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You'll need more data, new skills for coming leadership standards

Collaboration is key to meeting requirements

The Joint Commission's new Leadership standards aren't effective until Jan. 1, 2009, but quality professionals will need to start preparing now to address new requirements for conflict management and disruptive behavior, skills required of leaders, communication among leaders, and creation of a culture of safety. A more explicit description of the role of medical staff leaders in addressing organization-wide issues also will be required.

"Play well with others" pretty much sums up The Joint Commission's new leadership standards, says **Patrice Spath**, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "While no one can deny that working together in a collegial manner is the right thing to do, achieving such an environment doesn't happen overnight — especially in those organizations with a long history of adversarial relationships among departments and disciplines," she says.

As a general rule, it takes three to seven years to change the culture of an organization, says Spath. "Organizations that haven't yet begun to meet the intent of the new leadership standards may find themselves behind the eight-ball two years from now," she says.

Safety is focus

Since the new Joint Commission Leadership Chapter focuses heavily on patient safety, safety issues will likely become the prominent focus of most performance improvement activities, says **Nancy McLean**, RN, BSN, MHSA, senior consultant at Courtemanche & Associates, a Charlotte, NC-based firm specializing in regulatory compliance.

"To meet this change in the standards, the quality professional, if not also functioning as the safety officer, will need to develop a strong collaborative relationship with the safety officer," says McLean.

By far, the biggest mistake people make when trying to change the organizational culture is to plunge ahead without establishing a high enough sense of urgency among all stakeholders, says Spath. "Don't overestimate how easy change will be, especially when changes may drive people out of their comfort zones," she says. "Meeting the new leadership standards

will take more than holding a few meetings or sending out a few memos."

At University of Washington Medical Center in Seattle accountability for safety culture has already been integrated and defined with the governing board, senior leadership, and medical staff leadership, says **Cindy Angiulo**, MSN, RNC, assistant administrator of patient care services.

"In alignment with our patient- and family-centered care model at the medical center, we have also included patient and family advisors at this oversight level," says Angiulo.

On a regularly scheduled basis, formal multidisciplinary committees review performance improvement initiatives and outcomes, reported safety and quality issues, and oversight of key quality measures and safety indicators, adds Angiulo.

Quality professionals at Minneapolis-based Fairview Health Services are currently working to establish a policy for disruptive behavior that is consistent at all hospitals in the system, says **Alison H. Page**, MS, MHA, the organization's chief safety officer. Most of the hospitals already have policies addressing appropriate conduct and behavior expected of employees and medical staff.

"We have had policies in place to deal with disruptive behavior. We are doing more and I would like to see use of 'restorative justice' and 'just culture' principles," says Page. "We are moving to a better place on managing this issue, regardless of The Joint Commission."

Fairview's new policy underscores the connection between behavior and patient safety, and attempts to provide helpful details in terms of expected norms, says Page.

The organization also is working toward establishing policies and behavior expectations that prevent disruptive behavior from occurring in the first place, says Page. "For example, we are implementing team training, which focuses heavily on the need for respectful relationships amongst clinicians," says Page. "We believe patient safety and care quality are greatly enhanced when the organizational culture reflects healthy communication and professional, respectful behavior on the part of all practitioners."

New roles for quality

The new standards likely will place the quality professional in an investigative role in order to determine if a given conflict adversely affects quality and safety of care, says McLean.

"Governance, leadership, and the medical staff will need to determine who will be trained, or is already trained, in conflict management and will be given this responsibility," she says.

At first glance, the likely candidate for this role appears to be a behavioral health professional, but the standards state that the individual is charged with "protecting the safety and quality of care," notes McLean.

"Taken as a whole, the focus in the chapter is

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on safety and quality of care. The quality professional has long been the guardian of quality care," says McLean. "The additional responsibilities will slip easily into their current role."

Some additional training in conflict resolution may be required, but most quality professionals are already adept at this skill, and are aware of the importance of focusing on incidents and behaviors as opposed to individuals, says McLean.

The standards place a strong emphasis on collaborative relationships. "The proverbial three-legged stool model of hospital leadership, where each of the three major players — governance, leadership, and the medical staff — balance each other and carry equal influence, is being pushed to strong collaborative relationships with the new standards," says McLean.

The Leadership Relationships section focuses entirely on collaboration among governance, leaders, and the medical staff, adds McLean, with the goal of managing conflict between leadership groups to protect quality and safety of care.

"This is a forced collaboration, holding all three groups accountable for the priority focus of quality and safety of care," says McLean.

A few years ago, University of Washington Medical Center developed a professional collaboration policy for medical staff and physicians in training. The goal was to create an environment of professional collaboration that promotes communication, to improve clinical outcomes and patient safety. "It is this policy that identifies the accountability of medical staff to conduct themselves in a professional and cooperative manner," she says.

The policy also encourages prompt identification and resolution of alleged disrespectful or disruptive behavior. "Informal, collaborative efforts are used to restore a member's behavior to actions consistent with policies and professional standards," says Angiulo. The policy identifies a formal procedure for investigation and resolution, for cases in which behavior has not been appropriately modified by these informal efforts.

Your hospital's process should address whether records will be kept regarding any conflict resolution activities, says McLean. "In development of the process, remember to be sure to include all the requirements and be careful if you choose to put in additional requirements which are not required by The Joint Commission," she cautions.

Once any requirements appear in a policy or are a part of your process, you must follow these closely or risk getting a requirement for improvement for not following your own policy, warns McLean. "Once again, the quality professional is invaluable in helping to build the least restrictive process or policy that meets The Joint Commission standards," she says.

Data on conflicts

Quality professionals will need to gather data on how often interpersonal conflict and disruptive behaviors are occurring, says Spath. "Some hospitals have developed something like an incident report for these occurrences," she says.

You may also be involved in assisting the medical staff or hospital to develop definitions for conflicts and disruptive behaviors, adds Spath. She recommends taking these steps to prepare for the new Leadership requirements:

• Go through the standards and highlight all of the "must have" or "must do" requirements.

"Then, conduct a gap analysis," says Spath. "What do you already have in place? What still needs to be completed?"

• Identify the individuals or groups responsible for creating the new policies or performing the activities required by the leadership standards.

For instance, what department is responsible for coordinating the annual safety culture survey? What individuals/groups will review the survey results and determine how to respond to improvement opportunities?

• Define what constitutes a conflict or disruptive behavior that could affect safety and quality.

Conflict between people is a fact of life — and it's not necessarily a bad thing, says Spath. "However, it becomes a bad thing when it potentially interferes with the provision of quality patient care," she says.

Conduct that is often considered disruptive includes sexual harassment; shouting; using vulgar, profane or abusive language; and other forms of intimidating or abusive behavior, says Spath.

• Create a process for disclosing conflicts or disruptive behavior.

Determine how reports will be made, who will receive the reports, and how incidents will be investigated and resolved. Often, incidents involving physicians are reported to the chief of staff or department chief, and incidents involving

hospital employees are reported to the CEO or a division senior leader.

"It should be clear how reports are investigated and what will be done if the physician or staff member has engaged in disruptive behavior," says Spath.

• Determine how you'll measure whether people are indeed "playing well" with one another.

"This is where the quality department plays an important role," says Spath. For example, the organization's leaders will need data that show whether the culture is changing for the better and if communication among caregivers has improved.

"Such information is not always easy to obtain. Start now to identify the measures of success," says Spath.

Some of these will be process measures, such as whether the conflict of interest policy is being followed as required. You will also need to identify outcome measures, such as the number of patient incidents attributed to communication breakdowns among the health care team.

"Measurement will need to continue for quite some time," says Spath. "Until changes sink down deeply into the culture, new approaches are fragile and subject to regression."

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The Texas Medical Association, Physician Health and Rehabilitation Committee has developed a model medical staff code of conduct policy, which is available on-line. The policy can be accessed at http://www.e-tmf.org/code_of_conduct.asp.] ■

Take these steps for noncompliant physicians

Work with, not against, physicians

When it comes to non-compliance by physicians for core measure requirements, quality professionals often feel powerless — they have plenty of data but not enough clout.

"This is a challenge nationally, and is not an issue related to one particular institution," says **Gregg Meyer**, MD, senior vice president for quality and safety at Massachusetts General Hospital in Boston. "The truth of the matter is, there is no one right approach or any magic bullet."

Here are steps to take to address this problem:

1. Start with the premise that, by and large, physicians want to do the right thing.

"If that's the case, then why is it we are not giving the right care and ordering the right medications with 100% reliability?" asks Meyer. One problem is general awareness — although many hospital administrators can probably cite the list of core measures right off the top of their heads, it's rare to find physicians, unless they spend a lot of their time focusing on quality, who can do the same, he says.

"Although some of the data have been out literally for decades, for example in terms of the importance of prescribing beta blockers for heart attacks, it takes a very long time to translate research into practice," says Meyer.

2. Acknowledge that physicians have limited resources.

Physicians may feel that they need to choose other priorities because these are more pressing needs than compliance with core measure requirements. "Physician may think there is something much more important to do," says Meyer. "At the end of the day it may be important for me to see that this patient gets pneumococcal vaccine, but I really need to focus my efforts to ensure that they don't need to be put on a ventilator."

3. Make it easy for physicians to comply.

"My sense is that we could really do a much better job than is generally done, to make it easy to do the right thing," says Meyer.

He suggests getting physicians onto computerized systems where they are prompted to make sure that a heart failure patient goes home on the right medications, or flagged to make it easy to see

whether a patient has been vaccinated in the past.

"A lot of times, people fall into the trap of saying 'We need to do these things because they are core measure requirements and therefore we need physicians to do them,'" says Meyer. "But much of the time, it is actually teams and systems that are needed, and this should be an important focus for quality professionals."

Confront non-compliance

What if after all of these issues are addressed, a physician still does not comply, leading to poor compliance scores being publicly reported? "My experience is that this is a pretty rare event. This is not going to be a commonplace phenomenon," says Meyer. The first thing to do is to talk to the individual to understand the reason for their non-compliance, he advises.

"Sometimes you can learn some of the most valuable information from the person who is holding out, instead of saying they are a bad apple and we need to bend them to our will," he says.

In all likelihood, the physician truly believes that he or she is doing the right thing, just as staff who develop "workarounds" are trying to come up with a way of doing things more efficiently, says Meyer.

Core measure compliance is an issue that reflects whether the medical staff are engaged with the hospital around its quality agenda, says **Alice Gosfield**, a Philadelphia-based attorney and consultant specializing in quality improvement. "If you want to engage physicians on quality, focusing on 'core measures,' per se, likely won't get you there," she says. "That said, the issue becomes the nature of the defiance."

For instance, a physician may tell you that "I won't do it because I don't believe in the measure," which, in a facility that is really serious about quality, would raise an issue to be addressed as a serious matter to take into account in maintaining clinical privileges, says Gosfield. "But, if 50% of the medical staff are not there, then you have a very different set of problems, because your culture hasn't caught up with your rhetoric," she says.

Physicians may be resistant to relinquishing clinical autonomy to conform with evidence-based medicine, or view core measure protocols as "cookbook medicine," says **Julia Slininger**, quality improvement advisor for San Francisco-based Lumetra's Hospital Project Team. "In addition, there may be a gap between training on core measures and accountability," she adds.

If this is the case, use a "top down approach," with extensive leadership involvement from the board, CEO, or department chiefs. "On the floor, quality management staff, with the assistance of the nursing staff, can identify events of non-compliance and educate the physicians," advises Slininger. "Change bylaws to link performance in quality measures to reappointment."

Also, inform physicians that adherence to these measures will most likely in the future be linked to Medicare reimbursement with the Physician Quality Reporting Initiative. "Explain that it's beneficial to get on board now," says Slininger.

"Getting compliance with core measures has been a challenge, and one that we are proud to say we have tackled," says **Denise Murphy**, RN, MPH, CIC, vice president of safety and quality at Barnes-Jewish Hospital in St. Louis, MO. "That doesn't mean every one of our measure scores is perfect, but it means that our medical staff are committed to on-going improvement to achieve safe, high-quality care for our patients."

Early on in the process, clinical department chairs helped identify physicians whose research interests aligned with the hospital's performance improvement agenda. Clinical nursing directors identified patient safety champions among the ranks of the junior faculty and house staff.

"Through these search efforts, we identified a core group of physicians whose efforts and eventual success stories laid the foundation upon which we have built a larger pool of safety and quality leaders," says Murphy.

As a result, medical staff actively participate in performance improvement initiatives to tackle "broken" processes and lead teams for several clinical improvement initiatives. "They have helped create on-line education modules, altered processes, redesigned the structure of treatment rooms, standardized training, and even changed call schedules to improve patient outcomes," says Murphy. "We have improved every core measure since we began this aggressive PI work."

Acute myocardial infarction reperfusion times improved from less than 50% to 100%; timely preoperative antibiotic delivery measures improved from 70% to 98%; and infection rates for ventilator-associated pneumonia are near zero for the hospital's six intensive care units.

"Much of this is related to physician partnerships in performance improvement," says Murphy.

Early in the process, a small group of cardiolo-

gists, emergency department physicians, and trauma surgeons agreed to learn Lean Engineering and Six Sigma concepts. These "early adopters" led the way through change once they saw how the study, redesign, and standardization of processes not only improved outcomes but streamlined their work.

That's an important realization, says Murphy, since non-compliance often is due to workload constraints.

When non-compliance does occur, the chief medical officer or a physician champion contacts the person involved, often using data or evidence from studies or guidelines, always with the focus on the organization's commitment to patients.

"We try to never use compliance with regulatory requirements as a reason for providing safe, high-quality care," says Murphy. "Physicians are more inclined to comply when they hear the evidence or rationale, and are approached in the spirit of wanting to do the right things for patients."

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Work with physicians on core measures: Here's how

Some aspects of core measure compliance call for a "handshake" between quality professionals and physicians, says **Christopher Sharp**, MD, **c**linical assistant professor at Stanford (CA) University Medical Center. Here are the best ways to collaborate:

• Give prompt and accurate feedback.

Physicians need to have some kind of report on how they are actually doing, which needs to be both accurate and specific to the physician. "It also needs to be timely. If feedback comes long after the event occurred, it's hard for it to be utilized," says Sharp.

"Some institutions have even taken that to the point of concurrent feedback, which is probably ideal." With real-time intervention, if physicians haven't embarked on the right process step, it can be recognized and rectified almost immediately.

• Be sure your data can hold up to scrutiny.

It's certainly true that physicians respond to data, but it's equally true that they will always question the validity and robustness of the data, says Sharp. At Stanford, quality professionals make sure that quality data are "very robust," which almost always requires individual scrutiny of the extracted data, he says.

"You can use tools that pull data from billing codes and automated databases, but we have found it takes someone actually looking at the chart with at least an abstracting background if not a clinical background," says Sharp. "You want to be able to say, 'Aha! This patient should have been included in this measure and here is why.'"

Otherwise, these errors may be caught by physicians themselves, who don't like bad grades and will push back strongly if they feel the data are faulty.

You need to have physicians validating the content of the data you provide, and validating the way you give feedback to individuals.

"This is difficult to do in a 'silo,'" says Sharp. "The idea that a quality professional can influence physician behavior without having a physician be intimately a part of that process doesn't work."

At Stanford, a cadre of unit-based medical directors was created, with each physician assigned to a given unit to work directly with nurse managers on key quality issues, including core measures.

Quality professionals give the physician unit-specific data on core measure compliance, and it's then the physician's responsibility to look at the data and see how they can improve the process.

This approach is financially supported by the hospital, adds Sharp, in order to send a message that it's valuable enough to pay for a certain portion of the physician's time to do this. This makes the physician more accountable to the hospital for that time, more so than if they were doing it on a volunteer basis, says Sharp.

"Once the data are provided to them, it's theirs to act upon," says Sharp. "We have found that if we provide the data back to an individual on that

Continued on p. 171

PATIENT SATISFACTION PLANNER™

Six Sigma project slashes LOS for SNF discharges

Initiative targets ambulation, early assessment

The length of stay for patients being discharged to skilled nursing facilities from St. Joseph's Hospital progressive ventilator care unit dropped by 7.5 days (a 47% reduction) following a Six Sigma pilot project that focused on better ambulation of patients, earlier screening for potential skilled nursing admissions, and timely discharge.

"We discharge a lot of patients to skilled nursing facilities. We felt that their length of stay was longer than it should be and that there were opportunities to coordinate the care of these patients in a more efficient and effective way, while improving the length of stay and the outcomes," says **Elizabeth Galvin**, RN, MBA, manager of clinical resource management for the Tampa, FL, hospital.

St. Joseph's Hospital is part of BayCare Health System, which includes nine not-for-profit hospitals in the Tampa Bay area.

In addition to the overall improvement in length of stay, the six-month project achieved the following outcomes in areas where the team focused:

- Functional status assessed upon admission increased by 28%. Activity levels ordered upon admission for a patient went up 131%. Ambulation one to two times a day for eligible patients rose 71%.
- The number of discharge planning assessments completed within 24 hours of admission increased by 43%. The percentage of discharge orders executed on the same day they were written rose by 25%.

The project was designed and implemented by a multidisciplinary team that included representatives from case management, social work, nursing, medical assistance, finance, medical records, and pastoral care, according to **Tanya Siddiqui**, Six Sigma Black Belt, who led the team.

The Six Sigma team chose 5 North, a step-down intensive care or progressive care unit for the pilot project. The unit has multiple patients on ventilators and with tracheostomies, and discharges a large percentage of its population to post-acute facilities, Galvin says.

"We chose this unit because the population has very complex needs and a high length of stay. The quality of nursing care and leadership was another factor in our choice. We knew we could count on the staff for the extra effort involved in any pilot project," Galvin says.

Patients in the progressive care unit include trauma patients, those with severe chronic illnesses, cardiac patients, or postoperative patients who need to remain on life support. They require a lot of complex care but are more stable that patients in the intensive care unit, says **Joanne Mayers**, RN, nurse manager of the unit.

"We face some unique challenges in our unit because of the clinical complexity of our patients, along with the fact that many of them are unfunded. We have a difficult time placing them because there are limited options in the Tampa area for discharging patients who are on a ventilator and who do not have funding," she says.

The team began the process in December 2006 by determining what the problem was and identifying opportunities for improvement.

They reviewed charts for a one-year period to determine what roadblocks prevented patients from being discharged to a skilled nursing facility in a timely manner.

"We all had feelings about why length of stay was longer than it should be and what the opportunities were. Part of the process was to determine what the issues were using statistics not anecdotal information," Galvin says.

The team identified three main areas of focus: ambulation of patients, early identification of potential skilled nursing and rehab discharges, and executing the discharge orders the same day they were written.

The team then drilled down to determine specific steps that could be taken to make improvements in each of the key areas.

'Ready, Sit, Go!'

They developed a pilot called "Ready, Sit, Go!" to alert the staff to the Six Sigma Project and its goals.

"We conducted education for all the nurses on the unit. Case managers and social workers were also involved in getting the word out that the project was going to begin," Siddiqui says.

During its chart review, the team determined that some patients, particularly those who came to the unit from intensive care, were becoming debilitated because of extended stays in bed.

"Many of the patients on the unit don't necessarily have to stay in bed. This was a big change in mindset for the physicians, nursing staff, and case managers," Mayers says.

Among the goals the team set were having all patients assessed for functional status as soon as they were admitted to the unit and making sure that everyone on the unit has activity-level orders within 24 hours.

If the physician doesn't order bed rest, the goal is to have the patients up in a chair a minimum of once a day and to ambulate them if they are able.

"Physical therapy did an inservice for staff on mobilization to teach them how to get those patients moving. Many of the patients on the unit could be ambulated by a nurse, instead of a physical therapist," Mayers says.

In addition to shortening the length of stay for patients going to skilled nursing facilities, the increased attention to ambulation also resulted in a decrease in the number of patients who needed to go to an extended care facility, Siddiqui says.

"Ambulating the patients more during their stay in a progressive care unit helps improve their conditions and allows them to go home healthier. This project has improved patient satisfaction and decreased the cost of health care. Patients are going home healthier with improved outcomes and their insurers aren't being billed for skilled nursing care," Siddiqui says.

In addition, because of the positive outcomes from the Six Sigma project, the nursing unit purchased a second special power chair that folds down to allow nurses to slide patients out of the bed, rather than lifting them.

"Like many hospitals, we have a no-lift policy because of increasingly morbidly obese patients. It's a challenge to get them up when they are obese and on a ventilator. Getting the new equipment makes it easier," Mayers says.

Like any new initiative, the idea of increased ambulation of patients initially met with resistance.

"The nurses completely support the process now that they have seen dramatic improvements from the ambulation. It's made the atmosphere on the unit more progressive and positive," Mayers says.

The project's goals called for a proactive approach to identifying patients who were likely to be discharged to a skilled nursing facility in order to facilitate getting the patients transferred once the order is written.

The nurses began screening patients upon admission or transfer to identify good candidates for a skilled nursing facility and alerting the case manager and social worker.

The social workers concentrated on getting the discharge planning assessment completed within 24 hours of admission to the unit.

"The social workers look at all of the aspects of the discharge from payer status and medical diagnosis to the support system at home early in the stay. They start talking to the patient and family about skilled nursing care early in the stay, getting them accustomed to the fact that the patient may not be discharged to home," Mayers says.

The team added a section to the discharge planning form that includes information about patients likely to be discharged to skilled nursing facilities. The case managers and social workers have a place to note information such as family concerns, copays and other insurance issues, potential outcomes, and deterrents to admission.

"We identified key family issues involving transferring patients to extended care facilities and tried to address them and to improve communication with the family in regards to these issues," Galvin says.

For instance, the terms "nursing home" or "skilled nursing facility" tend to have a negative connotation with family members. Instead, staff tell the family that the patient needs to go to a facility for rehabilitation.

The team determined that not all patients were discharged to a skilled nursing facility on the day their discharge orders were written, many times because the paperwork wasn't in order or medication reconciliation had not been completed.

In some cases, the physician fails to sign all the required forms for discharge; in other cases, the facility the patient wanted may not be available. Sometimes, transfers are held up by the patient's special needs or by requirements from a managed care organization.

"We are working to get the paperwork complete and everybody on board," Mayers says.

The interdisciplinary team on 5 North has a weekly length of stay meeting attended by their

physician advisor and Galvin, during which the team looks at long-stay patients and obstacles to discharge.

In addition, 5 North holds weekly interdisciplinary rounds to look at discharge issues with input from the rehab team on how the patient is improving physically.

During the daily huddle, the case manager, social worker, and charge nurse discuss any obstacles to discharging patients.

The nurses write the patient goals for each day on a dry-erase board placed in the patient rooms where it can be seen by the patient and family.

"It helps us communicate goals from shift to shift and keeps the patient and family aware of the goals," Mayers says.

Following the success of the Six Sigma project, the team is continuing to look for other opportunities to improve length of stay. The hospital is forming partnerships with extended care facilities and developing tools, such as virtual tours of facilities, to help the patient and family make informed decisions, Siddiqui says.

"We are involving the extended care facilities in this initiative, making sure they get a liaison on site to talk to the patient and family about issues and questions they may have. In addition, representatives from hospice care and palliative care are part of the rounds on the nursing floor and the unit," she adds.

The clinical resource management department at St. Joseph's is responsible for coordinating the care of adults in the main hospital. The average daily census for this group of patients is 425.

The department includes RN case managers and social workers who are unit-based.

The case managers have primary responsibility for utilization review, tracking and reporting avoidable days, managing observation patients who are placed throughout the hospital, tracking and reporting evidence-based measures, and driving the length of stay for their units.

The social workers have primary responsibility for completing the initial discharge planning assessments and coordinating the discharge planning process to alternative level of care facilities. They address patient psychosocial needs and arrange other discharge services such as transportation, outpatient therapy, unfunded patient prescriptions, and community services.

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Despite longer wait times, satisfaction still improves

Communication is critical for patients to be happy

In findings that at first glance may seem puzzling, the 2007 *ED Pulse Report* patient satisfaction survey by Press Ganey Associates indicated that while ED wait times continue to increase, so does patient satisfaction.

The survey shows that the average time a patient spent in the ED in 2006 was four hours, compared with 3.7 hours the previous year. However, overall satisfaction peaked at 83.1% during that same year, compared with a high of 82.9% in 2005. Even more striking, it was only 81.4% in 2003 and has steadily risen since then.

The answer lies in communication, says **Matt Mulherin,** a spokesman for Press Ganey. "EDs can compensate for wait times going up by providing better service quality in terms of communication," he says. He offers the analogy of an airline that has discontinued meal service. "That may tend to make customers less satisfied, but if at the same time you roll out a new rewards program or offer better communication from attendants, there will not be a drop in overall satisfaction," he says.

In the same way, EDs can compensate for long wait times by improving communications, Mulherin says. The patient typically is a well-informed health care consumer, he says. "They read about rising numbers of uninsured [in EDs], understaffing, and overcrowding," Mulerhin says. "They will have a higher tolerance as long as you are respectful of their time and keep them informed."

Improved communications may not be the only reason for increasingly high patient satisfaction scores, argues **Michael Carius**, MD, chairman of the ED at Norwalk (CT) Hospital. There also is an increased expectation regarding patient satisfaction on the part of hospital senior management, he says. "This has been impressed on those of us who are middle managers — ED chairs and nurse managers — or else perhaps we might enjoy employment elsewhere," Carius says. "There is also a general sense among all caregivers that patient satisfaction is important by itself, although this has a long way to go."

ED managers agree that beyond one hour, or

possibly two, the effect they can have on patient satisfaction drastically decreases, and that is borne out by the survey results that show satisfaction dropped as wait times increased.

If you see the patient after an hour, the key is to apologize for the wait, advises **Gregory Henry**, MD, FACEP, risk management consultant with Emergency Physicians Medical Group in Ann Arbor, MI. "You never, ever get into a fight with a patient over the wait time," he says.

Apologize first

At Wake Forest University Health Sciences in Winston-Salem, NC, "when our waiting times go beyond one hour, our faculty, residents, and nursing staff know to greet the patient with a simple apology for their wait, and then begin addressing their care needs," says **Bret A. Nicks**, MD, assistant professor and assistant medical director in the department of emergency medicine. "In addition, when our wait times are several hours, we routinely have someone make an announcement in the waiting area explaining that it is very busy in the ED and we appreciate their patience and will take care of their medical needs as quickly as possible."

The critical time appears to be two hours or less, Carius says. "Less than two hours and you have an opportunity to intervene," he says. During that time, Carius adds, his staff use handouts to explain the triage process and occasional long waits.

Norwalk has signs in the patient rooms explaining the long waits. They also have volunteers that carry the messages to the patients and families about the waiting times. "We apologize endlessly for delays that are beyond our control," Carius says. "But, in the end, if the wait is more than two hours, it is a losing battle."

How the patient perceives the wait also is a key factor, notes Henry. "If I say I think a blood test will be back in 40 minutes even though I know it's almost always 20 minutes, I'll be a hero if it comes back in 35 minutes," he explains. No patients complain if you say, "'We're done now, you can go early,'" Henry points out.

It's important for the ED physician to give all patients "anticipatory guidance," Henry says. "We lay out for them a realistic time frame and, when pushed, always overestimate the time," he says. "After all, you get to set the expectations."

Finally, says Henry, it's at least as important to concern yourself with family satisfaction as it is to focus on patient satisfaction. "More [complaint] letters are written to administration by, or prompted by, the family than the patient," he says. ■

Keep the patient's 'internal clock' in mind

Once a patient makes the decision to seek emergency care, their "internal clock" starts, asserts **Alex Rosenau,** DO, FACEP vice chair, department of emergency medicine, at Lehigh Valley Hospital and Health Network, Allentown, PA. The time to pain relief, the time to seeing the physician and then to final disposition are all significant points in their treatment journey, he explains. "Many techniques can help the patient to progress through the visit and still obtain a reasonable degree of satisfaction."

Bedside registration, triage staff test ordering, communication with the patient, and assurance from a physician that the patient was not forgotten all help in moving toward the goal and in satisfying the patient, Rosenau continues. "Pain relief is critical, and explanations by each staff member are immensely helpful," he adds.

TV's and phones in the room provide some help in the stable patient, and for their supporting family and friends, Rosenau notes. "Liberal use of the blanket warmer to assure personal comfort and, if appropriate, providing food and/or drink are some of the personal amenities that relieve discomfort and show professional yet personal caring," Rosenau observes.

Finally, he says, how the visit itself is "orchestrated" can set the tone for a good memory and a successful outcome. "Proper introductions to everyone in the room, listening through allowing a full airing of the patient's story — preferably with at least a few moments sitting at the bedside — answering questions and addressing unstated fears are all appreciated by patients," Rosenau shares. "Proper discharge instructions along with a printout of lab and imaging results to take back to a private physician are not only medically helpful, but are appreciated by the patient and their external medical care provider." ■

Continued from p. 166

level, it can be actionable, whereas if it is provided to an entire department, it is more diffuse."

• Work with physician champions to share best practices across units.

The cardiac unit may have very streamlined processes for cardiac measures, but the surgical care improvement project measures might get more focus in other units — yet, all these measures carry the same weight when reported. If a unit is struggling with compliance for a certain core measure, the quality professional acts as a liaison, working with physicians to bring best practices from other units, says Sharp. "A post-surgical unit will have different issues than a cardiac unit," he says.

• Designate specific individuals for each measure.

By having unit-based medical directors assigned specific core measure areas, the "go to" person for a given measure is clearly delineated, says Sharp. "That is something we didn't have before that we have always struggled with," he says. "This makes it very 'local' and allows you to enlist the help of a unit-based medical director, instead of going to the chief of staff yet again."

This way, quality professionals can go right to the champion to say, "We see that your unit is dragging with this measure. How can we help you? What are you not receiving from us that we can help you with?"

On several occupations, quality professionals have asked the champion to ferret out the reason for a certain physician's noncompliance. "Engaging a noncompliant physician is probably best done by another physician, who has the context and authority to approach that individual," Sharp says.

This allows for a frank conversation to take place, which may unearth surprising reasons for non-compliance, such as a physician's belief that a given patient should not be part of the guidelines. For example, the hospital has a population of patients who have had cardiac transplants, and there has been resistance around standardized procedures for vaccination for these patients — with valid reason.

"To get to the bottom of this required some peer to peer discussions," says Sharp. "In this unique population, any adverse event leads to a dramatic and tremendous workup." Physicians were aware that if their patient got a low-grade fever as a result of the vaccine, that would result in a slew of evaluations and tests.

"So we had to work with them to make sure that vaccination occurs before the patient is hospitalized," he says. "Further, if a cardiac transplant patient is significantly immunosuppressed, then they should not be falling into this measure. We have worked with our physicians to document this exclusion criterion, so that we win in this unique patient care population and the core measures."

• Try to see things from the physician's point of view.

While as a quality professional you would love to see 100% compliance for every core measure at your organization, the physician's goal is somewhat different, says **Steven Tremain**, MD, director of system redesign at Contra Costa (CA) Regional Medical Center. Simply put, the physician wants to do the best thing for the patient. Medicine cannot be reduced 100% of the time to protocols, emphasizes Tremain.

"What evidence-based medicine says is, the majority of patients will get the best care if we follow these steps. It doesn't say *all* patients," he says. "We are not looking for 100% compliance because that oversimplifies medicine."

However, physicians must document contraindications to allow for recognition of patients who can be excluded from core measures, stresses Tremain. "This also helps to identify physicians who need more coaching, and documents the need for 'push back' against certain core measures," he says.

He points to the controversy over the core measure requirement for antibiotics to be given within six hours of a pneumonia patient's arrival. (Initially, the measure required administration of antibiotics within four hours of presentation, but The Joint Commission increased the time frame to six hours after receiving complaints from the field. In addition, physicians are allowed to use a new data element, "diagnostic uncertainty," if the patient's diagnosis of pneumonia was not clear at arrival. Cases reflecting this data element will not be included in determining adherence to antibiotic timing standards.)

It is often impossible to determine whether the patient has pneumonia until eight hours after arrival or longer, says Tremain. To get 100% compliance with the previous requirement, physicians would be encouraged to give antibiotics for patients who wind up not having pneumonia, while overprescribing of antibiotics has been linked to hospital-acquired infections and "superbugs."

"This creates a monster. You can't tell if the patient has pneumonia, and so you end up giving

a whole bunch of people antibiotics who don't need them," says Tremain. "That is what is happening across the country so people don't get dinged."

The goal should be to give antibiotics when the pneumonia is recognized and not before, says Tremain. "If we are not careful, we will end up treating the paper instead of the patient," he says.

A smaller group of physicians don't have valid concerns about core measure requirements and simply resent being told how to practice medicine. "Some physicians still say, 'This is my God-given right to make all of these decisions, I'm smarter than the rest of you and don't you dare tell me how to practice.' But the culture is changing. There is a new breed who want to practice scientifically based medicine. But we need to agree upon what the science says," says Tremain.

Bear in mind that core measures are a "huge culture change" for physicians, adds Tremain. "We've been telling doctors for 2,000 years that they know best, and now in the last few years, we are saying there are some things that ought to be more automatic because the science knows best," he says.

Tremain says that there is no question that core measures can improve care. "I have spent years leading this kind of change, but I think we have to be careful about how we do it," he says. "We want to make sure we push the right behavior. When all is said and done, we want to create a safer environment, not just look better on paper. It's all about the patient."

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A White Paper on physicians and quality is available from the Institute of Healthcare Improvement free of charge. This resource includes tools to help hospital leaders create a written plan for physician engagement in quality and safety, and identify and prioritize initiatives for which physician engagement is essential. It can be accessed at http://www.ihi.org/IHI/Results/WhitePapers. Click on "Engaging Physicians in a Shared Quality Agenda."] ■

THE QUALITY - CO$T CONNECTION

Reporting organizational performance graphically

Which chart type should you use?

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

To enable senior leaders to gain knowledge about quality and safety performance within the organization the quality department should create a concise, yet complete, measurement report.

A balanced scorecard approach is often used to get the full picture of the health of an organization. An advantage of the balanced score card approach over the single aggregate measure is that individual measurement results can be seen. The balance scorecard has been likened to an airplane cockpit. Rather than giving pilots just one "trouble light" (the plane is either OK or not OK), a bank of gauges is supplied so that the pilot may see trends and where any trouble is developing. Certain alarm values exist to draw the pilot's attention when problems arise. Similarly, the balanced scorecard provides an overview of organization performance. "Alarm" levels can be built in through established targets or statistically defined control limits.

There are many types of graphic data displays that can be used to present performance measurement results and there are a few universal rules about which type of graph best portrays any given set of data. You are likely to find that, in many cases, the same data set can be shown many different ways. The hard part is determining which type of graph best supports the information needs of the board and senior leaders in the organization.

A table format is the simplest and least graphic of all data displays. Information is arranged in rows and columns. An excerpt from a table format report of high-level performance measures at a home health agency is found in Figure 1. Some balanced scorecard reports use a table format such as this. Whenever possible, report comparative data from other organizations along with your

Figure 1

Excerpt from 3rd Quarter Executive Team Performance Report — Home Health Agency

		Results		
	Target	1st Qtr	2nd Qtr	3rd Qtr
Strategic Category: Clinical Performance				
— Percentage of non-hospice patients with adequate pain control	≤ 90%	94%	95%	90%
— Percentage of hospice patients with adequate pain control	≤ 85%	91%	86%	82%
— Surgical wound infection rate	0 %	0%	.05%	0%
— Timely physician notification of significant changes in patient's status	100%	100%	98%	100%
Strategic Category: Operational Efficiency				
— On-time delivery of home health services	≤ 95 %	90%	89%	92%
— Average length of stay for non-hospice patients	≥15 days	12	16	22

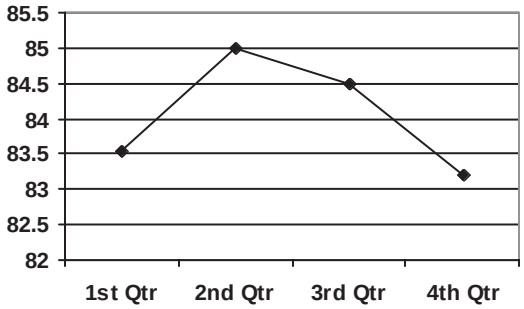
Figure 2

One Page Performance Measurement Report

Measurement: Employee Retention Rate — Results

Measurement Definition: Retention of regular and part-time employees during fiscal year 2007.

Rationale: Employee retention is a cost-effective recruitment strategy. The cost of replacing an employee is estimated at a minimum of one-third of the annual salary for that position. Failure to retain employees in appropriate numbers may erode the experience/knowledge level of staff members and may be disruptive to the quality and continuity of services.



Target: 85.5%

Measurement Formula: 100% minus (Annual number of full- and part-time employee separations / Annual average number of full- and part-time employees)

Data Source: Human resources information system

Reporting Frequency: Quarterly actual used to project annual experience on a quarterly basis. Annual experience calculated at conclusion of fiscal year.

actual performance results. This adds another dimension to the report.

Some organizations use a combination of graphic and statistical reports of high-level measures. In Figure 2 is a one-page performance measurement report that provides significant detail about the measurement, including the measurement definition, rationale for monitoring this topic, the organization's target performance, the formula used to create the measure, the data source, and frequency of reporting. A line graph is used to report the actual results. This one-page per measurement format can be especially useful when an organization first begins to report performance measurement data to the governing board and senior leadership and physician groups. Because a full or half page is devoted to each measure, many of the common questions can be addressed upfront. As people become more familiar with the measures, some of the explanatory notes can be eliminated and the format condensed. However, be careful not to abbreviate the report so much that it no longer provides sufficient detail.

Dashboards are another commonly used format for reporting high-level performance measures. They serve the same function as reports presented in a table format; however, symbols and/or colors are used to draw people's attention to performance concerns. A dashboard report, using star symbols, is shown in Figure 3. A key to understanding the

Figure 3
Excerpt from Dashboard Style Performance Report Card

Measures	1st Qtr 2007	2nd Qtr 2007
Infection Control:		
Hospital-wide	****	****
Surgical Site Infections	***	****
Mortality Rate:		
Surgery Service	*****	****
Medical Service	****	*****
Blood Product Transfusion:		
Appropriateness Criteria Met	*****	****
Transfusion Reactions	*****	*****
Congestive Heart Failure Management	***	****
Acute Myocardial Infarction Management	****	****
Pain Management	**	***
Patient Safety:		
Restraints		
Emergency Department	***	***
Inpatient	*****	****
Incidents		
Falls	***	****
Medication Errors	***	****
Sentinel Events	****	***
Documentation Compliance		
Overdue Records	***	***
Telephone/Verbal Orders	*	***

Key

Exceptional = ***** (Green) Below Normal = ** (Orange)
Above Normal = **** (Blue) Marginal = * (Red)
Normal = *** (Yellow)

meaning of the "stars" used to report results is provided at the bottom of the report. The actual report is printed in color with the stars being reported in different colors. Not only can governing board members and senior leaders quickly see how well the organization is doing by counting the stars, they can also judge results by the color-coding.

Creating a scorecard that relies on symbols and/or color to denote performance results requires some behind-the-scenes decisions. People must decide on the numeric levels that equate to the performance ratings. For example, what is an "Exceptional" nosocomial infection rate vs. one that falls into the "Normal" category? This decision should be made each year on a measurement by measurement basis with input from appropriate departments and physician groups. During this review, the numeric values that correspond to the performance ratings are revisited and revised as necessary.

For instance, to receive a five-star rating for pain management staff members must do well at

CNE *questions*

21. Which is recommended to assess whether an organization's culture is changing for the better?
A. Only process measures should be used.
B. Only outcome measures should be used.
C. Both process and outcome measures should be used.
D. It's not necessary to measure for a long period, since gains will likely be sustained.

22. Which is recommended to improve compliance with core measure requirements?
A. Seek to understand a physician's reason for non-compliance.
B. Reasons for non-compliance should not be taken into account.
C. Discourage physicians from relying on computerized prompts.
D. Avoid changing bylaws to link performance in quality measures to reappointment.

23. Which is recommended when working with physician champions to address core measure compliance?
A. Avoid providing feedback that is specific to individual physicians.
B. Give real-time, concurrent feedback so problems can be immediately rectified.
C. Instead of asking a physician to approach a non-compliant colleague, do so directly.
D. Have a single physician champion for all core measures, as opposed to multiple champions.

24. Which is true regarding EHRs and quality?
A. EHRs significantly improve quality measures in almost all cases.
B. Most organizations use EHRs to replace paper processes and do not take advantage of advanced features, such as clinical decision support and physician order entry.
C. EHRs have a negative impact on quality measures, even if the systems are designed to improve quality.
D. EHRs can replace other quality improvement initiatives, such as improving how patients interact with physicians.

Answer Key: 21. C; 22. A; 23. B; 24. B.

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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

assessing, treating, and educating patients about pain. If performance is two or more standard deviations above mean performance it is consider exceptional. An "above normal" rating is one to two standard deviations from the mean. The lowest rating is "marginal," which is performance that falls two standard deviations below the mean.

The senior leadership team, with input from medical staff leaders, must determine which key measures will be used to evaluate the organization's performance. It is up to the quality department to facilitate reporting of the results using a format that is easily understood and actionable. ■

EHRs often not used to their full potential

Study's findings are a 'wake-up call'

Electronic health records (EHRs) made little or no difference on 14 of 17 quality measures examined, and quality was worse for one measure, a recent study found. The findings were based on 1.8 billion physician visits in 2003 and 2004, with 18% of the visits utilizing electronic health records. EHRs were associated with better quality on only two of the 17 measures that were looked at.[1]

The results may surprise some politicians and leaders in EHR development, but shouldn't come as a surprise to quality professionals, says **Randall S. Stafford**, MD, PhD, one of the study's authors and director of Stanford (CA) Prevention Research Center's Program on Prevention Outcomes and Practices.

"First of all, it is important to recognize that the data are for 2004 and that the EHR systems in widespread use at that time were not as sophisticated as today," he notes. In addition, it's not known how many of the EHR-using physicians had access to or were using features that might have affected the quality indicators examined.

"And on a very basic level, we wouldn't expect EHRs to affect quality unless these systems are designed with this role in mind," Stafford says. "Despite these caveats attached to our findings, our results should be a wake-up call to those who see EHRs as the sole solution to current problems with health care quality."

While EHRs are a "very important tool," attaining high quality is going to require many strategies, says Stafford. Some of these may involve EHRs, but others need to deal with more fundamental issues, such as who provides chronic disease care and how patients interact with physicians, he says.

"Many of those pushing for rapid expansion of EHR use need to make sure that physicians are prepared to use those features that could lead to better quality," says Stafford. "They also need to make certain that other quality improvement strategies are not neglected."

Electronic health records alone do not guarantee improved clinical care process and outcomes, says **Crystal K. Kallem**, RHIT, director of practice leadership for the Chicago-based American Health Information Management Association.

"Quality improvement requires a wide variety of

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. ■

ongoing interventions and techniques," says Kallem. "Information technology is one tool that will assist with improving the quality of patient care. This tool must be utilized to its full potential to gain the level of improvement the industry wants and needs."

To gain the full benefits of EHRs, the appropriate functionality must be used to capture essential clinical data elements. Clinical decision support should be used to maximize the use of widely accepted clinical guidelines, engage the patient, and be incorporated into the natural workflow of the clinicians providing care, says Kallem.

"We are at a rudimentary stage in the evolution of using EHRs," says **William Hersh**, MD, professor and chair of the department of medical informatics and clinical epidemiology at Oregon Health & Science University in Portland.

Most organizations use EHRs to replace paper processes and do not take advantage of advanced features, such as clinical decision support and physician order entry, says Hersh.

"This study used a coarse measure of EHR adoption, which was whether physicians used them in any capacity," notes Hersh. "A much better approach would have been to focus on those who have made optimal use of them."

To improve care, users must implement features known to be beneficial, says Hersh. "There is a growing body of research that shows specific aspects of electronic health records improve care, such as use of clinical decision support," he says. "If electronic health records are just used to replace paper documentation, then they will not necessarily improve care. We also need more training of health care personnel in medical informatics."

This includes physicians and other clinicians, who need to know how to optimally use health information technology in their work, and informaticians, who will guide those clinicians in best practices for implementation. "Quality improvement is a process," says Hersh. "Just putting electronic health records into clinical practices is not enough."

Reference

1. Linder JA, Ma J, Bates DW, et al. Electronic health record use and the quality of ambulatory care in the United States. *Arch Intern Med* 2007; 167: 1400 - 1405.

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