements for the CHF discharge instruction measure, six elements must be addressed: activity level, diet, discharge medications, a follow-up appointment, weight monitoring, and counsel on what to do if symptoms worsen.

If all six items are not documented, you will not pass the measure.

"We know that many quality problems occur because of inadequate instructions at the time of discharge," says **Dale W. Bratzler**, DO, MPH, medical director of the Oklahoma Foundation for Medical Quality, based in Oklahoma City. To improve compliance, he recommends:

- Creating educational materials that address all of these aspects of care provided to the patient.
- Having the patient, the family, or caregiver sign forms that highlight education on these issues.
- Incorporating good discharge planning with documentation of all six elements.

Friedley recommends incorporating the recommendations outlined in the American Heart Association's "Get With The Guidelines" program. She points to statistics showing that in 2006, hospitals improved compliance from 69.6% at baseline to 79.4% after using these materials. (For more information, go to www.americanheart.org. Click on "Science & Professional," "Get With the Guidelines.")

Many top-performing organizations use a formal checklist to ensure that all required elements have been covered with the patient or family before discharge. "Use of a duplicate copy checklist is suggested so that the patient or family has one for reference," says Heinsohn. "The other becomes a permanent part of the patient's medical record as documentation that all elements were covered."

Organizations that perform well on the pneumococcal vaccine requirement have specific protocols

in place, staff that are proactively educated on the importance of the vaccine, and an established process by which a doctor's order is not required to administer the vaccine, says Heinsohn. "Hospitals without these key strategies have difficulty with the vaccine requirement."

There are a "host of reasons" that hospitals continue to struggle to achieve high rates of performance with this measure, says Bratzler. These include:

- Misconceptions about inpatient vaccination, such as believing that the vaccines don't work to prevent disease and complications, or that the vaccines are not safe for hospitalized patients;
- Physician resistance — some ascribe to the myths above;
- Systems issues, such as delaying vaccination to the day of discharge, which is a busy time, resulting in missed dosing;
- Lack of information about the patient's prior vaccination.

"There is little substance to any of the myths," says Bratzler. "Patients well enough to be discharged from an acute care hospital can safely be vaccinated. Adverse events are exceedingly rare." There is no reason to believe that hospitalized patients will react to the vaccine any differently than a patient in a physician's office, and they are probably watched much more closely, he adds.

The pneumococcal vaccine may not always prevent pneumonia, but it has been shown to reduce the complications of pneumonia when it occurs, he notes. He points to two large studies of Medicare patients, which showed that patients who have not had vaccine prior to admission and who do not get it while in the hospital, usually do not get the vaccine after they leave.[1,2]

"Hospitalization is a missed opportunity," says Bratzler. "Despite the best intentions to vaccinate the patient in the office, it usually does not happen."

The Medicare conditions of participation were modified in 2002 to drop the requirement for a physician signature to give an influenza or pneumococcal vaccine.

Standing orders are the most effective strategy for improving hospital vaccination rates with pneumococcal vaccination, says Bratzler. With these programs, medical staff approve a protocol for screening and vaccination of hospital patients, and then nursing (or pharmacy in some states) screens and vaccinates the patient without physician intervention or a physician order.

"Nursing can do this without an order, as long as there is a physician or medical staff approved protocol," he says. "No other intervention to increase vaccination rates is as effective. Here, nursing is in the position to save patient's lives by providing vaccine."

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Improve impact of rapid response with these steps

Effective teams help 'every patient in the building'

When it comes to implementation of rapid response teams, organizations fall into three distinct groups, says **Kathy Duncan**, RN, the Institute for Healthcare Improvement's faculty expert for the rapid response intervention. Here are her tips for each stage:

Organizations that have not started at all

"I think there is a huge audience out there that just hasn't been exposed at all to this concept. There are people who, for whatever reason, are just not going there," says Duncan. "They have decided they're good enough, and they really don't have any indication that they are going to

do anything in the near future."

Duncan challenges these organizations to look at the last 20 codes in their building and do an objective review. "Did you miss an opportunity to rescue this patient? Did you fail some sort of communication piece? Or did some other process fail?" she asks. "Every time someone does that exercise, what they find out is that they are not as good as they think they are."

Organizations that are still early in the process

"They have figured out this is a good thing, and are trying to get started — but they're still fumbling with some of the operational pieces," says Duncan. If this describes your organization, have a small group of people meet, ideally front-line staff from medical/surgical or critical care areas.

"They can work out details such as how to activate the team, and how to educate people so that it means something to them and is not just a poster on the wall," says Duncan. "People care what happened on the floor last night, so use examples from your own hospital."

Work on encouraging phone calls to the team by building a trustworthy system, so staff know that not only is someone going to come, they are going to come with a smile on their face. "The team has to break up those old myths we have in the hospital," says Duncan, about being reluctant to give staff "extra" work. "If I have an inkling of something going wrong, I can call one number and get three or four of my colleagues to help me take care of that patient."

Weekly meetings for 30 minutes are best, says Duncan — not to go through piles of data, but to look at what went well during the previous week and what didn't, and how problems can be fixed for the following week.

Organizations that are further along in the process

For the rapid response system to be reliable, it must work 100% of the time, says Duncan. When it does, the next step is to learn what the calls to the team really mean.

"Our STAT team has looked continually at the number of codes outside of the [intensive care unit]," says **Kim Barnhardt**, RN, performance improvement specialist at Carolinas Medical Center–Northeast in Concord, NC. "This has really been our target. We have decreased our codes per 1,000 discharges by about 60-65%."

Quality professionals review the codes to see what is being missed, and are considering doing a root cause analysis on each code outside the ICU, says Barnhardt. "We want the culture here to know that it is a very big deal when we have an arrest," she says.

To be more proactive, a new process has been implemented, with the ICU charge nurse, who is also the STAT team leader, asking every charge nurse at the "bed huddles" that occur at 9 a.m, 4 p.m., and 3 a.m., "Who are your sickest patients, and what are your concerns?"

"This has not been going on very long, so we are really just starting to see if it is making the impact we were hoping for," says Barnhardt. "We have re-structured the steering committee for this and changed leadership in the director role."

The hope is that this will bring a new perspective and insight to the STAT team, says Barnhardt. "Future plans are to have the team leaders out rounding in units each shift, and maybe even have a designated team of responders that are not in direct care in the ICU," she says.

This would allow the STAT team to evaluate the patient early, and keep in contact with the patient's primary nurse throughout the day, to get a baseline picture of what the patients of concern look like.

"Eventually, we would like to delve into the transfers into the ICU as well," says Barnhardt. "We feel that if someone is sick enough to transfer to the ICU, that the nurses should have called for a STAT response before calling and asking for a bed."

Once operational issues are working like clockwork, trends may become apparent, such as many calls for respiratory issues. Duncan recommends picking one area at a time and working on it for several months. Put every call in "buckets" — such as "Failure to Communicate," "Failure to Recognize," or "Failure to Plan." Then begin to work on them as if they are system failures.

"One of the things that pops out a lot of the time is patient respirations are shallow after being sedated after surgery, so the team is called and they give a reversal agent," says Duncan. "If you have several of those, start trending the numbers and ask, 'How do we put a process in place so we don't over-sedate people in the first place?'"

Patient-controlled analgesia pumps or protocols for postoperative orders may need to be changed. Or, calls may involve use of different or newer narcotics with doses not as understood, such as when an internal medicine provider is ordering pain medications, which may need to be brought up with the medical executive committee.

Only a few hospitals are at an advanced stage with rapid response teams. "They don't just have a

team and check it off the list and say they are done with that," says Duncan. "They are focused on every missed opportunity in their building. They have gotten codes way down to single digit numbers, and may go a month or two without a code at all."

These organizations look at every unscheduled trip to the ICU as a missed opportunity to rescue that patient. "These hospitals are really looking at it through different colored glasses, saying they want to focus on every failure," says Duncan. "They know that 99 times out of 100 it's not a person failure, it's a process failure. They drill down to fix that process failure, so they can guarantee their patients, 'If you start failing, we are going to recognize it and do something about it.'"

The ultimate goal of implementing a rapid response team is that five or six years from now, you will have corrected on system failures so that patients "never have to go down that trail," says Duncan. "Or, if they start deteriorating, you notice it in 10 minutes instead of five hours," she says. "You are not just helping that handful of patients, you are helping every patient in your building."

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THE QUALITY - CO$T CONNECTION

Are your hospital's discharges really effective?

Comprehensive assessment integral

By Patrice Spath, RHIT
Brown-Spath & Associates
Forest Grove, OR

Effective patient discharge is a priority area for all hospitals. Yet many patients who returned home after their hospital stay believe their discharge was inadequate in terms of the information they received and the information sought about their need for assistance at home.

Continuity of care is particularly important for people who have ongoing needs for care. In-hospital care planning processes must have the capacity to discriminate and respond to differing levels of need for coordination and post-discharge care. Discharge planning serves as the critical link between treatment received by a patient in the hospital and post-discharge care provided in the community.

Joint Commission standards require that discharge planning start as soon as possible. This may be prior to admission (for planned admissions) or at the time of admission (for unplanned admissions). Because proper discharge planning is important — even for patients who will be returning home — hospitals should have mechanisms to regularly evaluate compliance with the standards as well as the effectiveness of the process.

Discharge planning requires a systematic, problem-solving team approach. All members of the health care team need to be involved in one or more steps of the process:

- Assessment of patient physiological, psychological, social, and cultural needs.
- Care plan development — identifying and documenting discharge strategies as part of an integrated planning process.
- Implementation of a plan — arranging for the provision of services, including patient/family education and referrals.

Discharge planning begins with, and is contingent on, a thorough, accurate, and complete assessment by all those involved with the patient in hospital. This comprehensive assessment requires an understanding of the patient's home and social circumstances, such as:

- available family resources and preferences for post-hospital care;
- cultural, linguistic, and religious needs;
- home environmental impediments to recuperation;
- existing responsibilities not being met due to admission;
- capacity to perform activities of daily living;
- the community services that were used before admission and likely to be needed on return home.

Sources of information include the patient, family, patient's physician, and other community

providers that delivered services and care to the patient prior to admission. An assessment of the patient's post-discharge needs may also involve a home visit by hospital staff, such as the occupational therapist, to assess the environment to which the patient will be discharged.

Screen and care planning

Many patients returning home from the hospital have no continuing care needs and do not require a comprehensive assessment or plan. Often the pre-admission or admitting nurse can determine whether a patient falls into this low-risk category and referral to a case manager is not necessary. Screening criteria should be used by the nurse to identify patients in need of more comprehensive discharge planning and service provision to support their return home. The use of risk screening tools ensures that case management resources are used only for the most appropriate patients.

A plan of care must be developed to address potential problems that patients will face upon leaving the hospital. This plan encompasses treatment needs identified by physicians, nurses, and allied health professionals. Even if the patient is not seen by a case manager, a plan of care is still required and it should be written in a way that allows for quantitative analysis of the patient's progress against expected outcomes.

The patient and family must be actively involved in the care planning process. This ensures that their needs and preferences are taken into account. Another group that should be considered during care planning is the community providers that may be needed to meet the patient's post discharge needs. Consideration should be given to:

- The suitability and capacity of community providers to meet the post-discharge needs of the patient in terms of expertise and resources.
- Timing discharge to coincide with the operating hours and availability of community services.
- Providing adequate notification to community providers to ensure that services will be in place by the estimated discharge date.

Coordination and implementation of discharge activities can start as soon as the care plan is developed. Certain services may be initiated even before the patient's admission. The patient and family should receive information and education about:

- the anticipated course of treatment and dis-

CNE *questions*

17. Which is recommended regarding a physician champion for quality initiatives?
A. Avoid using physicians to explain your data to medical staff members.
B. Give data and literature to the champion and craft a change plan together.
C. Ask only department heads to be champions.
D. If no physicians volunteer, work without a champion.

18. Which is required by The Joint Commission's new medical staff standards regarding performance data for low volume practitioners?
A. If you only have data for two procedures and both patients died, it clearly indicates a problem.
B. If you only have data for two procedures and they both go well, it indicates a good track record.
C. A department doesn't need data for psychiatrists.
D. Data should be looked at as they become available.

19. Which is accurate regarding pneumococcal vaccination?
A. The vaccination is not safe for hospitalized patients.
B. The vaccine doesn't effectively prevent disease or complications.
C. Vaccination should be delayed to the day of discharge.
D. Patients well enough to be discharged from an acute care hospital can safely be vaccinated.

20. Which is recommended to improve rapid response teams?
A. Educate staff using examples from your own hospital.
B. Avoid involving front-line staff in educational efforts.
C. Discourage staff from making unnecessary calls to the team.
D. Focus on reducing staff workload.

Answer Key: 17. B; 18. D; 19. D; 20. A.

CNE 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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

charge date;
- ongoing health management;
- an appropriate post-discharge contact to answer queries and address concerns;
- medications (including reconciliation);
- the use of aids and equipment;
- follow-up appointments;
- community-based service appointments;
- possible complications and warning signs;
- when normal activities can be resumed.

Referrals must be made to outpatient services (such as radiology, pharmacy, occupational therapy) and external agencies or services (such as Meals on Wheels, home health care, maternal and child services). These referrals should occur as soon as the patient's expected date of discharge is known, to be certain that the transition from hospital to home goes smoothly. If case managers are not available to make these arrangements, staff nurses or another member of the health care team should be responsible. On the day of discharge, everything should be set for the patient's expeditious and seamless return to home.

Post-discharge evaluation

Ideally, the hospital conducts some level of post-discharge evaluation. The purpose of following up on a patient after they have left the hospital is two-fold:
- To evaluate the impact of the planned interventions on the patient's recuperation and possibly identify recurrent and new care needs.
- To assess the effectiveness and efficiency of the discharge process.

Follow-up of patients post-discharge (either via telephone and/or contact with the patient's physician or other community providers) provides the opportunity to find out if the problems identified as requiring intervention post-discharge were adequately addressed and to deal with any new problems. It also provides the opportunity to reinforce teaching initiated in the hospital and provide assurance to the patient and their home caregivers. This part of the discharge process is key to ensuring continuity of care.

The expected outcomes identified on the care plan should form the basis for questions to be asked of the patient. For example, if an exercise regime was initiated for the patient while in the hospital, this person would be asked if they are exercising and if their range of motion is improving. In addition to questions specifically related to care outcomes, the following questions may be asked to gauge the effectiveness and efficiency of the discharge process:
- How are you coping?
- Do you have any questions?
- Have you received the services arranged by the hospital and when?
- Is your family or other caregiver able to provide adequate support?
- Have you visited another hospital or the emergency department since discharge?
- Have you received services other than those arranged by the hospital?
- Were you satisfied with your hospital dis-

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

■ What to do if physicians refuse to practice evidence-based care

■ How to be sure that electronic health records improve quality

■ Proven strategies for a concurrent data collection process

■ What data you must collect for disruptive behavior

charge and post-discharge care?

Evaluation and follow-up provides the opportunity to evaluate not only the effectiveness of the discharge process, but also the effectiveness of the interventions set in motion by hospital caregivers. There are clear benefits in practicing effective discharge, such as improved efficiency, better health outcomes, and improved satisfaction for patients. An ongoing evaluation of the hospital's discharge planning process allows caregivers to identify strengths and weakness. ■

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d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	10	9
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	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
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Expect new roles, skills as quality becomes top priority

Make yourself the expert who can lead, be 'consultant to all'

Hospital-based quality professionals have a golden opportunity to step into new leadership roles, due in large part to the growing impact of pay for performance.

"Today's quality professionals have an increasing impact in their organization, as the entire health care system in the United States shifts its focus to the quality of patient outcomes and begins to tie or structure reimbursement processes to those outcomes," says **Carol L. Sale**, RN, MSN, director of performance improvement for Norfolk, VA-based Sentara Healthcare. "No longer are insurance providers paying the same thing for an appendectomy that stays two days vs. six days."

Patient safety is "bubbling to the top of the priority list" for hospitals, says Sale.

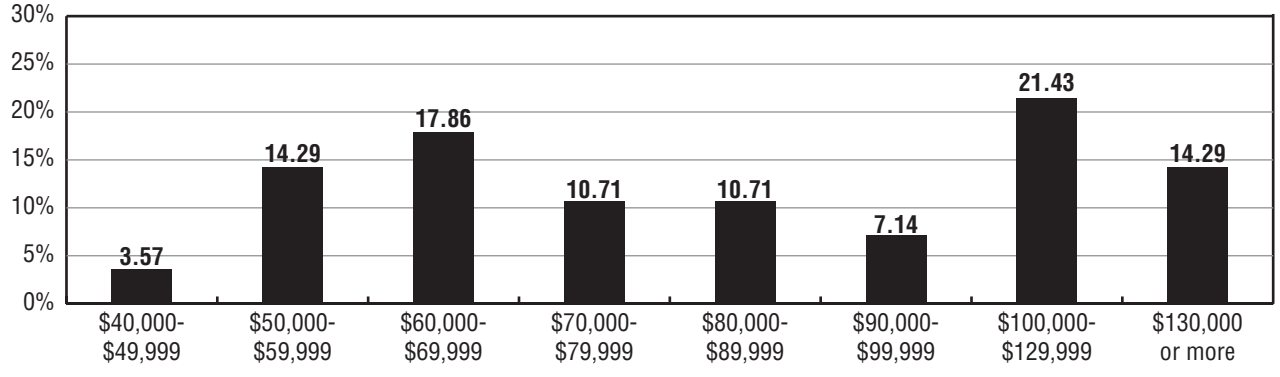
To make the most of this development, become the "consultant to all" and volunteer to help with many projects, advises **Patricia A. Wardell**, RN, CPHQ, CIC, vice president of quality management at St. Jude Medical Center in Fullerton, CA.

"Read everything you can get related to performance improvement. Increase your knowledge about infection prevention. Be the expert who can lead or mentor others to perform root cause analysis and failure mode and effects analysis processes," says Wardell.

You need analytical skills

The findings of the 2007 *Hospital Peer Review* Salary Survey, which was mailed to readers in the June 2007 issue, show that a growing number of quality professionals have graduate degrees. According to the survey, 50% of respondents have a graduate degree, while 25% have a bachelor's. "A bachelor's or master's degree for this role is

What is Your Annual Gross Income from Your Primary Health Care Position



becoming the minimal educational level many organizations are looking for," says Sale. Other key findings:

- 89% of respondents were over age 45.
- Only 7% of respondents worked in quality for three years or less, while 50% worked in the field more than 15 years.
- 43% of quality professionals supervised three people or less.

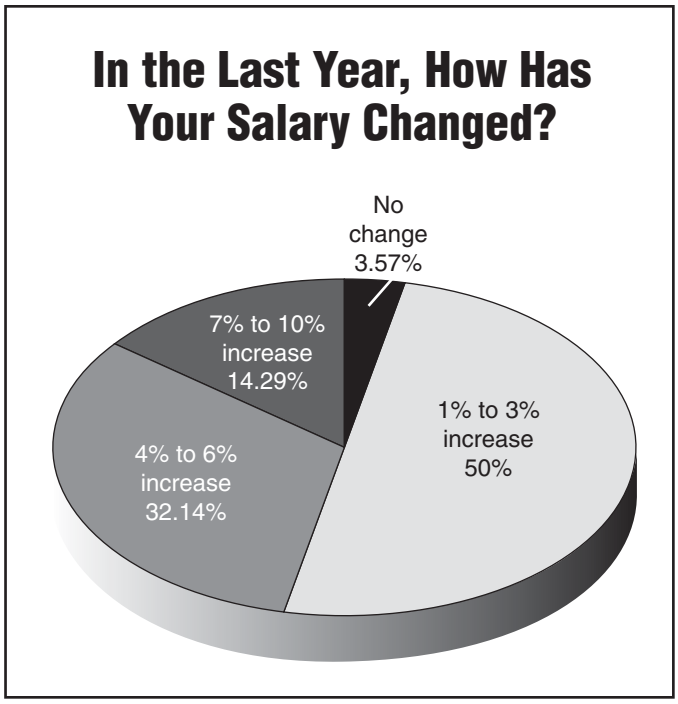
Long hours are the norm: More than half (58%) of quality professionals are working more than 45 hours a week, with 26% less than 40 hours, and another 36% work between 41-45 hours a week.

But putting in a long day's work isn't enough to really get ahead: Educational preparation and clinical experience will clearly improve your marketability and credibility, says Sale.

More and more, quality professionals are expected to have or develop analytical skills, giving them the ability to step back and look at the entire process in the sequence of patient care to identify the human factor errors, the causal factors, and what process changes need to be made to prevent a reoccurrence, says Sale.

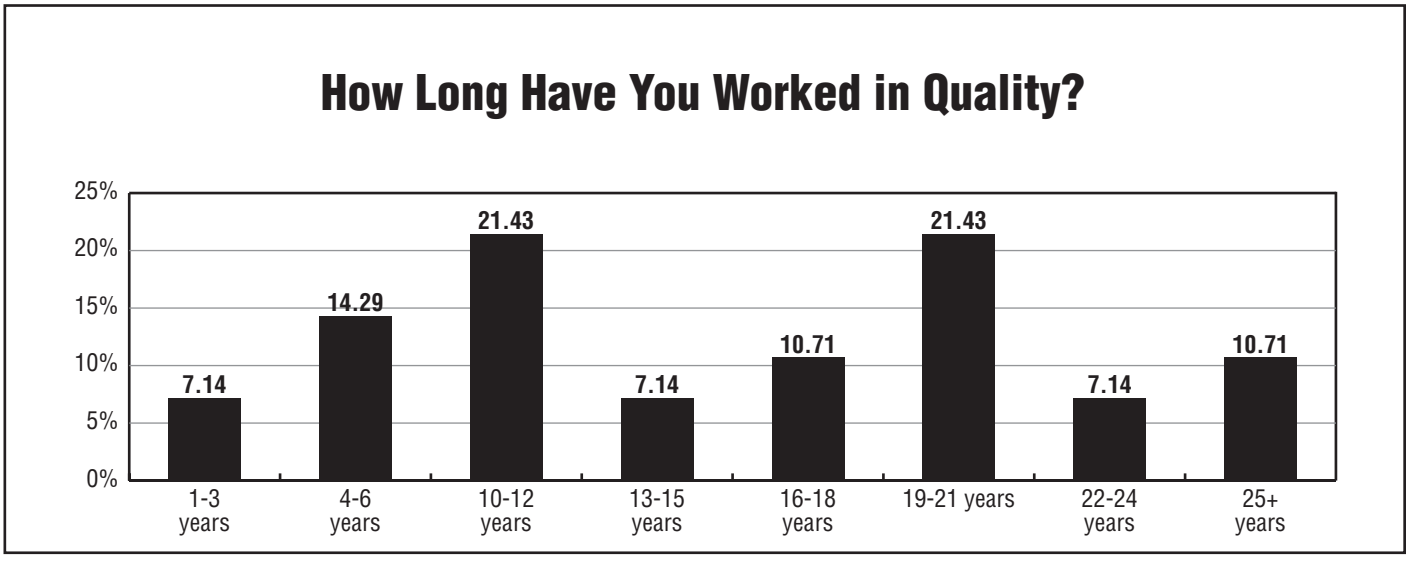
In addition, when an adverse event occurs, you need to be able to critically think about the "portability" of that event, says Sale. In other words, where else in the hospital or the health system could this type of error occur? If the failure was a lack of attention to detail or lack of having a questioning attitude, could failure of that behavior in another setting create a similar event under different circumstances?

"These are all skills that quality professionals will need to have going forward in health care," says Sale.



The industry is gradually responding to the growing demand for knowledge and expertise in these quality and analytical skills, adds Sale. Seminars and workshops dealing with data management, peer review, accreditation readiness, and event analysis are being offered by risk management consulting firms, medical staff consulting firms, The Joint Commission, the Agency for Healthcare Research and Quality, and the Institute for Healthcare Improvement.

"Education dollars tend to be the first thing that hospitals cut when funding gets tight," says Sale. "But those need to be considered strategic investment dollars to help get an organization where they need and want to go in quality management."



Obtaining credentials as a Certified Professional in Healthcare Quality (CPHQ) does three things for you: It increases professional self-confidence, it gives you more potential to become your organization's expert, and it gives you a better chance for new roles and salary increases, says **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, principal of Pasadena, CA-based JB Quality Solutions Inc.

"I have participated in the preparation of health care quality professionals for the CPHQ examination for over 20 years," says Brown. "My observations over time are that those who choose to become certified have to commit to study and be accountable for a significant, defined area of knowledge."

The CPHQ designation is now required or recommended for many roles in health plans and government-sponsored health care programs, and is encouraged and supported financially in many provider settings, adds Brown.

To command a leadership role in quality, you will need more knowledge of statistical analysis, information systems, and be able to evaluate the content of benchmarking data, says Wardell. "What web sites are reporting, where do they get their data, and how are they interpreted?" she asks. "Are the data accurate? Are they old?"

Exciting new roles

There is no question that quality management is having an increasing impact on hospital operations. New roles are being developed such as patient safety specialists, accreditation/regulatory specialists, quality coordinators, quality improvement nurses dealing with medical staff peer review, clinical effectiveness health data analysts, data analysts for health informatics, and many more, says Sale.

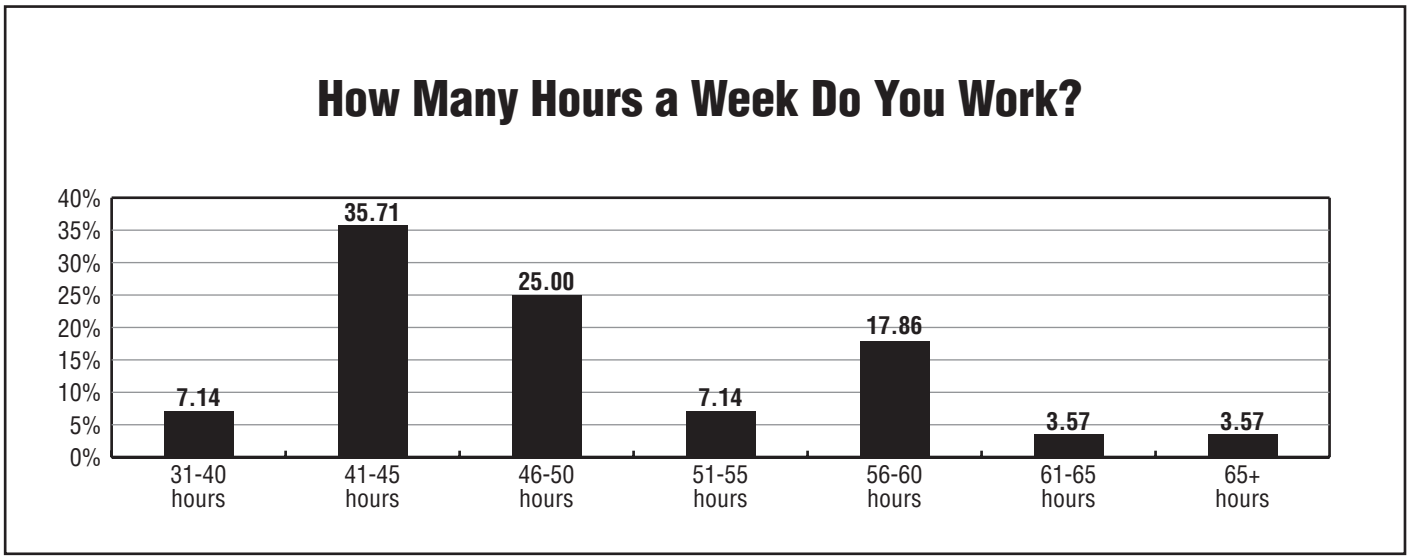
As the emphasis on public reporting grows, so does the quality professional's role as an expert to help analyze and interpret all the data, says Wardell. "The quality professional can also be invaluable when it comes to survey processes," she says. "Become the expert about The Joint Commission standards. Take on the role of survey coordinator."

Added responsibilities such as peer review, patient safety, and compliance with The Joint Commission's National Patient Safety Goals all add value to your role at your organization, which gives you more leverage to demand salary increases, says Wardell.

Quality professionals are getting involved in all aspects of organizational readiness for accreditation and regulatory compliance, including The Joint Commission, state inspections, and Leapfrog surveys, says Sale. "They are also delving into adverse event analysis, facilitating root cause analysis teams, and determining causal factors for events and how to prevent them in the future," says Sale.

Another new role is dealing with process improvements to enhance a patient's safety as they move through transitions of care — from critical care to step-down to the acute care unit, and all the ancillary services tied to their care, says Sale.

"As the health care industry begins to feel increasing pressure to improve the quality outcomes of their patient care, they will undoubtedly begin to look at their quality departments and the need to attract strong, qualified candidates," says Sale. "I would expect the dollars to follow as these roles grow and further emerge."



According to the survey, 50% of respondents reported a 1% to 3% increase in salary, 32% received a 4% to 6% increase, and 14% received an increase of 7% or greater. Just 36% of quality professionals reported an annual gross income under $70,000, with 64% earning more than $70,000, and 35% reporting incomes more than $100,000.

To really get ahead both salary- and clout-wise, you need to balance compliance duties with a leadership role for innovation in the future of health care quality, according to **Martin D. Merry**, MD, a health care quality consultant based in Sanbornton, NH.

"I feel so sad for quality professionals bogged down in compliance duties, even as I see their contemporaries who genuinely stake out territory in quality and innovation," says Merry. "I meet these successful people all the time, each of whom has escaped the 'gravity' of compliance to the 'orbit' of quality innovation."

Compliance will never be rewarded highly, while vision and innovation will be honored, promoted, and rewarded by organizations that recognize the value of these people, says Merry.

"The innovators move up, while those focused on compliance remain focused on the next Joint Commission survey," he says. "The best and brightest of the quality professionals are either honored by their current employers with promotions and financial gain, or they easily find jobs in more innovative and visionary organizations."

If you want to pursue the leading edge of health care quality, your opportunity is wide open, says Merry. "If you're comfortable with compliance, this is very good, and you will always be in demand if you do compliance well," he says. "But don't look for big salaries. Compliance is always a reactive, small game, compared to the big picture of quality innovation."

We are seeing quality professionals as vice presidents of patient care services and vice presidents for quality of health systems, says Brown. "I have one colleague and friend who moved from health care quality to work in quality and service for a major airline," she reports. "The sky really is the limit." ■