Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

June 2010: Vol. 17, No. 6
Pages 61-72

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New health care law may spell opportunity for quality managers

Impact on outcomes seen as positive, but time frame concerns some

The recently passed health care reform legislation may have generated controversy in political circles, but there appears to be a consensus among health care quality observers that it will strengthen the position of hospital quality managers and give their roles even greater importance. Observers also applaud many of the components of the bill that address quality, although there is some concern that many will not take effect for several years.

"The day has really arrived for quality," says **Janet Corrigan**, PhD, president and CEO of the National Quality Forum.

"Over the past few years, those who do quality improvement in hospitals have taken much more of the limelight; this will do a lot to even further our importance in our health care delivery system," says **Evan Benjamin**, MD, FACP, senior vice president of health care quality for Baystate Health in Springfield, MA, and an associate professor of medicine at Tufts University.

"I see projects that will be very expansive around changing the payment of health care — things like hospital care organizations," he says. "And quality managers will be part of those discussions." Beginning in 2012, he notes, there will be accountable care organizations for outcomes, quality, and safety, as well as efficiency. "Those with experience in health care quality management will be very important," Benjamin asserts.

"I think it will certainly enhance and make the role [of the quality

KEY POINTS

- New health care law emphasizes quality, safety, and efficiency.
- Pay-for-performance emphasis requires attention of quality managers.
- Many quality provisions will not kick in for several years.

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manager] even more critical than it is already," adds Corrigan. "Quality is an integral part of various payment programs; the legislation includes payment incentives tied to reducing avoidable readmissions, to reducing health care-acquired conditions, and provisions for many demonstration projects on payment tightly linked to better care and better patient outcomes."

There is a huge emphasis on public reporting and pay-for-performance programs, she continues. "That just provides even greater incentives for quality improvement, greater reinforcement for improving quality, and doing the best for patients," Corrigan says.

But a different kind of "day" has arrived for purchasers, says **Leah Binder**, CEO of The Leapfrog Group. "The moment for purchasers to act has arrived," she declares. "The new law could be detrimental or helpful to quality; it could raise costs considerably — and is likely to do that for purchasers if they don't act aggressively."

For purchasers, she continues, "It will no longer be acceptable to sit back and wait for the federal government to manage a benefits program and make sure it works for your employees; from a purchaser's point of view, they are all scrambling to be compliant and see if it costs more — and it will, at first. [Fees on] pharma, devices, and so on, will raise premiums almost immediately."

Now is the time, she says, for purchasers to begin to manage benefits so they get their money's worth. "The cost-cutting measures are five years away — and those are only pilot programs," Binder notes. "The quality measures are years away, so the QI and cost-cutting measures are long-term. That's a problem for purchasers; unless purchasers look at the actual performance of providers in the community and negotiate pay-for-performance contracts, they won't get value for their purchasing dollar."

Addressing quality

In terms of timing, says Benjamin, "over a two- to five-year timeline, there are a lot of elements in the bill that have implications for those who do health care quality work. First is the way in which we start thinking about health care; overall, there is much more about quality of care, measurements, and value of care."

As you start talking about value, he explains, "there will be a greater need to measure quality, safety, outcomes, and defects in a way that has a lot more accountability."

For example, he notes, beginning in 2012 there will be more penalties for excessive readmissions. "Many folks in quality leadership are already trying to understand the root causes behind readmissions and ways to reduce them," notes Benjamin. "There is also language we need to pay attention to around bundling. This talks about establishing many pilots around bundled payments to hospitals and providers. A large portion of that will be around measurement of health care quality; there will be a single payment, and we will be responsible for quality outcomes and efficiency."

The bill, he continues, also promotes more value-based purchasing. "And quality managers

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices. USPS# 0012-967.

POSTMASTER: Send address changes to Healthcare Benchmarks and Quality Improvement, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $549. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $92 each. (GST registration number R128870672.)

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EDITORIAL QUESTIONS

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will have to be aware of more value-based purchasing for Medicare."

In addition, he notes, "There are words in the bill around adding a 1% penalty to hospitals that have higher rates of hospital-acquired conditions, which could be significant for many hospitals." Accordingly, he says, it will be important for quality managers to stay on top of the clinical as well as administrative aspects of health care.

Other advantages seen

Corrigan also notes several positive aspects of the law. "First of all, there is support for what many of us are calling the quality enterprises — a set of functions many different groups participate in," she notes. "There is a set of national priorities and goals for improving quality, safety, and affordability of care. It directs the secretary [of the Department of Health and Human Services] to establish a national strategy and priorities — in conversations with multi-stakeholder private groups." This excites Corrigan, she says, because "it could help align private and public sector leaders."

Second, she continues, there is support for measure development and maintenance. "I think that can be really critical," she says. "It is expensive to develop really good evidence-based measures in the field and maintain them over time."

Third, notes Corrigan, the concept of "consultative partnership" is built into the legislation. "This is a multi-stakeholder group put together to advise the secretary on the selection of measures for public reporting and payment programs," she explains, "So a better-developed mechanism around measures will be used."

Finally, she says, the law includes a number of other important provisions, such as expansion of the Hospitalcompare website. "This will really enhance that site and its usefulness to patients and families and others," says Corrigan. "And we will see continued active development and enhancement of public reporting."

Binder, however, is not quite so sanguine. "There's lots of talk in the bill about how to do pilots for bundling payment arrangements and other changes in the way of pay rewarding performance, which we want to see; that's great, we support it," she says. "We also agree the idea of value is in the bill, but the idea of covering more Americans is in it now, whereas for the other aspects it's 'Five years from now, we'll think about it.' That's progress, but if you're a purchaser and you get next year's rate increase, you do not care what happens five years from now; you want to know why it costs so much and what you can do about it."

In summary, says Binder, "We would agree there's a lot [that's good] in there, but it's five years away."

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QI efforts lead to success in VTE prophylaxis

Online education, computer alerts used

While Brigham and Women's Hospital in Boston has been successful in reducing the incidents of venous thromboembolism (VTE), it has taken an ongoing effort and a combination of successful interventions, says **Sylvia McKean**, MD, SFHM, FACP, a senior hospitalist. "National and international registries have shown that prophylaxis is still underutilized," she says.

Actually, she says, prophylaxis is not complicated (although, as the data on hand-washing compliance have shown, complexity and compliance rates may not always be linked). "The key thing to remember is that you basically need to do a risk assessment on all adult patients," she says, "because about 90% of patients who are hospitalized on a medical service should get pharmacologic prophylaxis; only about 10% may be low risk or have a contraindication to heparin."

That number is so high, she explains, because there are many major risk factors — including

KEY POINTS

- VTE prophylaxis is not a complicated process.
- CPOE alerts can remind physicians to do risk assessments.
- Online "resource room" is available for staff education.

SHM's VTE 'resource room'

The Society of Hospital Medicine (SHM) developed a web-based educational resource for hospitalists, a VTE "resource room" (http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_LandingPage.cfm). "The overarching goal of SHM was to bridge the gap between the best evidence in terms of medical prophylaxis and actual practice," **Sylvia McKean**, MD, SFHM, FACP, a senior hospitalist at Brigham and Women's Hospital, notes.

"Even though the risk of VTE is lower in medical patients than in surgical patients, larger numbers of people are at risk because there are so many medical patients and because these patients are not receiving appropriate prophylaxis." In addition, she notes, the society's core competencies in hospital medicine, issued in 2006, include having hospitalists know how to do a risk assessment for VTE and prescribe appropriate prophylaxis for hospitalized patients.

The resource room includes the following information:

- how to use the resources;
- getting started;
- project planning and implementation;
- monitoring and learning;
- continuing to improve;
- sample protocols, order sets, and other tools.

This resource, notes McKean, presents principles for conducting QI in the hospital and includes sections such as "Ask the Expert," an interactive discussion community, an improvement workbook, and a downloadable project outline and tutorial.

Quality managers, she adds, should know that this site is available to non-SHM members as well. What's more, she says, the site is updated every six months. In addition to VTE, SHM has developed web-based resource rooms for the following intervention areas:

- acute coronary syndrome;
- BOOSTing care transitions;
- complicated skin and skin structure infections;
- glycemic control;
- heart failure;
- antimicrobial resistance;
- stroke.

"Your quality improvement person can access the site, and if they go to the resource room, it tells you what to do and how to initiate the intervention," notes McKean. "There's actually a QI workbook for every single condition."

In addition, SHM sponsors a "VTE Prevention Collaborative," through which hospital QI teams receive a year of mentoring from SHM experts to design, evaluate, and sustain a VTE prevention initiative. Mentors work with each site leader to tackle site-specific issues; mentoring includes scheduled telephone calls over a 12-month period, e-mail support, and instruction organized around the "VTE QI Implementation Guide."

A new cohort of 50 hospitals will be accepted into the collaborative in July 2010. For information about the program, contact: *vtepc@hospitalmedicine.org*. ■

acute medical illness; cancer (active or occult); inherited or acquired hypercoagulable states; prior VTE; acute infection; congestive heart failure; COPD exacerbation; acute ischemic stroke; acute neurologic disease; inflammatory bowel disease; obesity; pregnancy or postpartum state; immobilization; central lines; certain medications; and increasing age (patients over 40). "Basically, that covers everybody, unless they are admitted for observation to rule out conditions like myocardial infarction," says McKean.

The regimen for prophylaxis is also relatively straightforward: Therapy for moderate and high-risk patients is the same, unless the risk of bleeding is greater than the risk of clotting (since heparin is used). So, for example, heparin is contraindicated with a "GI" bleed, serious bleeding in the past couple of weeks, or a low platelet count (less than 50,000). Otherwise, McKean says, "Low-molecular-weight heparin is used in Europe and unfractionated heparin or low-molecular-weight heparin is used here." It also is important to remember to prescribe mechanical prophylaxis for patients at increased risk who have a contraindication to heparin and to reassess the risk of bleeding as the hospitalization proceeds.

CPOE yields results

The system at Brigham and Women's has evolved, thanks to the work of Samuel Z. Goldhaber, MD, in the cardiovascular division.

"He's an international expert in blood clots," notes McKean, "and he developed a computer alert system." The entire hospital, she notes, is on computerized physician order entry.

"Normally, patient order entry involves a blue computer screen," she recalls. "But when Goldhaber developed the alert system, the screen would turn red to remind people to order appropriate prophylaxis."

Use of the alert resulted in a 40% reduction in incidents of hospital-acquired VTE. "So, he didn't just improve the process, he improved outcomes," notes McKean.

The hospitalists at Brigham and Women's also have developed their own VTE prophylaxis standards for their service. "We all agreed on what the standard should be regarding risk assessment and prophylaxis," says McKean. There is an internal website for members of the hospitalist service containing this and other important information.

But for hospitalists who do not have access to CPOE and are asked by their institution to try to improve VTE prevention, resources from the Society of Hospital Medicine (SHM) could prove beneficial. (**See box, page 64.**)

"Across the country now, a huge percentage of facilities utilize hospitalists, and this helps them approach VTE in a uniform way," McKean explains. "They can get the workbook and work with their QI person without having to attend a course. They can just download the entire workbook." They can also enroll in the SHM VTE mentoring project.

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From 'worst' to 'first' in pressure ulcer incidents

Teamwork, consistent monitoring, audits key

About six years ago, Cooley Dickinson Hospital in Northampton, MA, had the highest rate of pressure ulcers in the state; including Stage I patients, it was in the 20%-30% range. Today, the facility can boast 10 quarters of 0%, beginning in December 2005.

"When I came, it was at 8.9% for Stage 2 and greater," recalls **Michele Craig**, RN, CWS, COCN, RN, wound and ostomy nurse. "We started doing quarterly surveys, and every quarter we'd check every patient's skin. If I found an ulcer, I'd do a chart audit, find out what happened, and present a case study at staff meetings."

Why were rates so high? "Often, things had not been charted — such as a patient refusing to be turned," Craig recalls. "I talked about what to chart, and how to do things differently."

Her goal, she continues, is to take care of the problem, not to point a finger at anybody. "It's always a systemic problem," she insists.

Craig conducted education sessions, going to the quarterly hospital staff education fair and teaching about pressure ulcers. "The NDNQI [National Database of Nursing Quality Indicators] pressure ulcer inservice on competence is very good," she notes. "I made it like a game show; I'd have people say what they thought the answer was after they brainstormed together." She also created a "Jeopardy" game using a template she found online about wound care.

KEY POINTS

- Several departments are made part of the process.
- Regular audits are conducted and system errors addressed.
- Staffs receive regular communication on their performance.

Creating a team

When Craig put together a new protocol, it led to a team atmosphere around pressure ulcers. "I built a protocol that called for the addition of physical therapy for people who have problems with mobility, and a dietitian for people with lower Braden Scores [a scale for predicting pressure ulcer risk] or low albumin; so I spent a lot of time talking to those departments," she explains. "They were initially very frustrated and felt this was a nursing problem, so I had to talk a lot with them about why it was everybody's problem. They always thought it to be an indicator of nursing quality, but it's really an indicator of hospital quality; for example, how well are nutritional and

Pressure Ulcer Precautions

When should a patient be on Pressure Ulcer Precautions?

- Total Braden Score of 18 or less **OR**
- **A 2 or less in any category OR**
- Any patient with a lower extremity orthopedic problem **OR**
- Existing or recent history of pressure ulcers

What do I need to do?

- Post sign over bed and stickers on chart
- Apply an air pump to the bed (except CC)
- Referrals to nutrition and P.T.
- Turn every 2 hours
- Aloe Vesta to the bony prominences twice a day
- Heel boots for red heels, patients with lower extremity orthopedic issues, and diabetics
- Keep knee gatch in the flat position, elevate legs with pillows if needed
- Waffle chair cushions for all patients with red or broken skin on bottoms
- Keep the HOB at 30 degrees or less if possible
- Address moisture with toileting programs, condom catheters, barrier creams
- Address incontinence of diarrhea with a rectal pouch or Flexiseal tube
- Foam ear pieces on O2 tubing or alternate cannula

Source: Cooley Dickinson Hospital.

mobility issues being met?"

She made a number of other early changes, such as removing the bath blanket from beds so that there were fewer layers between the patient and the mattress. "I also worked with the respiratory department to get foam earpieces and an oxygen cannula (tube) that actually goes underneath the ears because I had noticed an increase in ear pressure ulcers," Craig says.

How does Craig handle things if she notices something is not right? "I go to the staff meeting and talk about it, or to the department head, and we talk it over," she says. "They often have excellent ideas of how to make something work."

Craig says consistency is one of the keys to her success. "We do a daily Braden Score, and we have a check-off for pressure ulcer precautions so there is documentation to support what we've done," she notes. "For example, I found a lot of times pumps would be on the bed but not necessarily turned on. I track that quarterly to look at the percentage of precautions that are documented. We're 100% a lot of time on most floors now."

It's important, she adds, to let staff know how they are performing. "I put signs up on each floor, like the documentation percentage is such and such," Craig explains. "It helps people to know you are watching, but I also write some positive notes to let them know I appreciate what they're doing."

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Dealing with short discharge opportunities

Admissions from ED leave little time to plan

When patients are admitted through the emergency department (ED) and multiple clinicians are involved with competing priorities in their care, discharge planning can be challenging.

One solution is to improve communications between providers while targeting more effective patient communication at discharge.

"We identified communications with regard to discharge and education as being very important," says **Katie Starkey**, MS director of patient experience initiatives at Albert Einstein Healthcare Network in Philadelphia.

The goal was to improve patient education and make it routine to follow up with primary care physicians (PCPs) to give them more information about the patient's hospitalization, she adds.

"There are a number of competing priorities that make it more difficult to make sure

patients have everything they need when they leave the hospital," says **Mary Beth Kingston,** RN, MSN, NEA-BC, vice president and chief nurse executive at Albert Einstein Healthcare Network.

"About 80% of our admissions come through the ED, so we are less able to have scheduled admissions than other organizations," Kingston explains. "Our length of stay averages about 4.7 days, so that's a pretty tight LOS."

Although discharge planning begins at admission, it's still difficult to ensure patients have the information and other things they need at discharge, she adds.

"We can't discuss the discharge prior to admission like you can with surgical patients," notes **Cindy McGlone**, MBA, vice president, healthcare services at Albert Einstein Healthcare Network.

"We're trying to increase our patient satisfaction with the discharge process," McGlone says.

The health care organization's survey identified two discharge-related questions to target, Starkey says.

"When we looked at our results compared with the national average, we were below where we wanted to be on these items," she explains. "So, we implemented changes with our discharge instructions, which has improved our performance."

For example, a question on the survey asked patients, "Did you receive written instructions about the symptom or problem when you went home?"

After changing the discharge form to improve instructions, the hospital has seen an improvement in this area, Starkey says.

Identifying communication at discharge as a possible quality improvement initiative was a first step to improving the entire discharge process.

The hospital's discharge planning team has found that the first 24 hours after admission are a crucial time for the discharge process.

"Within the first 24 hours, the patient is assessed with a care management assessment," says **Donna Antenucci**, RN, senior director of care management.

Nurses do the initial assessment, and a multidisciplinary team that includes nurses, physicians, a case manager, and a social worker does a daily round, looking at all of the patient's issues, she adds.

"We look at what the patient's previous status was and how we can get the patient back to baseline," Antenucci says.

The multidisciplinary team also includes physician residents, says **Steve Sivak**, MD, FACP, The Paul J. Johnson Chairman, department of medicine at the health system. Sivak also is a clinical professor of medicine at Jefferson Medical College and medical director of Einstein Community Health Associates, internal medicine and family practice in Philadelphia.

"We have a large patient population and a large residency, and we work hard to integrate this into the discharge process," Sivak says. "The team meets each morning to discuss patients, and we give residents a period of time after rounds to accomplish some of the tasks we identified at rounds."

The goal is to identify patients who have been given a discharge date, particularly as the patient is closer to discharge, he adds. It's also necessary to make patient education as effective and efficient as possible, since there is little time to repeat and reinforce teaching. One of the more effective ways to teach patients as part of discharge planning is to use the teach-back method.

"We use teach-back and have hands-on instruction to make sure nurses are using it as intended," says **Justine Sgrillo**, RN, clinical manager of nursing.

"We taught nurses how to speak simply," Sgrillo says. "It was a huge initiative, and we thought it'd be a simple process; but it was more difficult than we thought."

In the typical hospital's discharge process culture, nurses will meet with patients, read discharge instructions, and ask if patients understand, Sgrillo explains.

"Most patients will say, 'Yes,' because they don't want to show you what they don't understand, or maybe they don't understand what they don't understand," she says.

Plus, nurses are crunched for time and are trying to get through this part of discharge planning as quickly as they can. The key is to show nurses how important teach-back is, beginning with showing them patient survey results, Sgrillo suggests.

"We've done some health literacy work, teaching nurses to bring the educational level down to the patient's level of understanding," Sgrillo says. "We showed them statistics about how patients learn better through repetition, and we gave them statistics on how much is forgotten immediately after it's taught."

The hospital held an hour-long workshop on patient education and health literacy, says

Christine Charles, MS, patient education coordinator.

"The video showed how patients felt about going to the doctor, and we had nurses role-play, practicing their interactions and good communications with patients," Charles says.

Spot checks during discharge planning also help.

"We do that weekly," Sgrillo says. "We do a lot of one-on-one teaching, and we look at copies of forms to see who is doing it well and who is not."

By making follow-up visits to the unit, discharge planning leaders give nurses an opportunity to ask questions and discuss issues that arise, Charles says.

"There's a point person on the unit who presents as a resource," Charles adds. "So, when I'm not available, other nurses can provide guidance for nurses."

Managers give nurses examples of well-written discharge forms. A typical discharge sheet might be a couple of pages long, with dense text, and a writing level that proves to be a stumbling block to patients who have low-level literacy, she notes.

One helpful tool is Project BOOST's PASS forms, which provide discharge instructions in a patient-friendly format, she adds. Albert Einstein Healthcare Network is involved with Project BOOST.

"Patient PASS: A Transition Record" is a one-page form that covers the essential information in boxed sections. For example, the form's main section reads, "If I have the following problems.... I should...." Under the first part, there are five numbered lines, and under "I should" there are matching numbered lines.

Another box, titled "My appointments" lists four places to write appointments, dates, and times.

A third box, also followed by numbers with space for writing, reads, "Tests and issues I need to talk with my doctor(s) about at my clinic visit." And there are boxes for "Important contact information," followed by a place for patient or caregiver and providers to sign and a separate section for "Other instructions."

Another important strategy is to help the patient with scheduling follow-up appointments, Sgrillo says.

"You need to go over this with patients, because they won't attend a follow-up appointment if you don't find days that will work for them," she says. "Whatever is called for, we'll make the appointment, because we think that's so important in preventing readmission."

The hospital has had some success with its new discharge instructions, according to recent survey results, Sgrillo says.

"Our first quarterly scores show that 81.7% agreed that the nurse explained things understandably, and this compares with a 55% national average," she says.

The problem with any initiative is that staff interest is high at first, but then it will slack off.

"It has its peaks and lows, and we need to work on sustainability," Sgrillo says. "Interest drops off after six months, so we need to reinvigorate." ■

Ways a hospital can improve DP process

Communication gap should be tackled

While hospitalists can provide consistency in the care of hospitalized patients, there can be drawbacks when it comes to transitions in care.

At least one hospital has tackled this issue as part of a quality improvement project, initiated partly through Project BOOST.

"We recognize that from the hospitalist perspective, we have taken over more and more of inpatient care of patients," says **Christina McQuiston**, MBCHB, clinical director of senior services and a hospitalist at Asheville Hospitalist Group and medical director, senior services and Project BOOST team co-leader at Mission Hospital in Asheville, NC.

"There's a communication/information gap that did not exist in the past, when primary care physicians provided care continuity from inpatient

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to outpatient," McQuiston says. "In the past, the PCP took care of patients in the hospital, knew what had happened to them, and continued to see them when they left the hospital."

This is no longer the case.

"Our hospitalist group has done a very good job of coordinating with the hospital and getting paperwork to physicians in a prompt manner when patients leave the hospital, but we were not doing such a good job of making sure patients go to see their PCPs at discharge," McQuiston explains. "We know that was not happening in other areas of the hospital, from general surgery to orthopedics, and we knew there were more gaps in care transition."

Hospital leaders identified two major issues that needed to be addressed to improve the transition of care process: First, the discharge planning, case management, and social work areas in the hospital were decentralized and had no standard practices, and, secondly, there were problems with communication during care transition, she says.

McQuiston first focused primarily on the communication hand-off piece, she says.

"It was only once we got into the weeds with this that we realized our discharge process was broken, and we saw this as an opportunity to deal with that issue," she explains. "We couldn't deal with Project BOOST until we dealt with that issue."

As hospital leaders recognized the problem and determined to improve the discharge process, they hired a case manager leader who became an integral part of the Project BOOST team.

"She's been able to pull our case managers and discharge planners together around the BOOST project, and they're taking a key role in this," McQuiston says.

So far, the changes are new, but there likely will be some outcomes based on 30-day readmission rates and patient satisfaction scores available by this summer.

Here are some of the steps the hospital has taken to improve its discharge process and care transition:

• **It uses a computerized discharge process.** The computerized discharge process involves a discharge piece called DEPART, which is a work in progress, McQuiston says.

"It's an interactive discharge record that all disciplines can enter information into, and everyone can look at the record," she explains. "Also, there's a medication reconciliation piece."

The information entered in the system includes information from nursing, occupational therapy, physical therapy, case management, nutrition/dietary, and physicians.

• **DP begins on the day of admission.** "What happens now is, the case manager has variable lengths of notification time from a couple of hours to several days, and that's one of the problems we're trying to address with BOOST," McQuiston says.

"We're starting the discharge process on admission, and we're introducing daily, multidisciplinary rounds," she says.

The core group participating in rounds includes a pharmacist, nurse, case manager, and physician, but anyone else can participate as needed, she adds.

"The purpose is to give much more warning to case managers and discharge planners, so they can address all the necessary issues prior to discharge," McQuiston says. "There are several pieces, and one is to identify patients who are likely to have problems at discharge or gaps in their care."

The goal is to start addressing these issues as soon after admission as possible.

For instance, one issue the hospital has addressed involves the patient's mobility in the hospital and at home, including patients' risk for falling and home safety issues, McQuiston says. Other issues discussed are patients' social support resources, need for durable medical equipment, and financial issues.

"Everyone who has something to contribute talks about these," she says. "If an RN knows something the PT doesn't know, then this can be communicated in the multidisciplinary rounds."

The goal is to provide staff with a format for this type of communication that is more immediate than having people write chart notes that might never be reviewed, she adds.

This method hopefully will bypass the silos in which each discipline does its own thing with too little interdisciplinary communication.

"We try to keep it efficient and complete the rounds in a timely manner," McQuiston says.

• **It sets goals and obtains buy-in.** "We elected to start this project as a pilot program with the express desire that this will be the model for how we do discharge planning and transitions across the hospital," McQuiston says. "We hope by piloting this to address barriers, because sometimes you don't know what your obstacles are."

The pilot project has obtained buy-in from staff and leaders, partly through having a nursing case manager champion the project, she adds.

Before the hospital hired a new nursing case manager, discharge planning leaders stressed to the hospital administration that it was important to have this new person involved very quickly with the discharge quality improvement project, McQuiston notes.

"So, the new nursing case manager was very supportive of all the goals of BOOST and felt she could be an advocate for the BOOST project with case managers and discharge planners on a hospital-wide basis," she explains.

"At that point, we had not decided who was going to be doing the follow-up calls, whether it'd be nursing or unit secretaries or physicians," she says. "But the new manager wanted this to be a case management piece, and she obtained buy-in on the unit for this plan."

It's been more challenging to obtain physician buy-in on the discharge planning changes, and work continues on this front, McQuiston says.

"The hospitalists I work with feel they do their piece fairly and conscientiously," she adds. "But they're often unaware of exactly what goes into making a good discharge and a good transition."

Another point is that no one wants to see his or her own workload increase.

"We've tried to sell this as a process that will not make more work for staff, but which will change the way we do things to make the process more efficient and effective," McQuiston says.

"If this is going to be successful, we cannot add another layer of bureaucracy or work," she says. "If we're going to put in something new in the process, then we'll have to take something else away, so it's really a re-engineering process."

• **It piloted changes.** Mission Hospital started a pilot project on the medical unit and has planned to add a pilot on the surgical unit, because the challenges are different, McQuiston says.

"Once we have worked out the kinks of what works and what doesn't, then we'll be ready to look at taking this hospitalwide," she says.

"What has happened is that as other units in the hospital have gotten wind of what we're doing, they've been eager to incorporate some things we're doing, and that's naturally coming about without us having to set a timeline or deadline to it," McQuiston says.

For example, the cardiovascular services have attended some meetings and have looked at making some changes based on the discharge improvements discussed there, she adds.

"We'll make all of our materials available for everyone," McQuiston says. ■

Pharmacists conduct med rec at admission

Error rates decrease

Pharmacist involvement in medication reconciliation is so crucial to patient safety that one 450-plus-bed Wisconsin hospital invested considerable staff resources to make this a smooth process from admission through discharge.

"Pharmacists as medication experts are ideal to do medication reconciliation, but it is a labor-intensive process," says **Kristin Hanson**, MS, RPh, medication safety officer at Froedtert Hospital in Milwaukee, WI.

In a recently published study, the hospital showed that the medication reconciliation process has resulted in a reduction of medication errors from 90% to 47% on the surgical unit since pharmacists were assigned to this role. Also, the error rate decreased from 57% to 33% on the medicine unit.[1]

"We've made significant improvements in patient safety, and I feel confident that this is how we want to handle it," Hanson says. "This is not an inexpensive and easy improvement to do, but we feel it's the right thing to do."

After collecting some preliminary data in 2005, the hospital decided it made sense from a quality and safety perspective to have pharmacists involved in medication reconciliation for all patients, she adds.

The hospital leadership's decision was reinforced by The Joint Commission's focus on admission and transfer in its National Patient Safety goals and by the Institute for Healthcare Improvement's 5 Million Lives Initiative's focus on reducing medical harm, Hanson notes.

"We decided to start efforts with the admission history and get as accurate a medication history as we could when the patient is admitted," Hanson says. "The key piece is getting that accurate medication list for what the patient is on at home."

The hospital's administration saw the pharmacy's proposal to have pharmacists conduct the medication history at admission, spending an average of 20 minutes per patient, and agreed to fund 3.5 additional FTEs of pharmacist time, she adds.

"With the administration's support and with safety being a top priority, these were our new positions," Hanson says.

All of the pharmacists at Froedtert Hospital are clinical pharmacists who work in a decentralized

environment. They are involved with 11 decentralized teams in inpatient care, divided by intensive care units (ICUs) and floors. So each pharmacist is trained to obtain medication histories at admission.

Since pharmacists became involved, the hospital has identified and addressed more medication discrepancies at admission and discharge than previously, says **Carolyn Oxencis**, PharmD, clinical pharmacist at Froedtert Hospital.

"When I came on board, my portion of the project was admission medication history and reconciliation of orders," Oxencis says. "I collected information from the regular patient care unit and different patient populations."

Oxencis found that 53% of patient cases had some type of medication discrepancy, including both intentional and unintentional.

The intentional discrepancies would be when a physician purposely changed a patient's medication after hospital admission because the hospital either had a different drug on the formulary or because the physician needed to hold back on the patient's regular drugs for safety issues. An example would be a physician stopping warfarin or aspirin when a patient was admitted for a bleeding problem.

But the unintentional discrepancies could pose safety problems.

For instance, Oxencis recalls reviewing the home and hospital-initiated medications of a new patient and finding that the hospital surgeon had prescribed Coumadin despite the patient having a normal INR and no history of clotting.

"When I did further digging into it, I found out the patient was taking Coricidin, an over-the-counter cough and cold medication, and the doctor had misunderstood," Oxencis says.

The doctor had read the order incorrectly, thinking Coricidin was Coumadin.

"So the doctor was about to give the patient an anticoagulant when all the patient had been taking was Tylenol and a cold medicine," she adds. "This made me realize how easily a medication error could occur."

By having a pharmacist involved in the admission medication reconciliation, a potential adverse event was averted.

"There are all types of different errors or discrepancies that can occur in a hospital," Oxencis notes. "Each of these could have a potentially different impact on an individual patient."

Examples of potential medication discrepancies include the following:

- wrong strength;
- wrong directions;
- unacceptable abbreviation;
- missing strength;
- missing route of administration;
- missing directions;
- inpatient medication omitted;
- home medication omitted.[1]

Froedtert Hospital's pharmacist-conducted medication reconciliation was implemented for all inpatients admitted to the hospital, except for patients admitted for observation or 24-hour admits, Hanson says.

"We did a few extensive pilots before implementing it," she adds. "And we did extensive training for pharmacists on how to do the best job and finding the best resources to pull from."

Each pharmacist attended a training session that lasts up to two hours, and they were given competency testing.

"Then there were also some one-on-one training and observation," Hanson says. "We've built in this training for all new pharmacists now."

The pharmacy department added the additional pharmacist FTEs into its practice model and made patient care area pharmacists responsible for conducting histories of patients in their area.

"Rather than having one person do all of the medication histories and reconciliations in the hospital, each pharmacist does it for their patients," Hanson says.

Pharmacists take patients' medication histories when they're admitted, but are also available for consultations during the patients' stay and at discharge. The medication history information is placed in the hospital's electronic medical record, which makes it easier for physicians to review.

"When we started this it was a much more paper-based system," Hanson notes.

"Because we have such a complete medication history up-front and throughout the continuum of care, it should provide quite accurate information

COMING IN FUTURE MONTHS

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for the discharge component," she says. "And now with the electronic piece improving the workflow, they don't need to have a pharmacist involved intimately with every single patient."

There are some plans to expand the pharmacist's role in the hospital, including adding more pharmacist time to working in the emergency department and putting a pharmacist in the pre-operative clinic, Hanson says.

"Patients come in to the clinic a week or two before surgery, which is the ideal time to interview them about their medications," she says.

REFERENCE

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Survey sheds light on lack of senior planning

Senior care isn't made a priority

A new survey, conducted by a worldwide company that provides private, in-home care for older adults, suggests that older Americans and their adult children do a poor job of planning for their future needs as health begins to fail.

The survey, conducted by Home Instead Senior Care of Omaha, NE, had these findings:

- 73% of U.S. adult children and 65% of Canadian adult children say they have not planned or thought about their parents' care needs as they age.
- 50% of U.S. seniors and 58% of Canadian seniors likewise have not thought about their own care needs as their health begins to fail.
- 66% of seniors can name no more than two non-family care options.
- 67% of adult children have not used any potential information resources on senior care.
- 54% of seniors have not used information resources on senior care.
- Nearly 80% of seniors seem unaware of the need for long-term-care insurance.
- Seniors and adult children underestimate the cost of skilled nursing homes.
- About 25% of adult children are aware of adult day care centers, while 35% of seniors know these exist. ■

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