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Measure quality of pediatric care or risk 'disastrous' consequences

Most quality initiatives focus only on adults

Do you have an effective system in place to evaluate the quality of care received by children at your organization? If not, you may find dangerous inconsistencies, lack of equipment, and inadequate training, according to several recent studies that have reported on quality problems with pediatric care. In addition, quality measures and performance improvement (PI) initiatives typically focus on adults and leave out children, say experts in pediatric care.

In one study, only 6% of 1,489 emergency departments surveyed had all the equipment recommended by the American Academy of Pediatrics (AAP)/American College of Emergency Physicians. Half lacked laryngeal mask airways used for ventilating children, only 12% had vascular access supplies for children, and 17% lacked Magill forceps for removing foreign bodies from a child's airway.[1] A 2006 Institute of Medicine report concluded that EDs are not well equipped to care for children, and that most children are cared for at general hospitals, which are less likely to have pediatric expertise, equipment, and policies.[2]

A 2003 study got a lot of attention when researchers reported that only 54.9% of adult care adhered to recommended processes, but a subsequent study, published in 2007, found that the percentage was even lower (46.5%) for children, based on 1,536 medical records from pediatric patients in 12 metropolitan areas.[3,4] Children received 67.6% of the indicated care for acute medical problems, 53.4% of the indicated care for chronic medical conditions, and 40.7% of the indicated preventive care.

"Everyone assumed that care for kids wouldn't be worse than adult care, but in fact it is," says **Charles Homer**, MD, CEO of the Cambridge, MA-based National Initiative for Children's Healthcare Quality (NICHQ). "It's becoming clear that there is actually an even greater problem with kids. And I do think that it is starting to get people's attention."

The consequences of poor quality pediatric care are "disastrous," says **Ameer Mody**, MD, MPH, clinical director for pediatric emergency medicine at Children's Hospital of Orange County, CA. "The wrong-sized equipment in a child's resuscitation can be life-threatening."

Pediatric patients have always been a challenge for hospitals, largely because there are so many variables when caring for children of different

sizes and ages, whereas adult care is more standardized, says **David Jaimovich**, MD, chief medical officer of Joint Commission Resources, which recently launched a consulting program to help hospitals improve the safety of ED services for children. Normal vital signs differ depending on the child's age, medications are weight-based and not standardized, and infants and young children are unable to communicate with health care providers, he notes.

Though much of the recent research has focused on the ED, other areas of the hospital are also at risk for giving poor care to children. "There really isn't one specific area that is immune to quality issues in pediatric patients," says Jaimovich. "It really transcends all departments and permeates into every area, from radiology to laboratory."

He gives the example of the ability to perform microsampling for an infant, so that 5 ML of blood is not needed for a simple lab test. "That would be nothing for adults, but it may be a lot for a 3-kilogram baby who comes to the ED in respiratory distress," says Jaimovich.

There is no question that someone trained in adult medicine is much more comfortable caring for a 55-year-old patient with respiratory distress than a 5-month-old infant, says Jaimovich. "The needs of the infant are different, the size of the equipment is smaller, and the training and skills that are necessary for the staff to care for that child are different," he says.

Attention is increasing

Quality problems with pediatric care are getting increasing attention, and that is likely to continue. "Sometimes it takes something catastrophic for the media to put a spotlight on something," says Mody. "It may take one case that finds the right media outlet."

And in November 2007, a much-publicized story broke about actor Dennis Quaid and his newborn twins. The two, along with a third pediatric patient, received an overdose of the anticlotting drug heparin at Cedars-Sinai Medical Center in Los Angeles. The year before, three infants died after receiving an adult dose of heparin at an Indianapolis hospital.

"People are beginning to understand that there are special issues for kids that we need to pay attention to, such as dosages and mislabeling," says Homer. "The stories that grab peoples' heartstrings are often pediatric stories, because there is nothing more tragic than error harming a child. But while those stories get people's attention, the systematic strategies to address them tend not to address kids' issues."

The recent medication events in neonates with heparin shine a light on an important issue, says **Karen Cox**, RN, PhD, FAAN, executive vice president/co-chief operating officer at Children's Mercy Hospitals and Clinics in Kansas City, MO: Infants and children are not "little adults."

"A medication error that would be insignificant in an adult could have potentially devastat-

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ing results in a child," she says.

In any hospital, large or small, where children make up a small percentage of patients, they are cared for in a place surrounded by systems, equipment, medications, and clinicians who for the most part are focused on adults. "These hospitals must insure that care to this vulnerable population is separate and pediatric-specific," says Cox. "It is not so much limited resources as the wrong kind."

The Institute of Medicine's landmark 1999 report, *To Err is Human*, which estimated that up to 100,000 people die each year because of preventable medical errors, was a huge wake-up call for the public and jump-started many quality initiatives, but it was focused only on adult care, says Homer.[5]

"The fact is that the same deficiencies apply to kids. And in fact, care of children may be even more error prone, because of the variable weights of kids, lower frequency of many conditions, and the fact that most systems such as medication administration systems and computerized physician order entry really aren't designed for kids," he says. "The attention paid to the quality of care of kids is long overdue."

Separate pediatric measures on the horizon?

Hospitals are required by the Centers for Medicare & Medicaid Services (CMS) to report compliance with numerous quality measures to show that adults with stroke, chest pain, pneumonia, and other conditions are getting evidence-based care, but no such system exists for children. "Medicare has a huge influence on the quality of care. But the reality is with children, there is not a big payer that can influence things at a national level," Mody says. "If hospitals don't see many children, it's more challenging to have systems to monitor the care. There is also a financial element — pediatric visits don't make the hospital a lot of money."

Children's health care is not a major source of expense or revenue for general hospitals, where attention and resources tend to be funneled into areas where the cost of care is greatest, says Homer. "The federal government has powerful leverage over the adult health care system, and Medicare has many innovative initiatives around quality," he says. "But while the federal government pays a very large amount for children's health care through Medicaid, it hasn't taken the same leadership role in developing models, which the private insurers would then emulate."

Currently, Joint Commission standards cover all ages and don't specifically address niche populations such as pediatrics. "It may be that at some point in time we may look at that, and whether we need to create a safer environment for pediatric patients," says Jaimovich.

A consortium of organizations, including the AAP, is advocating for separate quality measures to be developed for pediatric patients by The Joint Commission and the National Quality Forum. "My belief is that if CMS were to drive this program, then we'd start to see private insurers following their lead. And then we would see some interest on the part of The Joint Commission," says Homer.

As it stands now, pediatric care is usually not evaluated at hospitals. "They are clearly not measuring this," says Homer. "I've had many conversations with hospital CEOs and everyone says they care deeply about children. But from their perspective, this is just such a small portion of their overall mission and business. And there are competing priorities."

Do a baseline assessment

To assess the quality of pediatric care at your organization, "start from the ground floor up," says Mody, and examine equipment and supplies, staff training, policies, support services, and quality improvement processes.

The first step is to do a baseline self-assessment and answer these questions, says Jaimovich: What is our leadership doing to create a safe environment for pediatric patients? How do our policies impact the care of pediatric patients? What pediatric training do medical and nursing staff have? What about the entire team caring for an infant — does the nurse have the education to make sure medication is provided in a safe and effective manner? Is the pharmacy equipped to handle microdosages depending on the size of the patient?

"No one institution can be everything to everybody," says Jaimovich. "Organizations need tools, assistance, and education to help them with specific areas to meet the needs of the community they serve."

Designating a pediatric patient safety champion is one way to address this. Jaimovich recommends selecting someone with a clinical background who can take a leadership role "in the trenches."

A nurse or pharmacist with significant experience in pediatrics would be ideal for this role, says Cox. "If there is not enough for full-time work specific to pediatrics, they could do other things within the quality department," she says. "However, they would always be expected to be

an advocate for issues specific to children."

The champion would provide the organization with a "very distinct process for QI in the pediatric area," Jaimovich says. For example, if the champion discovered near misses in the medication management area, he or she would work with pharmacy to create a safety initiative to prevent it from happening again, and then revisit it to measure improvements.

The pediatric champion's role should be incorporated into the hospital's overall quality improvement system, says Homer. "The institution needs somebody whose paid job includes specific responsibility for pediatric safety," he underscores.

Look at the National Patient Safety Goals with an eye toward children and their specific needs, says Cox. For example, pain management requires a number of valid and reliable tools to assess pain at different ages, and when establishing a patient fall program, the focus has to be much different for pediatric patients. "There are issues with adolescents who may be embarrassed to ask for help to the bathroom," she says. "Approaches to risk mitigation have to be developmentally based."

Cox recommends benchmarking with other organizations and sending staff to the NICHQ's annual forum. "Using trigger methodology on 100% of pediatric health records has been shown to yield higher numbers of adverse events than traditional incident reporting systems," adds Cox.

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A 2007 report from The Institute of Medicine entitled Emergency Care for Children: Growing Pains *covers pediatric emergency care planning, preparedness, coordination and funding, and pediatric training in professional education. To order the report, contact: The National Academies Press, 500 Fifth Street NW, Lockbox 285, Washington, DC 20055. Phone: (888) 624-8373 or (202) 334-3313. Fax: (202) 334-2451. E-mail: zjones@nas.edu.*

A December 2007 American Academy of Pediatrics policy statement gives recommendations for improving safety for pediatric patients in emergency departments. To obtain a copy of the policy statement at no charge, go to the AAP web site: aappolicy.aappublications.org/cgi/content/full/pediatrics;120/6/1367.] ■

Multidisciplinary peer review 'more objective'

Responsibilities laid out

Review of physician performance by peers is effective when done properly, but the process is time-consuming and often very subjective. Often, the criteria for determining judgments are not expressly stated, so reviewers often use their own criteria to assess the quality of care, says **Charlotte Jefferies,** a consultant with Pittsburgh-based Horty, Springer & Mattern.

"This often occurs in departmental reviews," says Jefferies. "A retrospective, subjective peer review process by a group of direct economic competitors does not work and is very risky. And simply changing the scoring system or paying stipends to a quality reviewer does not change a bad design."

Establishing a multidisciplinary committee that focuses solely on peer review matters can be helpful in structuring a more objective, criteria-based process.

"To the extent that it can be done, quality must be defined in advance. Then the work of the med-

ical staff leadership is to help practitioners achieve that quality," Jefferies says.

An effective peer review committee can comprise the vice president of medical affairs or medical director, the director of quality/performance improvement, and at least one physician from each clinical service/department.

"In order to avoid the problems of the past, the duties of this committee should clearly demonstrate that the goal of peer review is performance improvement when possible," says Jefferies.

The responsibilities of a multidisciplinary peer review committee should include:

- Oversight of the implementation of the medical staff peer review policy;
- Review and approval of the quality indicators developed by the clinical departments and the quality/performance improvement department;
- Review and familiarity with patient care protocols and guidelines developed by national organizations;
- Identification of those quality indicators which do not require focused physician review but do require educational letters to the practitioner being reviewed;
- Review of cases referred to it, as outlined in the peer review policy;
- Development of performance improvement plans for practitioners when appropriate;
- Regular reports to the medical staff leadership regarding peer review activities;
- Review of the effectiveness of the peer review policy, and recommendations for revisions or modifications, as necessary.

The multidisciplinary peer review committee should be established as a subcommittee of the Medical Executive Committee, and should mandate a uniform method by which peer review is performed, says **Douglas L. Elden**, chairman of the Northbrook, IL-based National Peer Review Corp.

Without a centralized multidisciplinary peer review system, cases requiring multidisciplinary peer review are often sent from one department to another, with each department blaming the other, says Elden.

For example, in a case involving questions about surgery and anesthesia, the department of surgery peer review committee may determine that the deviation from the standard of care occurred due to the anesthesiologist, and terminate the peer review without action or recommendation. At the same time, the department of anesthesiology peer review committee may determine that the deviation occurred due to the surgeon, and terminate the peer review without action or recommendation.

"Without a centralized peer review infrastructure to track the case and a multidisciplinary peer review committee to enforce the appropriate analysis, the peer review of the case will be unresolved, and the issues forgotten," says Elden.

The multidisciplinary peer review committee should have the power to assign cases to the following, says Elden:

- Individual or multiple peer reviewers working together on a case for reporting to the committee, such as anesthesiologist and a surgeon reviewing a surgery case;
- Subcommittees, such as a group of anesthesiologists and surgeons reviewing a surgery case;
- Clinical services, divisions and sections, such as a case assigned to the department of anesthesiology and the department of surgery, with a time requirement for returning the report to the multidisciplinary peer review committee;
- External peer review, in accordance with the organization's policy.

At Riverside Methodist Hospital in Columbus, OH, a multidisciplinary peer review committee functions as an oversight committee for other peer review committees. As a larger institution, Riverside has too much peer review activity to do it all in a single committee, says **Robert L. Thompson**, MD, chair of the multidisciplinary peer review committee.

The committee handles cases being litigated, professional conduct peer review, complex cases referred from department or section peer review, and cases where department or section peer review committees have conflicting opinions.

An individual department or section peer review committee may not have the expertise to complete a determination for a complex case — an ideal setting for multidisciplinary peer review to occur. "However, much of peer review is less about super special expertise and more about meeting the accepted standards of care," says Thompson. "That is the arena in which multiple practitioners of different disciplines can function well, and determine if the care delivered was appropriate or not."

Difficulties will arise

Sometimes, findings and assessments made by the various specialties represented on the peer review committee contain disparities, or may even dispute the findings or conclusions reached by other members of the committee.

"In those cases, coordination of the peer review reports and process is necessary to resolve issues and to prevent gridlock," says Jefferies.

Sometimes the committee may find it prudent to send the matter under review back to the department chair or to the medical staff leadership with specific questions or concerns, or refer the matter to another medical staff committee for review. "The findings must be reconciled," says Jefferies. "The goal must be to achieve a final peer review report, which contains the coordinated findings of the committee and an action plan to improve the practitioner's performance."

The key to effective peer review is early detection, prompt action, and education. "Each member must be experienced and respected, and have a clear understanding of the duties to be performed," says Jefferies. "Individuals serving on the committee should receive information and training in the elements and essentials of peer review."

One criticism of multidisciplinary peer review committees is that the practitioner being reviewed has expertise that very few have, and therefore, cannot be reviewed by other specialists or even generalists.

"However, much of the less-than-optimal care delivered is not in this super expertise category, and is more about the daily need for compulsive attention to detail in the care of the patient," says Thompson. "Being caught up in the argument of 'only a similar expert with my training can review my case' leads to frustration and delay."

A medical peer review committee is only as good as the physicians who sit on the committee, says Thompson. "Poorly informed, disinterested practitioners will not provide the type of product that the modern peer review process should — fair, evidence-based, objective determinations," he says.

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Hospital revamps CHF documentation process

Core measure compliance improves dramatically

At Maimonides Medical Center in Brooklyn, NY, congestive heart failure (CHF) has been among the top discharge diagnoses for many years.

"Long before Joint Commission and CMS [the Centers for Medicare & Medicaid Services] said that CHF was high on their list for patient care improvement, we were taking this population very seriously," says **Sheila J. Namm**, JD, RN, MA, vice president of professional affairs. "We are working to prevent a revolving door readmission process for these patients."

Here are key changes that were made to improve compliance with core measure requirements for CHF documentation:

• The discharge instruction sheet was revised to make documentation easier for clinical staff.

Before the format was changed, Namm held meetings with staff who used the discharge instructions and reviewed monthly compliance data. "We got a lot of feedback to make sure the documentation is not onerous," she says. "Initially, the sheet had a statement about specific criteria that had to be documented, but it turned out that wasn't sufficient."

Checkboxes were added and highlighted stating "for CHF patients, please address the following." This prompts the clinician to cover all the required criteria with the patient, gives the patient a document to take home and read, and allows this to be documented quickly and easily.

As a result of this change, there was some improvement in compliance noted, but not sufficient to meet the desired goal, so the CHF core measure team is working on additional improvements, says Namm. Compliance rates for discharge instructions went from 30% in 2005 to 84% in 2007, she reports.

• A monthly core measure team meeting is held with the clinical staff leadership that provides care to CHF patients.

Representatives from cardiology, nursing, and pharmacy meet each month to review cases identified by performance improvement, to see which aspects of the care didn't meet criteria. "We are now down to individual cases, which have failed to meet the criteria set by CMS," says Namm.

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Communication barriers, lack of coordination challenge care of behavioral health patients

Hospital to 'create windows' for front-line providers

It puts behavioral health patients at risk if the players coming to the table are not coordinating efforts to make the most efficient use of available resources, notes **Mark Catalano,** LCSW, manager of admissions at Seton Shoal Creek Hospital in Austin, TX.

Factors that typically challenge that process, he adds, include a lack of readily available psychiatric expertise and communication barriers between caregivers.

At Seton Shoal Creek Hospital and in the city of Austin as a whole, Catalano says, health care leaders are looking at a multi-faceted solution involving a mobile assessment team, telecommuting, standardization of tools and data tracking, and enhanced cooperation and communication between psychiatric hospitals and the emergency department (ED) clinicians who send them patients.

Part of the focus at Seton, he explains, is on "trying to create windows so that ED physicians and social workers know our capacity, what kind of patient is best for us, and which patients go on which unit." It's crucial not only to let them know what's available, Catalano points out, but to realize that each facility has its own way of describing patients.

Seton Shoal Creek uses a standardized risk assessment tool on every patient, including those in inpatient units, Catalano notes. "What we need from the ED [caregiver] is how high the risk is for that patient."

The number derived from the assessment determines whether and where the patient will be placed at the facility, he adds, but often the ED clinician is "not speaking the same language" as staff at the psychiatric facility during the assessment process.

In many cases, Catalano says, the patient in question has been to Seton Shoal Creek before. "We may have seen the patient 10 times, but he or she is new to ED staff and they describe the patient in a way that conflicts with our experience."

A behavioral health patient who presents at the ED "may be at the baseline for him or her," he adds, "but the ED [care provider] thinks the person is out of control." With accurate communication, Catalano says, "we may be able to say, 'Oh, that patient is just coming in to get a meal,' and give them suggestions on how to handle the person."

With such issues in mind, Austin's behavioral health leadership is working to standardize the assessment process across the city, Catalano says, "and see if we can agree on a core set of assessment tools, such as CIWA [Clinical Institute Withdrawal Assessment], CINA [Clinical Institute Narcotics Assessment], neither of which is used by any of the EDs, and a suicide or homicide/aggression assessment."

The implementation of such tools, he adds, will require education for ED nurses and social workers.

A pilot program started at Seton in July 2007, Catalano notes, focused on training social workers throughout the hospital network.

"We brought in all of our on-call social workers for the network — those who work all night — and educated them on our internal assessment forms so they could do our assessment for us," Catalano says.

When presented with data "on forms we recognized and used, with scores we would use internally," he adds, Seton personnel "know we can trust that [information]."

The payoff carries through to the utilization review piece of the process, Catalano notes, "when from the beginning we get good documentation."

Also under way, he says, is development of a software-based database that would allow "all the players — the ED, the emergency medical services, and the behavioral health hospitals — to share information," he says.

That information would be available, for example, when a patient presents to the ED or is en route to the hospital with an overdose, Catalano adds. With standardized data in one system accessible to all, he says, caregivers can check to see if and where appropriate beds are available for the patient.

Reminiscent of the television commercial about the efficiencies gained "when banks compete," Catalano says, Austin's two private psychiatric hospitals could quickly respond to an alert on a patient needing care with, for example, "We've got a level 12 bed on this unit, and it looks appropriate" because initial responders have used the standardized screening tool.

"What EDs want from us is for us to pull patients rather than them having to push them," he points out, "and the more we can trust the form and the language, the more we can do that."

ED not 'the enemy'

In the past, behavioral health providers tended to have an adversarial attitude toward the various EDs in town, Catalano notes. "We realized that we were looking at EDs as the enemy, feeling they were trying to dump patients or not give us all the information and [cases would be] different from what was presented on the phone."

The reality, however, is that the EDs "are our customers — the front line that finds patients for us," he says. "We've tried to [shift] our thinking and say, 'What do we need to put in their hands so they are better able to deal with the patient and can become our best sales force?'"

Seton Shoal Creek was on track to develop a mobile assessment team for behavioral health patients, Catalano notes, but it now looks as though the city of Austin — with matching in-kind contributions from the hospital networks — will take leadership of that project.

The idea, he says, is for caregivers to load information into a city-wide system while observing a patient onsite.

"We're looking at putting together teams in which a social worker and nurse would go out and look at the patient, with one psychiatrist assigned to oversee a certain number [of teams]," Catalano explains. The psychiatrist would be available to evaluate the individual in person if necessary or could use telecommunication to consult on the case.

Personnel for the mobile assessment team would be hired for the city under the auspices of the state Mental Health Mental Retardation (MHMR) department, he adds. The operation would be tied to the state psychiatric emergency services, Catalano says, "which are the 24-7 gateway to the state [behavioral health] hospital or other services."

At Houston's Memorial Hermann Hospital, where Seton staff made a site visit, a mobile assessment model is in place, he notes. "A medical director is paid to be available and is on call if the nurse or social worker on the team goes out and needs the physician piece."

The psychiatrist participation is "more to help smooth things out with the ED physician if the social worker is recommending something and the ED physician is not in agreement," Catalano says. "The trust factor is a barrier."

Houston is "a year or two ahead on the [telecommuting] curve," he adds. "It's another option for the mobile assessment team if they can't get to the facility across town in a timely fashion. Depending on the level of need, the social worker might do the initial assessment or the physician on call might do it."

In Austin, Catalano continues, there are plans to use mobile assessment in the same way. Returning to the example of a patient in the ED who has been there all night and into midmorning, he says, if such an individual could be interviewed via telemedicine by a psychiatrist or other behavioral health specialist familiar with his case,

a lengthy stay and possible admission may be avoided.

"This is a way to reach out into the front line and add our level of expertise," Catalano says. "We see these kinds of patients day in and day out."

Call center role outlined

A behavioral health call center has a vital part to play in facilitating the treatment of a psychiatric patient who presents at the ED, notes **Sue Altman,** president of the Phoenix-based Call Center Consulting Network.

"The ED is really set up for medical patients and typically is already overcrowded," adds Altman, who offers strategic planning and positioning services for call centers. "Behavioral health issues are usually not dealt with very quickly in the ED. The last thing you need is somebody having a meltdown."

ED clinicians, of course, do a screening as quickly as possible to determine if there is a medical issue, she says. "If there is an overdose, obviously they would process that and, if necessary, admit the patient to a [nursing] floor."

However, a situation in which someone appears to be disoriented, with homicidal thoughts, auditory hallucinations or delusions, Altman says, "is usually not something an ED physician is comfortable assessing."

In such cases, she continues, ED staff would contact the call center, "which would get someone there to assess patients and get them on their way to the right destination for care, including [arranging for] some kind of transportation, often an ambulance."

That could mean mobilizing a social worker who is in a different part of the hospital, she says. "Case managers may be trained to do these quick assessments if need be."

If the facility is part of a system of hospitals and the necessary resources are not available at that location, Altman says, call center staff may call on one of the system's behavioral health professionals who may have to drive there quickly.

"They will do an assessment," she explains, "and typically call the call center back because it is arranging bed availability. Call center staff," Altman adds, "would know if the behavioral health facility or state hospital or psychiatric emergency service — which is like a big psychiatric ED — has a bed."

These psych EDs can hold a patient for 23 hours, but don't have inpatient facilities, she notes. "When patients present at the ED with bipolar [disease] or other conditions, in most cases, if they can be started on meds, within 23 hours — the length of time they can be held for observation — [staff] can have them under control and they can go home, with some follow-up."

Navigating the system

One of the problems in the behavioral health arena, Altman says, is that people who need the services don't know how to navigate the system. "Psychiatric or behavioral health services are not typically organized to serve an entire city or organization."

In medical care, physician offices are the "feeder system" for hospitals, she points out, but there appears to be a big disconnect between the psychiatric hospital and private practice psychiatrists or therapists.

Even people who have health benefits may not have much coverage in this area, Altman notes, and "there is a big movement for therapists not to accept insurance at all."

"[A condition] that may have been nipped in the bud if the patient had talked to someone at the primary care level may get really out of control before a family member [intervenes]," she adds. "If these people can't afford care or don't have resources or fear the stigma, they may lose their job and alienate from the family before it's obvious they need care badly."

The nation's uninsured population is another growing crisis, Altman says, which "hurts on both the medical and psychiatric side."

In two or three cities where Altman is working on call center strategies, she adds, private and governmental behavioral health providers are joining forces to look at solutions to the breakdown in services.

"What they recognize is they're all seeing the same patients, and end up just trading them," Altman points out. They may receive inpatient care, she says, "but once they return to their lives, if they can't get in to continue management with a psychiatrist, you're really just putting them right back in the same situation."

Efforts under way to centralize and track data, Altman says, are designed to answer questions such as, "Are [providers] seeing the same 100 patients or are there really 1,000 patients?"

"We know how many go through each of the [organizations] — they all have the counts — but until we look at the data level, we won't see that Jane Smith has visited all of us in the past month," she adds. "It could look like 1,000 people need services, but it could be the same 400 coming two or three times a month."

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'One-stop connection' gets technology boost

Call center coordinates psychiatric services

A major software upgrade has dramatically increased the ability of a New Jersey health system's behavioral health call center to serve as a "one-stop connection" for local emergency departments, psychiatric emergency screening services, and a stand-alone psychiatric hospital, says **Dawn Fenske,** director of Saint Barnabas Management Services in Toms River, NJ.

The call center is "customizing screens, creating reports, and converting all of our data from the old to the new software" since going live with the behavioral health component of a software program already in place on the "concierge" side of the operation, Fenske adds.

The concierge center, she notes, handles physician referral, class registration, and other non-clinical services for Saint Barnabas HealthCare System, while the behavioral health side coordinates the care of psychiatric patients across the Livingston, NJ-based system.

"We make sure the client has medical clearance, has all of the prerequisites for inpatient admission, has all paperwork completed, and that signatures are [obtained] if it is an involuntary admission," Fenske says. "If legal [counsel] is needed, we make sure it's involved. We act on behalf of both the patient and the facility."

Once the call center has all the information, she adds, "we call the unit, tell them patient so-and-so is coming in and the estimated time of arrival, and make sure there is a bed for the patient."

Employees of both call centers occupy a large suite, with non-clinical staff on one side, clinical staff on the other, and files in the middle, Fenske says. Hours for the nine non-clinical employees are 7 a.m. to 8:30 p.m. Monday through Saturday, with Sunday hours soon to be added.

The behavioral health call center has 12 employees and is open 24-7, she says, with two employees who telecommute. "We set up the overnight staff at home because the software [allows them to] print to the office and their safety is taken care of."

With the new software, Fenske says, "We were able to write our own guidelines for behavioral health — more or less a checklist of the needs and requirements at different levels of care. It pretty much creates a medical record, which is sent as a report electronically to whatever level of care the patient is admitted."

The non-clinical side of the call center had been using the E-Centaurus software, a product of LVM Systems, for more than five years, she says, while the behavioral health side had continued to use "a homegrown product" that fell far short of meeting its needs.

With the old system, Fenske adds, "the reporting aspect was nearly impossible and it was costly to create one," among other shortcomings.

Now response time is immediate and the system is able to search for physicians and therapists "in so many different ways," she says. "If a physician wakes up and says, 'I need a report for this,' we can create it or have it created." As part of the call center's arrangement with the vendor, Fenske notes, LVM will create a certain number of reports on request.

"If we need a report on first-time admissions, or readmissions within 30 days, I send a request and they shoot it back," she says. "I look at it, may need to tweak it, and we have exactly what we need. It's immediate."

Previously, such a report might take 10 days or two weeks, Fenske says, "and would come to us with a big bill attached."

Because the software is Windows-based, its components — modules for intake, triage, physician referral, compliments, and complaints, among others — look familiar to users, she adds. "There are so many things within the software to allow our growth. With our homegrown system there was no room for growth."

[Editor's note: Dawn Fenske can be reached at dfenske@sbhcs.com. Look for more information on Saint Barnabas' call center operation in a future issue of Discharge Planning Advisor.*]* ■

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"We have initiated several improvement projects around that. Most often, we find that the problem is documentation issues, and we then educate specific physicians."

For example, documentation may be required in several places in the patient's chart, such as the progress notes and discharge summary, but is found only in one place. "You can see the care was given, but the documentation was not as specific as CMS would like," says Namm.

• Physician-specific data are provided to the chairman of the department on a quarterly basis.

"We can see if certain individuals come up frequently as not providing the care or not documenting the care. But what we have found so far is that no specific physician or group of physicians stands out," says Namm.

• The CHF team is now capturing patients managed by a clinical department other than medicine, and are diagnosed with CHF while in the hospital for another diagnosis or procedure.

This group of patients doesn't necessarily have CHF as its primary diagnosis, if, for example, they come in for a surgical procedure and develop CHF as a new condition. "The CHF nurse practitioners are identifying these patients prior to discharge, consulting and recommending the plan of care," says Namm.

• The discharge prescription process for patients was automated, so the clinician only has to write prescriptions once.

At the same time the prescriptions are printed and electronically documented in the patient's record, an information sheet is printed for the patient about their medications. "That medication sheet can also be provided to their next treating practitioner," says Namm. "This was a major initiative."

Even though the organization has computerized order entry, physicians, residents, and physicians' assistants still had to hand write prescriptions at discharge, and then document these medications in the medical record.

"There were multiple places they had to write the information," says Namm. "Now, they just have to do it in the computer system, which prints the actual prescription and provides instructions for patients. Since physicians don't have to do it two or three times, our rates continue to go up in compliance."

• Monthly chart reviews are done.

"We review several hundred medical records per quarter, so we are doing a very adequate sampling. We get a very good picture about whether the changes we made in processes are working," says Namm. "And if they are not working, we bring it back to the core measure committee."

For example, the process for documenting that adult smoking cessation advice was given was changed to flow better. Although a smoking history is documented on the initial history and physical, there was not a consistent place designated in the medical record to document that smoking cessation counseling was given that would satisfy CMS requirements. This information is now included on the discharge summary.

The hospital's compliance rate for smoking cessation counseling increased from 89% in 2005 to 100% in 2007. "We also decided that all patients should be given smoking cessation advice and resources available for support, although CMS only requires that this information be given to patients with a history of smoking within one year prior to admission," says Namm. "We are not singling out one patient population. It has become routine for all patients upon admission."

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Heart failure deaths cut 50% using Six Sigma process

Six Sigma, DMAIC used

Patient deaths from heart failure were decreased by 50%, readmissions reduced by 12%, and complications reduced by 77%, as a result of a quality improvement initiative at Texas-based Valley Baptist Health System.

Six Sigma principles and the organization's own DMAIC (Define, Measure, Analyze, Improve, and Control) methodology were used to redesign standard operating procedures, in order to comply with national standards for heart failure.

Valley Baptist staff reviewed 300 medical records and created an aggregate score for each measure. Next, the team identified the greatest variances in the process and barriers to uniformity.

Resulting improvements included staff and physician education, a process to identify heart failure patients on admission, and documentation

tools and reminders to facilitate compliance.

In the near future, the organization is hoping to be able to incorporate the data into its newly upgraded electronic medical record, so that documentation is required and not optional as a patient with heart failure is being treated.

Physicians on Valley Baptist's cardiac care committee were key drivers in developing the new procedures. From October 2005 to August 2006, the improvements affected 626 heart failure patients. "The improvements are projected to affect as many as 7,000 patients over the next 10 years," says **Tomas A. Gonzalez**, MD, MBA, senior vice president and chief quality officer. "This means less people dying and less people coming back to the hospital."

Maintaining gains

In 2005, 100% compliance with heart failure core measures was achieved, and this result has been sustained over time. **"**One of the toughest challenges is always to maintain the gains," says Gonzalez. "In 2007, we were ranked the No. 1 hospital in the entire country in compliance with the core measures for heart failure in the Premier/CMS demonstration project. To maintain the gain, we have several approaches which work in parallel."

Each unit is measured on its compliance on a monthly basis. "If you don't measure something, you don't know how you are performing and you definitely will not know how to improve it," says Gonzalez.

The quality professional's role is to promote awareness, facilitate meetings and brainstorming for solutions, maintain the Six Sigma methodology, data collection and analysis, and compile performance scorecards. "Their role is to guide the quality improvement strategy and maintain the goal, but their role is not to impose a solution," says Gonzalez. "The solutions are developed by the frontline caregivers — the nurses and physicians."

Data are gathered daily and analyzed monthly on the four core measures related to heart failure management: measurement of left ventricular function documented; ACE inhibitor given or the contraindication documented; smoking cessation counseling documented; and complete discharge instructions documented.

Internal auditors and monthly compliance reports are very specific when it comes to nurse and physician compliance.

"We name names — we make it very personal," says Gonzalez. "The data are specific to each individual nurse and physician. Each person has a rating — we can tell you how Nurse A has performed over the past two years. We can tell you if Nurse B is failing to comply with the standard. We can tell you if Physician C is getting it right every time, or if Physician X is struggling to document."

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'Daily rounding' checklist improves ICU compliance

Takes a multidisciplinary effort

Using a "daily rounding quality checklist," which takes just a few minutes to complete, the Los Angeles County/University of Southern California Hospital increased compliance with "care bundles" to prevent ventilator-associated pneumonia (VAP) and other intensive care unit complications.

"Just as a good pilot would never take a plane into the air without an adequate pre-flight checklist, we have utilized our quality checklist to ensure that we are guarding daily against potential adverse events," says **Joe DuBose**, MD, assistant unit chief of trauma services. "The checklist is a surprisingly simple device."

A paper format is used, and most of the boxes on the checklist are simple yes/no answers, such as whether the patient had a "sedation holiday" within the last 24 hours, whether the patient was assessed for weaning, and whether the respirator circuit was examined for gross contamination. "Before and after" data were collected to determine if the checklist improved compliance with 16 prophylactic measures for VAP, deep venous thrombosis or pulmonary embolism, central line infection and other ICU complications.

A multidisciplinary team assessed compliance a month before the checklist was implemented, and for three months after the implementation. Results were impressive: The tool improved compliance with every measure that wasn't already at more than 95% compliance.

For example, compliance increased from 35.2% to 84.5% for elevating the head of the bed more than 30 degrees, one of the VAP prevention measures. In

addition, central line duration over 72 hours decreased from 62.4% to 52.8%, and ventilator duration over 72 hours decreased from 74% to 61.7%.

The below data are continuously collected and analyzed:

- ventilator-assisted pneumonia — bundle compliance measures;
- percentage of head of bed elevation 30 degrees or greater;
- stress ulcer disease prophylaxis;
- deep vein thrombosis prophylaxis;
- sedation holiday;
- glucose control type and glucose range;
- central line catheter days and presence or absence of central line;
- documentation of weaning protocol evaluation;
- code status documentation;
- continuous subglottic suctioning;
- endotracheal tube fixation

"Change always represents a challenge, but with the right efforts and the right champions of these causes, effective tools can be developed and utilized without representing a burden on the organization," says DuBose. "The ICU fellow has been the primary collector, guardian, and critic of the data, proving that in the modern era of health care we all have to be quality professionals."

Implementation of a daily quality rounding checklist should be based on best-evidence practices applicable to the patient population in question, says DuBose. "It should also include multidisciplinary input and periodic review, and be practical and functional," he says.

The checklist allows the bedside team to make real-time correction of deficiencies. "The bedside portion is both simple and effective," says DuBose. "If for some reason DVT prophylaxis has not been administered in a complex ICU patient with multiple medications, or has not been started yet because they had a liver injury, for example, it can immediately be corrected."

The data are recorded on the sheet, and later that day entered into an Excel spreadsheet, with data analyzed on a monthly basis. "If for some reason we see our compliance lower for the month with any respective measure, we can then focus on why that happened and introduce corrective action as needed," says DuBose.

Nearly every aspect of the project benefitted from multidisciplinary input, including glucose control efforts, says DuBose. "Without the discussion and input from our nursing colleagues, we would not have recognized the need for further education of the nursing staff to improve glucose control in our ICU," he says.

Currently, the organization's biggest challenge is to teach and educate all staff — physicians, nurses, respiratory care therapists, ancillary personnel, and students. "We are one of the largest teaching institutions in the country and have a full array of students from various disciplines who rotate continuously throughout the surgical ICU," says **Shirley Shot Nomoto**, RN, MSN, trauma program manager.

The trauma interdisciplinary teams conduct daily rounds with specific emphasis on education in areas of quality improvement and patient safety. At the monthly trauma quality improvement committee meeting, measures are reported to the leadership council, medical staff, nursing, lab and pathology, radiology, trauma staff, and ancillary personnel.

"Areas of success are discussed, as well as areas needing improvement," says Nomoto. "Since we have interdisciplinary and collaborative membership at this forum, corrective actions are discussed, including recommendations for improvements."

At one recent meeting, the hospital's leadership council recommended implementing reduction of central line infections as a hospitalwide project for all ICUs. "Physicians and nurses worked together to review the process of reducing errors in the placement of central lines," says Nomoto. "They focused on hand hygiene, maximum sterile barrier precaution, chlorhexidine skin antisepsis, optimal catheter site selection, and daily review of central line necessity."

After data on compliance are analyzed, recommendations for improvement are made by the committee members. "Several members participate on both the interdisciplinary teams and the trauma QI committee, so information is communicated accurately and timely," says Nomoto.

Reference

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THE QUALITY - CO$T CONNECTION

Don't fail to communicate critical test results

Compliance continuing to be problematic

By Patrice Spath, RHIT
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It could be a routine preoperative check X-ray that shows a suspicious-looking lesion or a STAT blood test suggesting a potentially virulent infection. The test results must be communicated to the ordering physician. When critical test results are not received by the physician in a timely manner there can be tragic results. In 2005 The Joint Commission added a National Patient Safety Goal requiring improvements in the communication of critical tests and test results. This is essentially a performance improvement goal. Hospitals must measure, assess, and improve (if appropriate) the reporting of results. Recent data from Joint Commission surveys show that compliance with these requirements continues to be problematic.

To comply with this patient safety goal, each diagnostic area must identify critical tests and critical results. Be sure to include input from attending physicians in this process to ensure everyone is in agreement as to the definition of "critical." Some hospitals use the following definition: any test or test result that would immediately change the course of care. For instance, a head CT scan of a trauma patient or an oxyhemoglobin in the case of suspected carbon monoxide poisoning — these would be critical tests given the clinical situation. Critical results are different. It is the results, not the test itself that is critical. For example, an electrocardiogram might not be considered a critical test; however, the results are critical if the study reveals a potentially dangerous arrhythmia that requires immediate intervention.

It is not necessary for each diagnostic area to have an extensive list of critical tests or test results. Hospitalwide there may be as few as five to six tests or results that are considered critical. Don't get bogged down in creating a comprehen-

CNE *questions*

13. Which is true regarding the quality of pediatric care?
A. Problems have only been identified in emergency departments, not other hospital units.
B. Children are at lower risk of medication errors than adults.
C. Children are at higher risk for errors because care is less standardized than with adults.
D. The majority of pediatric emergencies are cared for at children's hospitals.

14. Which is recommended for multidisciplinary peer review committee?
A. Encourage reviewers to use their own criteria to assess the quality of care.
B. Don't take into consideration whether or not peer reviewers are direct economic competitors.
C. Avoid sending a disputed matter back to medical staff leadership.
D. Demonstrate that the goal of peer review is performance improvement.

15. Which action was taken at Maimonides Medical Center to improve compliance with core measure requirements for documentation of congestive heart failure patients?
A. Clinicians were asked to document discharge prescriptions in multiple places in the medical record.
B. Checkboxes were added to the discharge instruction sheet.
C. Physician-specific data is no longer required.
D. Only specific patient populations are given smoking cessation advice upon admission.

16. Which change was made to improve heart failure care at Valley Baptist Health system?
A. Individual nurses and physicians receive monthly data showing their compliance with core measure requirements.
B. Individual staff members are not named in reports on compliance.
C. Data are analyzed on a monthly basis only if compliance begins to decrease.
D. Quality professionals, not frontline caregivers, develop solutions to improve compliance.

Answer Key: 13. C; 14. D; 15. B; 16. 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

sive list. It is better to take a gradual approach and over time refine the list. It should be considered a "work in progress" in keeping with the intent of ongoing performance improvement.

Critical tests are probably the most difficult to identify because the patient's clinical condition must be taken into consideration and not just the test. For instance, a head CT head for a patient with a possible concussion may not be as critical as the same test done for a patient who has obvious head trauma. Rather than identify specific tests, some hospitals use the following definition: A critical test is defined as a STAT test with critical values/results or other results that are determined by the diagnostician to be critical to the patient's subsequent treatment decisions. Other hospitals have selected specific tests and designated them as critical. Examples include:

- CT head scan to rule out subdural hematoma or as part of a stroke protocol;
- chest X-ray after central line placement to rule out unexpected pneumothorax;
- chest X-ray to evaluate endotracheal tube position;
- CT spine scan ordered to rule out fracture in trauma cases.
- arterial blood gas showing the following results: pH <7.20 & >7.50, PaCO2 <20mmHg & > 55mmHg, or PaO2 <55mmHg;
- cerebrospinal fluid gram stain;
- pathology frozen section.

In addition, some hospitals allow the physician to designate any test as critical at the time of ordering. It is also important to acknowledge that the diagnostician should immediately initiate physician contact for any condition that appears to need prompt treatment.

Once you've identified tests and values that are considered critical, establish turn-around targets for each. Start by gathering some baseline data about current practices. What you want to know for critical tests: average time from order of the test to time of report. What you want to know for critical values: average time from identification of critical value to time of report. Then ask the reporting department and receiving physicians to agree on the definition of a "prompt" turn-around for each test or value. If you begin with just a list of the most critical tests and results, it is easier to establish expected turn-around times. If your initial list includes some tests or results that are considered by some to be less critical, turn-around targets may be harder to agree on.

For critical tests, an acceptable turn-around (from order to report) must be defined. This includes identifying how quickly critical tests must be completed by the diagnostic service and how quickly the results must be reported. Depending on the test, the

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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. ■

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reporting of results might be anywhere from a few minutes to an hour. For example, the ordering physician should be immediately told if a patient's radiology exam shows any of the following: endotracheal tube in bronchus, tension pneumothorax, ruptured aneurysm, saddle emboli, significant intracranial bleed, cervical spine fracture, or unexpected free intraperitoneal air. In less urgent situations, such as a hemoglobin of less than 6g/dl for an adult patient, it may be sufficient to notify nursing personnel or the ordering physician within 30 minutes.

Periodically revisit your list of critical tests and test results and make incremental changes either based on patient safety concerns, when new tests become available, or when technological advances allow for even faster reporting.

Educate all stakeholders in the turn-around expectations and then regularly gather and analyze information to determine how often targets are being met. It is important that all steps in the reporting process are defined and the steps are documented so that timeliness data can be gathered. For example, make it clear who is responsible for calling the nurse with critical laboratory results and what the nurse is responsible for documenting in the patient's record. Often hospitals require the date and time the results were communicated and the name and title of the person who called the nurse with the results. Also define how quickly the nurse is to communicate the results to the ordering physician and how this communication is documented and what to do if the ordering physician cannot be contacted within the required timeframe.

Tests performed in services such as radiology require interpretation by a physician with subsequent reporting of the results. In these circumstances, you'll need to document the time the test was completed, the time when it was read by the radiologist, and the time the results were reported to the ordering physician. If the process is not entirely electronic, each time increment will need to be manually entered into a log or on the report itself.

Joint Commission surveyors assess compliance with this safety goal and related standards by reviewing patient care records and determining the degree of adherence to the recommendations. Surveyors will want to see your list of critical tests and critical results/values, the target turn-around time for the tests and value, and your measurement strategies. Because this patient safety goal has been in place since 2005, Joint Commission surveyors will expect to see you've got at least 12 months of timeliness data and the data are being used to make turn-around improvements.

Resource

Communicating Critical Test Results Toolkit. Massachusetts Coalition for the Prevention of Medical Errors. Available at: www.macoalition.org/Initiatives/CCTRToolkit.shtml. ■