

Healthcare Benchmarks and Quality Improvement

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Wide-ranging collaborative drives improvement in patient safety

PDA's provided to staff for safer medication administration

A broad collaborative covering numerous hospitals in Tennessee has implemented an impressive patient safety initiative for which results were just reported in the *Journal of Rural Health*.¹ The collaborative involved three main initiatives:

- providing clinical staff with PDA's to aid in safer medication administration;
- use of a tool provided by the Agency for Healthcare Research and Quality (AHRQ) to assess an institution's safety culture;
- standardization of protocols in the emergency departments of participating facilities.

The PDA's were pre-loaded with a drug database software program with drug information, such as dosing, drug-drug interactions and adverse reactions, as well as formulary and pricing information. The software provided clinical tools, including diagnostics such as lab reference values, clinical tables and guidelines, symptom assessment, disease and condition compendium, and medical calculators.

A provider survey on the impact of the PDA's revealed that:

- 83.2% of respondents reported increased self-reported drug knowledge;
- 88.6% reported improved drug-related decisions;
- 93.3% said they were better able to inform patients;
- 77.7% said the use of the PDA's reduced the potential for

Key Points

- Access to instant information about medications can help reduce errors.
- Use of safety culture assessment tool highlights opportunities for improvement.
- Collaborative model enables hospitals to share successes, failures.

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adverse drug-related events;

- 66% said patients were more satisfied with their care.

A follow-up AHRQ patient culture survey one year after the initiation of the collaborative showed:

- improvement in overall perceptions of safety from 56% to 69%;
- increase in frequency of events reported from 51% to 69%;
- supervisor expectations of promoting patient safety increased from 72% to 80%;
- communication openness increased 50% to 67%;
- nonpunitive response to errors increased

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Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

from 35% to 50%;

- hospital management support increased from 72% to 78%.

The collaborative involved the Tennessee Hospital Association (THA), BlueCross BlueShield of Tennessee, the Upper Midwest Rural Health Research Center, the University of Southern Maine, and Q-Source (the quality improvement organization for Tennessee)

"I think we had the right people at the table; having the rural research centers involved gave the project a lot of credibility, and it was extremely important to have the necessary funding from BlueCross BlueShield because we had to make pretty significant investments in technology," says **Bill Jolley**, MPA, vice president of THA. "We had a good cross-section of hospitals involved, and their engagement was extremely beneficial; they really bought into it from the top down."

Getting things going

Jolley says the initiative came about because "there was some initial interest by BlueCross BlueShield in supporting our small and rural hospitals in some capacity as related to quality and patient safety. We had several discussions with them and had also been made aware of the research and work being done out of the rural research centers." THA was the "convener" of the hospitals, generating initial interest, he adds.

"Bill Jolley had experience with my center and contacted us because we do critical access hospital monitoring work, and they wanted us to evaluate the project," says **Jill M. Klingner**, RN, PhD, assistant professor of health care and operations management at the Labovitz School of Business and Economics, the University of Duluth, MN, as well as investigator at the University of Minnesota Rural Health Research Center and lead author of the article. "Judy had done a good deal of patient safety work, so she was a natural."

"Judy" is **Judy Tupper**, MS, CHES, research associate and managing director, population health and health policy, the Cutler Institute for Health and Social Policy at the University of South Maine Muskie School of Public Service. She "guided the hospital staff through much of the project," Klingner notes.

"We brought to the table relevant safety interventions and asked hospitals to do the self-assessment," says Tupper. "From that, we were able to come up with three interventions over two years." Actually, she adds, there originally

Initiative leads to new patient safety center

Encouraged by the success of a patient safety initiative for rural hospitals (see cover story), **Bill Jolley**, MPA, vice president of the Tennessee Hospital Association (THA), has spearheaded the creation of the Tennessee Center for Patient Safety, which has “Allowed us to continue our work, not only with this project, but to expand into looking at infections and other areas of patient safety.”

BlueCross BlueShield of Tennessee, which provided the funding for the collaborative, continues to make some financial contributions, says Jolley. “The original project gave us a nice springboard for creating the center,” he continues. “Because we were successful, BlueCross BlueShield was pleased, and we’ve also been allowed to make available the [the Agency for Healthcare Research and Quality] culture survey through our web site. This was not just one of these projects where you get funding and when the project no longer exists everything is over; we can

do sustainable work beyond that defined project.”

The new center is housed within the THA; it is not a separate corporation. “Our senior vice president, Chris Clarke, heads it up,” says Jolley. “We’ve also been able to bring on a couple of other staff people, including Darlene Swartz — who was chief nursing officer at one of the hospitals participating in the collaborative.”

Jolley says he is not altogether surprised at the success of the collaborative. “We’ve always had high expectations of our rural hospitals and knew they would perform well — but they exceeded our expectations,” he says. “And that’s not just a subjective opinion; if you look at the measures used to evaluate performance, you can tell it made a difference. I think the progress we made as far as changing the culture within those hospitals as relates to quality and patient safety was measurable.”

The fact that the original project has garnered a lot of exposure, as well as state and national quality awards, also played a role in making the new center possible. The impact of the collaborative, Jolley summarizes, “goes way beyond this project.” ■

were going to be two interventions — the PDAs and the protocols. “We thought the AHRQ tool was going to be part of the assessment, but it turned into an intervention. It offered a great opportunity to try to improve parts of the patient safety culture and allowed us to look at national benchmarks for the first time,” Tupper says.

Her center, she continues, provided staff resources. “We were expected to take a leadership role in facilitating different interventions,” she explains. After BlueCross BlueShield funded the purchase of the PDAs, for example, “we used East Tennessee University Medical librarians to do the training.”

Tupper and her team held quarterly face-to-face meetings in Tennessee, and also had monthly conference calls. “We were able to build up very strong relationships; everyone shared how things were going,” she recalls. “We also brought in best practices we could identify nationally.”

The Tennessee QIO, she continues, took the lead with ED protocols. “They asked any of the hospitals if they wanted to contribute their protocols, and then put a collection together and turned around and gave it to the hospitals so they could bring them to individual meetings,” says Tupper.

Sharon Doran, RN, director of the “Quality Plus” program and safety and risk management

at Gibson General Hospital in Trenton, TN, says her facility was asked to participate in the collaboration in early 2007. “We were given an outline of things they wanted to accomplish and a list of projects; we decided which would be the most beneficial,” she shares. The options were reviewed at each hospital by the quality staff, the medical staff, and the governing bodies, she adds.

The PDA initiative made great sense for the rural hospitals, she notes. “The availability of information on an instantaneous basis was just not there,” she says. “We did not have access to large libraries without going off campus, but we needed that information to be *on campus* on the front end for doctors, so when they were prescribing medication they could have the information right at their fingertips, talk to patients about the meds, check for adverse interactions, and reduce medication errors.” The PDAs, she explains, were linked up to a site at East Tennessee.

The ED protocol initiative, she continues, involved networking with other hospitals to develop a set of evidence-based protocols. “We shared them through meetings, and Judy and Jill made sure we were sharing them,” she says. “We then took them back to our medical staff so they could be tweaked to fit our facility.”

In terms of the PDAs, she says, some of the

older staff members were “a little more resistant,” but that was just a matter of overcoming the learning curve. “The people from East Tennessee and Bill Jolly had a special education session for the doctors,” she adds. “I and one other staff member were very computer savvy and went initially to the doctors as needed, reinforcing the key messages and making sure they were using the PDAs.” Most of the doctors, she says, “were really excited to have them.” Toward the end of the study, she adds, nurse managers were also given PDAs.

Doran says that medication errors have dropped “at least 15%,” which she calls “a dramatic drop,” especially since according to the study the reporting of adverse events actually increased. “We continue to slowly see more decreases,” she says.

In addition, Doran continues, staff felt the time they were spending on the job was better utilized. “Staff satisfaction also improved,” she says. The subsequent patient safety culture surveys, she shares, showed a much higher awareness of safety.

There also was some resistance to the protocols, says Doran, since some doctors object to standardization. “But I had been working with them for over 12 years,” she notes. “And once you’ve proved yourself to them and explain how you can make their life easier in the long run, they accept it. We were also careful to choose the ER, because they have a very proactive physician director who is very open to doing this kind of thing — he’s a quality manager’s dream.”

Keys to success

The key to success for such a wide-ranging collaborative, says Klingner, is “having engaged staff at each individual hospital — and we really had that. A lot of the quality managers or directors of nursing had strong physician or CEO champions — and you really need that dedication of leaders. You also have to identify which projects you need; in order for the project to work, it has to be something everybody cares about. In these hospitals, they had similar needs so it was easy to target these three initiatives.”

“I give the credit to preparation of the staff preceding the actual project, picking champions who were proactive and had good staff relations,” adds Doran. “You have to be careful about picking the right people on the front end. We also had excellent buy-in from administration, which is critical, and the support of THA and the research

staff — they were really good facilitators for us in everything we did.”

“It was a great experience to work with the small hospitals,” says Tupper. “The combination of the hospital association, the research team, the funder, and the QIO — everyone came to the table. The great thing was that everybody agreed there would be no competition around patient safety; it freed them to work together as a collaborative.”

Tupper adds: “We’ve developed a model here that has worked with critical access hospitals in Maine; you can take a small initiative, do it quickly, and spread it out to the whole institution.”

Klingner agrees. “I think this is a unique collaborative that really can be a model for other kinds of projects,” she asserts. “You had the hospital association and the QIO involved in some ED guideline sharing — a real cross-section of stakeholders that helped to neutralize some of the ulterior motives that might have been there if you just had the insurance company or the hospital association involved. This made it not ‘just’ an improvement project — not something designed to meet any of our individual priorities. These kinds of collaboratives really have lot of potential to make a big difference.”

Reference

1. Klingner J, Moscovice I, Tupper J, Coburn A, Wakefield M. Implementing patient safety initiatives in rural hospitals. *J Rural Health*. 2009; 25:352-357.

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Hand-washing compliance goes from 33% to 95%

Steering team of key players drives process

If at first you don't (totally) succeed, keep trying. . . That should be the motto of the quality leaders at Bay Medical Center in Panama City, FL. Not content with QI efforts that boosted their staff hand-washing compliance from 30%-33% to 65%-75%, they implemented additional strategies that got compliance all the way up to 95%.

A team effort spearheaded by a multidisciplinary steering team and the decision to take responsibility for hand hygiene out of the infection control department and making it a hospital-wide initiative were among the keys to success, says **Robert Campbell**, PharmD, director of performance improvement, patient safety, and regulatory compliance.

"We started a throughput initiative as part of our performance improvement program, and we wanted be sure we included quality," he recalls. "We evaluated the different quality projects going on and identified hand hygiene as having the potential for improvement."

At one time, he notes, hand hygiene was considered an infection control problem. "The attitude had been, 'Let them take care of it,'" he notes. "But everyone wanted to make it a hospital problem and attack it as a team effort."

The framework for developing the steering team was created by a consulting firm that had been working with Bay Medical. "They helped us look at the items we wanted to be on the table, and developing benchmarks, targets, and so on," says Campbell.

The team included all hospital administration, other key leaders, and staff who were being groomed for leadership. "We started with observation; we conducted rounds, and when we noticed that someone was not washing their hands, we pointed it out to them," says Campbell. This involved rounding by select managers, directors, and administrators who observed and recorded, but did not report the findings beyond conversations with the individuals who were not in compliance.

Key Points

- Hand hygiene no longer infection control's responsibility; it became a hospital-wide initiative.
- Task force includes staff being groomed for leadership.
- Posters with catchy slogans serve as staff reminders.

Subsequently, the CEO, CFO, vice president of human resources, and other members of the leadership team joined in the rounding. As part of their rounding routine, each leader did 10 observations a week. Other individuals who were already rounding regularly became even more visible. "The idea was that people would see this was such a serious issue that even the CEO became personally involved," Campbell explains.

Poster 'children'

These efforts raised compliance to 65%-70%, but the team wanted to see even more improvement. "We got the idea for a catchy slogan," says Campbell. "A now-famous poster picturing the CEO washing his hands sported the tagline, 'Hand hygiene: So easy, even our CEO can do it!'"

"They were put up all throughout the hospital — on every elevator, in every nursing unit, in the OR, in the lounges, by the front door near the elevators — *everywhere*," says Campbell.

They received such a positive response that additional posters were created. For example, neurosurgery featured a poster with two identical twin neurosurgeons washing their hands. The tagline read, "Hand hygiene: It's not brain surgery!"

Then, a poster was created featuring a surgeon saying, "If I can do it, you can do it!"

"If you knew him, you'd understand why this worked," says Campbell. To keep the goal in sight, only those with continual good hand hygiene could apply to be the subject of a poster. Rewarding those who demonstrated continual good hand hygiene with pocket sprayers of hand sanitizer provided a further incentive.

Observations increase

During the initial phase, recalls Campbell, about 30-50 observations were made per month. "For October, so far we have over 700 observa-

tions,” he notes. “We have so many more because now it is not just infection control and the steering team, but now we are incorporating the nurses on the floors to do peer review. The manager receives their reports and sees who is compliant and who is not.”

Employees who are noncompliant are treated as they would be if they had violated any other hospital policy; the first time the manager provides counseling and they are given a verbal warning, and with each subsequent violation, additional steps are taken, such as written warnings placed in their file.

When it comes down to it, says Campbell, viewing hand hygiene as a hospitalwide problem was probably the single greatest key to reaching 95% compliance. “I do a monthly presentation at the leadership meeting, and when [the consultant] handed over the project to me, I put up a poster that showed where things stood when this was an infection control problem and when it became ours,” he shares. The poster said “Them vs. Us.”

“I used it to show how if we come together we can accomplish great things,” says Campbell.

The approach was so successful in addressing hand hygiene, he adds, that it is now being incorporated into a surge planning initiative. “Everyone is at the table — all units — because we all have specific pieces of the problem,” Campbell concludes.

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Reduce one-day stays when observation is better

Transitions were not optimal

Hospitals sometimes fail to transition patients to the optimal level of care, which can create issues with quality of care and reimbursement.

A recent quality improvement project found that most one-day stays in a hospital were related to patients having chest pain symptoms. And many of these one-day stays originated in the

emergency department and were unnecessary, an expert says.

The project found that patients were transitioned inappropriately, leading to higher costs and Medicare claims denials.

“We worked with 17 hospitals in a process improvement effort,” says **Mary Helderman**, RN, CPUM, an oncology nurse in Terre Haute, IN. Helderman wrote a quality improvement report on one-day stays when she was the project coordinator for the Hospital Payment Monitoring Program (HPMP). HPMP, which had the goal of measuring, monitoring, and reducing the incidence of improper fee-for-service inpatient acute care Medicare payments, was disbanded in August 2008.

“We took a sampling of patients from the 17 hospitals and found that 79.9% didn’t meet admission criteria,” she recalls.

“So that’s a large percentage, and the estimated overpayment for those amounted to over \$600,000,” Helderman adds. “When we looked at charts at three different intervals for 17 hospitals, there was an estimated overpayment of \$1.5 million over a two-year period.”

The baseline sampling was retrospective, and the other two samples were done before the claims were submitted, she says.

The idea was to have physicians clearly write whether they wanted a patient to have an observation stay or to be admitted to the inpatient acute area, she says.

“We found that maybe when the physician would write an admit to outpatient care, the person registering the patient would see the word ‘admit’ and interpret it as an inpatient stay,” Helderman explains.

The problem could be the forms made the patient’s transition unclear, or that people were not looking as closely at the forms as they should, she says.

Some hospitals seeing this report decided to implement a case management team in their

Key Points

- A recent quality improvement project found that most one-day stays in a hospital were related to patients having chest pain symptoms.
- Many of those one-day stays originated in the emergency department and were unnecessary.
- The project found patients were transitioned inappropriately, leading to higher costs and Medicare claims denials.

emergency departments, Helderman says. Other smaller hospitals implemented weekend coverage of case management to catch inappropriate inpatient stays before Monday morning, she adds.

"Others focused on education, educating staff on the difference between an inpatient stay and an observation stay, and they gave staff information about payment and denials," Helderman says. "Some started focused monitoring on inpatient stays to see where the gaps were in the process and to implement some changes there."

And some hospitals did concurrent chart reviews, rather than wait until patients were discharged to review their charts, she adds.

[For more information, contact: Mary Helderman, RN, CPUM, oncology nurse, Terre Haute, IN. Phone: (765) 505-0102.] ■

Pharmacists can assist in fall prevention programs

Medications among most common causes

When St. John Medical Center of Tulsa, OK, started a fall prevention program in 2006, the group included a pharmacist.

"We wanted anyone on the group who could possibly prevent a patient from falling," says **Polly Robinson**, PharmD, clinical pharmacist with St. John Medical Center.

Robinson, as the pharmacy representative on the committee, assessed safety by reviewing and assessing each patient's risk for falling, including patients' potential risk from their medication regimen.

"The group wanted a pharmacist to assess each patient's medication as they entered the hospital," Robinson recalls. "That would be nice, but we didn't have the money to hire 10 more pharmacists to do that."

So Robinson researched the issue and found that one of the most preventable and reversible causes of falls is patient medications and that patients who've already fallen are most likely to fall again.

"So we chose to focus on those patients who've already fallen," she explains. "We review their medication and identify common causes of falls."

Each time a patient falls, a nurse enters data into a hospital computer system, and that infor-

St. John Medical Center's medication review for falls

St. John Medical Center in Tulsa, OK, has developed a medication review for falls sheet that includes a one-page documentation chart of patients' potential medication risks for falls.

Here are some items included in the chart:

- Patient name
- Date of birth
- Room
- Number of routine medications
- Psychotropics
 - Sedative-hypnotics, especially benzodiazepines (BSDs)
 - Neuroleptics (antipsychotics)
 - Tricyclic antidepressants (TCAs)
 - Selective serotonin reuptake inhibitors (SSRIs)
- Cardiovascular medications
 - Digoxin
 - Antihypertensives, especially diuretics
 - Class 1A antiarrhythmics
- Other medications
 - Anticholinergics — sedating antihistamines, TCAs, antipsychotics, and some antiemetics
 - Anticonvulsants
 - Opioid analgesics (within first 48 hours of initiation or dosage increase)
- Other risk factors to consider
 - Elderly patients who are 65 years or older have altered pharmacokinetics and may be more sensitive to medications
 - Renal function impairment may result in medication accumulation and increased risk of adverse reactions
 - Patients taking 4 or more prescription drugs, regardless of pharmacologic classification, are at an increased risk for falls
 - Anticoagulants/antiplatelets may directly increase the risk of injury from falls due to an increased bleeding risk
 - Patients with untreated osteoporosis, urinary incontinence, delirium, and/or pain have an increased risk of injury from falls.

The form is signed and dated by the pharmacist.

Source: Polly Robinson, PharmD, CGP, FASCP, Clinical Pharmacist, St. John Medical Center, Tulsa, OK.

mation is reviewed regularly.

A pharmacist reviews the charts of patients who've had a fall and sees which of their medications could be changed, such as lowering the drug dosage, Robinson says.

When a change is made and approved by a physician, the pharmacist documents the change and labels it in the "falls" category, she adds.

This information is stored electronically and can be used to chart trends and for quality improvement initiatives. **(See sample information from Falls Review Sheet, pg. 7.)**

For example, the hospital has made some changes in standard prescription dosages to prevent falls, including changing temazepam (Restoril®) 30 mg orders to 15 mg dosages for patients who are 65 years or older. Or these patients are changed to a more selective GABA agonist, such as zolpidem (Ambien®), with 10 mg prescribed for patients who are younger than age 65 or 5 mg prescribed for patients who are 65 years or older, Robinson says.

"We noticed Restoril often was the culprit in falls," Robinson notes. "So we focused on that medication and reviewed a lot of preprinted order forms."

With physicians' approval the dosage was lowered and changed.

Now that zolpidem is available in a generic form, it can be used as a safer drug that is not more expensive for the hospital, Robinson says.

"Before zolpidem was a more expensive drug and it was prescribed in 10 mg for everyone," she adds. "So we added age-dosing."

Also, physicians previously would select a pain medication from four or five different opioid choices. Now they're steered to one opioid that has a lower risk of causing falls, Robinson says.

"As another example of changes made to decrease fall risk, we have simplified the choices of pain medications on our preprinted order forms," she adds. "And we've enacted a policy limiting the use of meperidine [Demerol®], an inferior pain medication with increased risk for CNS side effects."

A medication review for falls turned up another trend: "We noticed a lot of patients were taking diuretics right before bedtime," Robinson says.

"The peak of action of those diuretics was right when they were sleeping, so they'd wake up and need to go to the bathroom, and then they'd fall in the bathroom," she explains. "So we changed the automatic times of those diuretics to be given

Key Points

- Fall prevention program needs to include pharmacist.
- Suggest dosing and medication changes to physicians.
- Create list of drugs placing patients at risk of falls.

no later than 5 p.m., and with the change we saw a trend of decreased falls at night."

The number of falls decreased from 1.4 falls per night per 1,000 bed days of care down to 1.1 falls per night in a very short time frame, Robinson adds.

The falls sheet used by pharmacists includes one side with medications that are known to increase the risk of falls, based on a recent literature review. The list includes psychotropics, cardiovascular medications, and others, including anticholinergics, anticonvulsants, post-anesthesia, and opioid analgesics.

This educational piece also includes details about why the listed medications have the potential to increase risk of falling, including this information:

- **Selective serotonin reuptake inhibitors (SSRIs):**

- New use of SSRIs is associated with a greater risk for falls. Recommend starting with a low dose for the first week, then slowly increasing to therapeutic levels.

- Doses \geq the equivalent of 20 mg of fluoxetine have a higher risk for falls.

- May induce hyponatremia, which can lead to delirium; recommend monitoring electrolytes.

- **Antihypertensives:**

- Antihypertensives have been proposed to contribute to fall risk via postural hypotension (drop in SBP of \geq 20 mm Hg, in DBP of \geq 10 mm Hg, or to a pressure of $<$ 90 mm Hg when standing).

- Diuretics have been significantly associated with falls (vertigo, orthostatic hypotension, frequent urination). Most studies have found a non-significant relationship between antihypertensives and falls.

- Inadequate treatment of a cardiovascular disease may also be a factor in increasing fall risk.

- **Post-anesthesia:**

- Risk for falling is greatest within 48 hours post-anesthesia.

Pharmacists also make suggestions to physi-

cians when they note a prescription that might entail a fall risk.

For instance, a pharmacist might say, “This patient is elderly and taking temazepam and on 30 mg every night at bedtime for sleep, and that’s a very high dose for an elderly patient,” Robinson says.

This approach is short and to the point, she says.

Then the pharmacist would recommend to reduce the temazepam prescription to 15 mg or to try some other sleep regimen, such as seeing if there were other medications that were keeping the patient awake and which could be adjusted, Robinson explains.

“We look at the medication profile to reduce the medicines that cause falls risk,” she adds. “The goal is to review the patient’s medication and back-up your suggestion with detailed information about risks for falls.” ■

Repeat chronic pain visits reduced from 19 to two

Six out of the top 10 chief complaints of frequent ED users are related to pain, according to a new study.¹ To reduce repeat visits of chronic pain patients, ED nurses at University of Wisconsin (UW) Hospital and Clinics in Madison use a “non-narcotic protocol.” Of 15 patients who averaged 19 ED visits over the previous year for pain-related complaints who were notified about the new protocol, ED visits decreased to an average of two visits per year.²

“Some patients with chronic pain may need to be on narcotics,” says **Tom Meyer**, MD, an ED physician at UW and coordinator of the Madison Citywide ED Chronic Pain Quality Improvement Initiative. “But these should be prescribed by a single practitioner. The patient should be monitored to be sure that the medication is enhancing function both at home and at work. And if we have evidence that the patient is acquiring drugs from other physicians in order to increase their dose, then they should be reassessed.”

If ED nurses identify patients at risk for inappropriate use of narcotics, they alert Meyer by e-mail or verbally and ask him to review the patient’s chart. According to **Sue Wolfe**, RN CEN, care team leader for the UW’s ED, at times ED nurses “begin to get that ‘I know I’m being

Key Points

- Alert ED physicians about patients at risk for inappropriate use of narcotics.
- Help patients to set up a patient management contract with a physician.
- Explain that escalating doses are unsafe.

taken for a ride’ feeling, and the patient may be abusing the system. This gives the doc a heads up to look a bit further into this, or we may talk to the person’s primary care physician to come up with a plan.”

She adds, “The computer system that we use is very helpful in alerting the staff that the patient may have a pain contract with another physician. We are also able to see easily the number of ED visits and the reason they are coming.”

Next, Meyer assesses whether the patient is primarily coming in for chronic management of pain. If that is the case, the patient is sent a letter stating that narcotics no longer will be given in the ED.

After the patient receives the letter, he or she often comes back to the ED seeking narcotics once or twice afterward.

“The ED nursing role is to explain that we want to help the patient and assign them a practitioner,” says Meyer. “We’d do the same thing if a patient asked for antibiotics every time he or she had an earache, sore throat, or congestion.”

If the patients return with a complaint of chronic pain, they are reminded by ED nurses or physicians that they have been sent a letter stating that they will not get narcotics while in the ED. Instead, the patient may be given a non-narcotic medication along with a nonpharmacologic intervention. For example, a migraine patient may be placed in a quiet, dark room, given cold packs to the head and neck, and given instructions on dietary changes.

“The patient is discharged to follow up with their primary care physician,” says Wolfe. Many of the ED’s chronic pain patients did set up a pain management contract with their personal physician.

“When patients come in asking for pain medications right away, we need to be more aware of the possible need for education and behavior modification for pain control,” says Wolfe. “It is very hard to take care of patients with a recurring pain problem that they feel would best be served with additional narcotics, knowing that this does

not seem to help in the long run in many cases.”

As for patient reactions to the ED’s new protocol, these vary widely. “Some do get angry, though not nearly as many as we would have guessed,” says Meyer. “We explain that we really are not trying to stop the use of medication. We are just trying to do the safest thing for them, which is not escalating doses.”

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To improve health literacy, follow QI model

Goal is to create a culture change

The way the Group Health Plain Language Network approaches work is based on quality improvement models, according to **Kimberly Wicklund**, MPH, manager of health information & promotion at Group Health Cooperative in Seattle.

That’s because the network is trying to create culture change within the organization, which is similar to how a lot of improvement work is done in health care, she explains.

Therefore, the members of the network determined to get senior leader buy-in for its health literacy efforts, identify champions throughout the organization, train staff and raise awareness, create tools for people to use in order to implement the network’s recommendations, and do some reporting and evaluation.

That’s the framework used to approach the work, explains Wicklund.

To get senior leader buy-in, the network wrote a charter for an official initiative. Champions for health literacy weren’t hard to come by, for the diverse makeup of the network meant there was at least one in most departments. They not only reinforce the message but also serve as gatekeepers for the information coming out of the department, says Wicklund.

The continuing medical education department

approved a web-based training program, and the network developed a PowerPoint presentation about plain language and how to use it in order to address staff training and awareness. They also developed a toolkit for the Intranet with information on how to communicate in plain language. Articles about plain language are frequently placed in the staff newsletters published by the various departments.

Wicklund said a lack of resources has made reporting and evaluation more difficult to complete. Therefore, the network seeks opportunities for evaluation where the results can be easily tracked. For example, the health promotion department wrote a letter to group health members in plain language and did not receive any calls from members confused about the content. Before writing letters in plain language, the department usually received about 20 calls about content. ■

Put a stop to registration delays; make these changes

Registration delays mean poor customer service scores for access — which in turn means big headaches for patient access directors. If registration wait times are too long, this will have a negative impact on patient satisfaction, physician satisfaction, and the clinical departments who are waiting for the patient, according to **Joe Palumbo**, CAM, CHAA, manager of patient access site administration at Rex Healthcare in Raleigh, NC. “Patients will either voice their concerns at the time of registration or in the clinical area. Some will wait and mail a letter with their concerns.”

Diane Murphy, RN, BS, MSHCA, also a patient access manager at Rex Healthcare, says that pre-registration and pre-call are two process approaches that allow the department to streamline the registration process at time of service.

“Each scheduled case comes across with key elements from the scheduling system to our admit-discharge-transfer system,” Murphy explains. “Our pre-registration co-workers continue to process the account to a seamless registration.”

This processing includes pulling over insurance and demographic information from previous visits to eliminate repeating asking the same questions at the time of face-to-face registration. If the patient is new to the facility or no insurance

is available at the time of pre-registration, a report is generated to the pre-call coworker to call the patient and gather the information over the phone prior to registration. Once the correct information is obtained, the verification team will confirm the insurance information before the date of service.

“From a QA/QI [quality improvement/quality assurance] standpoint, we track and review our wait times, along with peak registration times and daily volumes, to adjust staffing accordingly,” says Murphy. “We also share the outcomes with our front-line co-workers at our monthly staff meetings. Our wait times are also part of our annual performance goals for patient access.”

Monthly outcomes are presented using a spreadsheet in a visual presentation, tracking each point of service and the department’s year-to-date performance. Intake specialists are also provided with a monthly report card that lists all of the outcomes that the coworker is accountable for. These include registration accuracy, upfront collection percentage, customer compliments, and average wait time.

“The coworker receives a verbal coaching if their performance needs improvement,” says Palumbo. “But if the coworker meets all of their individual goals, patient access has a ‘Pay 4 Performance’ program. This program rewards intake specialists for their extra effort in a monetary way monthly. Each month, the outcomes are reviewed by management to ensure that the momentum is maintained.”

“Unlike most health care systems, we consider our department to be more than just admitting and registration,” says **Deloris A. Neal**, regional director of patient access for Resurrection Health Care in Chicago. “We train our registrars to be an integral piece of the revenue cycle process.

“The five-minute registration process that our patients go through accurately ensures great financial outcomes when each patient is processed accurately,” says Neal. “We monitor the patient visit history. When we notice a hospital visit has occurred less than 90 days ago, we can

fast track the registration as long as there has not been a change in the demographics or insurance.” Patient access staff now schedule 98% of all patient services. “This concept was developed so patients would not have excessive wait times in registration, thereby delaying the clinical service they are scheduled for. This generates backlog for the physician, which eventually will reflect negatively on our physician satisfaction,” says Neal.

Currently, patient access schedules 5,000 patients a month on average, with a 1.2% average abandoned call rate. All calls are answered within an average of 22 seconds. “We monitor our patient flow to gauge our high and low volumes and allocate the staff as needed,” says Neal. “Nonetheless, it is still very unpredictable.”

For this reason, patient access has found it beneficial to cross-train registrars to work in all locations so staff can be re-assigned as need.

“Unfortunately, we still struggle with walk-in patients who come to the hospital for basic lab tests or X-rays, where no appointment is required and patients are registered on a first-come, first-served basis,” says Neal. ■

NEWS BRIEFS

Quality varies widely from state to state

The Agency for Healthcare Research and Quality’s (AHRQ) annual release of state-by-state quality data continues to give states mixed reviews for the quality of care they provide. As in previous years, AHRQ’s 2008 State Snapshots show that no state does well or poorly on all quality measures.

COMING IN FUTURE MONTHS

■ How analytics can help improve hospital quality

■ E-prescribing consortium seems to improve patient safety

■ Benchmarking collaborative recognizes hospitals achieving performance improvement

The 2008 State Snapshots provide state-specific health care quality information, including strengths, weaknesses, and opportunities for improvement. The state-level information used to create the State Snapshots is drawn from the 2008 *National Healthcare Quality Report*, which was released in May by Department of Health and Human Services Secretary Kathleen Sebelius.

New features in the 2008 State Snapshots provide more ways to analyze the quality of health care for each state compared with all states, as well as states in the same region.

To access this year's State Snapshots tool, go to: <http://statesnapshots.ahrq.gov/>. ■

TJC, HHS team up in language access effort

The Joint Commission (TJC) and the U.S. Department of Health and Human Services (HHS) Office for Civil Rights announced that “amid growing concerns about racial, ethnic, and language disparities in health care, “the organizations have developed a video titled “Improving

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Patient-Provider Communication.”

The new video supports language access in health care organizations.

In a joint news release, the organizations said that health care organizations face challenges to accommodate increasingly diverse patient populations — more than 28 million people with hearing loss (National Institute on Deafness and Other Communication Disorders estimate), and about 47 million people who speak a language other than English, according to the U.S. Census Bureau.

With many competing priorities in health care, the news release states, the video explains why particular attention should be paid to federal civil rights standards and The Joint Commission's accreditation standards pertaining to effective communication and language access.

“Ineffective communication between patients and providers can result in misdiagnosis, inappropriate treatment, or medication errors,” says **Amy Wilson-Stronks**, project director in the division of standards and survey methods and principal investigator for hospitals, language and culture study at TJC.

“When a provider cannot communicate effectively about a disease or treatment, or when a patient cannot describe their illness, they lack the basic connection needed to result in appropriate care. Appropriate communication is necessary for ensuring quality and safety in health care,” she says. ■

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