

Healthcare Benchmarks and Quality Improvement

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IHI program building foundation for more quality-conscious providers

'Open School' med students are initiating their own QI programs

Quality experts have long bemoaned the fact that medical students are taught precious little about quality and patient safety, but that trend has been changing thanks to a program sponsored by the Institute for Healthcare Improvement (IHI). Called the Open School, it was launched in September 2008 and now has more than 22,000 students registered, according to Director **Jill Duncan**, RN, MSN, MPH.

The goal of the school, she says, is "to advance health care improvement and safety competencies in the next generation. It's an attempt to address the fact that many academic organizations were teaching improvement and safety in a very limited capacity — some not at all — so we wanted to bring it directly to students."

The school's offerings, she explains, "vary from what feel like formal courses to case studies, video clips on YouTube, discussion boards, and journal articles." Probably the development the IHI found most interesting, she continues, "is that while the program was initially targeted at students, we've also found a large number of faculty members showing interest. They view the content and integrate it with their course curriculum and share it with other faculty so the knowledge can be spread."

But the program's reach extends beyond pure academic pursuits; a number of the students have already initiated QI projects on their own. "Their numbers are growing," says Duncan. "We're

Key Points

- Organization seeks to offset lack of QI education in medical schools.
- Health systems have started to form their own chapters.
- Quality managers can play an important role as mentors.

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excited because when we think about the Open School and online content, a big part of the culture is building experiential learning.”

Student tackles diabetes care

One of the students who has put her knowledge to practical use is **Saranya Kurapati**, who initiated a program targeting diabetes care — and also developed an elective course on quality. She recently received the 2009 David Calkins Memorial Scholarship for her work, which gave her free entrance to the 21st Annual IHI National Forum and a \$1,000 stipend to cover travel costs. Kurapati, a student at Loyola University of Chicago Stritch

School of Medicine, will get her MD in June.

Although she had been involved with QI and the IHI for a while, “It was my third year when I was actually on the ground in the ward, seeing patients, working in teams, and began to see what I could do to change the system,” she says. The Open School, she adds, “gave me more background tools and skills to do things in a much more professional manner.”

At the beginning, she recalls, she took the online courses. “While I broadly understood the concepts of QI, I did not truly understand what it meant; nor could I articulate it to people I wanted to join me.” So, she says, she gained “foundational knowledge” about QI — the history of how it came about, and how it can be applied to health care.

“I also learned about patient safety and how the two connect,” she says. “I learned about the PDSA [Plan Do Study Act] cycle and how to take an idea to a QI intervention and do continuous and rapid cycling.” In addition to being able to e-mail IHI experts, she says, “They had a number of white papers available for free, so if I was interested in a specific topic, I could read about it in greater depth.”

Her intervention took place at a medical student-run free clinic. “I kept going to the clinic and asked myself if this was really the best way to do things,” she recalls. “After the Open School, I realized there were a lot of interventions we could do to improve care in the clinic.”

She used the framework of the PDSA cycle to implement her initiative. “It struck me while on the wards that diabetic foot disease was the No. 1 cause of traumatic foot amputation,” she says. “So many of the patients we have at the clinic are diabetic — but how many times did I do a diabetic foot exam?”

So, Kurapati conducted a chart review, asking the secretary to pull three random weeks of patients. “During that period we saw 60 or so patients, and 20 were diabetic — of whom none had received a foot exam in the last year,” she reports. “Unfortunately, I don’t think we’re alone.”

She saw this as “A good way to demonstrate that a small and meaningful intervention could be done anywhere.” She then created a little note: “If your patient is diabetic, please remember to perform and document a diabetic foot exam.” Then, on a random Saturday, she had every chart reviewed. There were only 10 patients that day; of the 10, three were diabetic, and two of those three received proper foot exams.

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Editorial Questions

For questions or comments, call **Steve Lewis** at (678) 740-8630.

"The intervention was not as robust as I would have liked, but it demonstrated to me, and to those who ran the clinic, that with very little effort we can improve basic care," says Kurapati. "After a small intervention we realized we could make a big change."

Student becomes educator

Kurapati is continuing to spread the word about QI. She has created an elective for fourth-year students in QI at Loyola. "I drew heavily on IHI and on Dr. Chad Whelan, director of the hospitalist program, who's been a tremendous resource and mentor," she says. "I told him I wanted others to learn about QI, and he took it head on, agreeing to teach the course."

Kurapati says she will be doing a knowledge-based assessment to see how much the students know about QI. Meanwhile, she says, there is hope that Loyola will incorporate the course into its curriculum.

In addition, using her diabetes initiative as a springboard, she is now creating a QI model for medical student-run clinics. "There is not one article in the literature on QI in medical students," she notes, adding that she discovered that fact after asking the school librarian to research the matter.

"The next step is not there, but in how it is applied," she emphasizes. "Students are so interested in this effort, and almost every single medical school has a student-run clinic."

A role for quality managers

Both Kurapati and Duncan say there is a definite role for quality managers as mentors of medical students. "I absolutely believe that; it's important to have them as mentors," says Kurapati. "At Loyola, you're given a three- or four-year rotation that takes you everywhere, and it may be hard to consistently engage in a QI initiative, but at Loyola the quality managers have been incredibly open to speaking with me and getting involved in whatever capacity I wanted them to."

She says that mentorships are "desperately needed among students," and that if it is not possible to do it in person it could be handled via e-mail. "Quality managers or patient safety officers could teach QI to students, as well as to the other health care professionals," she says.

"We have five hospitals where we are doing a small test with some local chapters; they are

paired with a local hospital to see how they mentor these students who have expressed an interest," says Duncan. She adds that this program is "just getting started," and that interested quality managers can contact her at openschool@ihi.org or jduncan@ihi.org.

In addition, says Duncan, "We really hope hospitals will begin to see students as another partner in the community, so they can engage them while they're still students and can be influenced in an important way into thinking about quality of care and safety. It's a unique opportunity to do this while they're receptive to change, as opposed to them seeing it as something they just have to do as part of their jobs."

At present, she says, 25 chapters have been started in health systems, and "They are usually started in the quality department."

Kurapati adds that the school will "absolutely" impact quality and patient safety in U.S. hospitals. "There is a gap in education and training that students desperately need filled," she notes. "Also, students can feel incredibly empowered. As part of the hierarchy, you are at the bottom, but you're also not mired in the quagmire of the status quo; you can bring a fresh perspective. When students feel that there are small interventions which can do a lot to impact patient care, that's really empowering."

[For additional information, contact:

Jill Duncan, RN, MSN, MPH, director of IHI's Open School. Phone: (571) 236-8466.] ■

Quality award winner takes 'STEPPS' to improve

Hospital uses TeamSTEPPS philosophy

Exeter (NH) Hospital has already demonstrated its ability to improve quality and patient safety, but it's nowhere near finished. The facility, which has been named to Harvard Pilgrim Health Care's 2009 Hospital Honor Roll in recognition of its excellence in clinical quality and patient safety, is launching a new initiative based on the TeamSTEPPS program jointly developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD). (Honor Roll designees are those adult, acute-care hospitals whose performance was

among the top 25% nationally, as reported by the Centers for Medicare & Medicaid Services.)

“We are proud of the recognition but far from satisfied,” says **Barbara Hughes**, DNP, RN, vice president of system quality for Exeter Hospital.

The TeamSTEPPS program incorporates many of the most effective safety tools developed from the airline industry, national defense programs, and other highly safety-focused organizations and applies them to care settings such as the emergency department, operating rooms, and obstetrical services.

First released in 2006, TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals.

TeamSTEPPS seeks to provide higher-quality and safer patient care by:

- producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients;

- increasing team awareness and clarifying team roles and responsibilities;

- resolving conflicts and improving information sharing;

- eliminating barriers to quality and safety.

TeamSTEPPS has a three-phased process aimed at creating and sustaining a culture of safety with:

- a pre-training assessment for site readiness;

- training for onsite trainers and health care staff;

- implementation and sustainment.

“This program has the ability to revolutionize the way we work together as a team and communicate during challenging patient encounters so that we provide our patients with the safest environment and best clinical outcomes,” says Hughes.

Project goals clear

Hughes is very clear on her goals for the program. “We are looking at preventing errors and improving patient safety,” she asserts. In fact, she says, the program has grown out of Exeter’s own patient safety initiative. “Basically, we did a culture of safety survey a couple of years ago,” Hughes recalls. “We were pleased overall, but we felt there were still opportunities for improvement — especially in high-risk areas like communications and handoffs.”

One of the reasons TeamSTEPPS was chosen, she continues, is that it helps identify preventable

Key Points

- Evidence-based program seeks to optimize outcomes.
- Culture of safety survey identified opportunities to improve.
- OR, ED, and labor and delivery developed departmental goals.

errors. “They’ve been doing training for the last couple of years for health care organizations, and there is no charge,” says Hughes. (There are Five Team Resource Centers at Duke Medical Center, Durham, NC; Carilion Clinic, Roanoke, VA; University of Minnesota Fairview Medical Center, Minneapolis; Creighton University Medical Center, Omaha, NE; and University of Washington Medicine, Seattle.) “The only thing you have to pay for is to send folks to the training. You complete a readiness assessment, they evaluate you, and you get accepted.” (To apply for eligibility for training, call 877-6STEPPS.)

The TeamSTEPPS National Implementation Project also will provide support and guidance for the Team Resource Centers and their trainees through a user support network. This network will ensure proper implementation of TeamSTEPPS principles by offering channels of communication through webinars, a toll-free telephone line, and a web site. Trainees also will receive continuing education through new tools and measures that are researched, developed, and validated to supplement the curriculum.

Exeter sent six individuals to the three-day “Master Training” course — the chief of surgery, head of the ED, the quality coordinator and director of accreditation, one of the nurse leaders in the ED, and two family practice physicians from obstetrics. “Now the facilitators have come back and developed a project plan,” says Hughes. “They’ve also developed a scope for training and project goals; clinical and team goals; team assessment evaluation; and are now creating a training plan for all staff in the OR, the ED, and labor and delivery. We have a couple hundred folks who will go through training, which is just now being rolled out.”

Department goals customized

In terms of team goals for the various departments, they are customized for each specific area, Hughes explains. “In the OR, we will be using specific tools and techniques they learned in the

TeamSTEPPS training program,” she says. “These include the interdisciplinary briefs, where you stop and evaluate the situation and take a ‘time out.’ We are also looking to consistently sustain the goals of the Surgical Care Improvement Project [SCIP] at greater than 95% compliance; one of the ways we hope to do that is by using some of the teamwork tools and techniques.” SCIP is a national quality partnership of organizations committed to improving the safety of surgical care through the reduction of postoperative complications.

In the ED, on the other hand, the focus will be on handoffs, in particular between the department and inpatient units. “There we will use the SBAR [Situation-Background-Assessment-Recommendation] tool and focus on core measures for conditions such as pneumonia and medication events related to handoffs,” says Hughes. “So, you decide what is significant for your particular area.”

The chief of surgery is the lead for the project, says Hughes, while she is providing administrative oversight.

[For additional information, contact:

Barbara Hughes, DNP, RN, vice president of system quality, Exeter Hospital. Phone: (603) 778-7311. Web site: [http://teamstepps.ahrq.gov/.](http://teamstepps.ahrq.gov/)]

Video gets patients more involved in hand hygiene

Patients, physicians report more questions asked

A hand hygiene video developed by the Centers for Disease Control and Prevention (CDC) that asks patients to become partners in ensuring compliance by reminding caregivers to wash their hands prior to any treatment was shown to be effective in increasing the frequency with which patients questioned their providers about hand washing.

The video, called “Hand Hygiene Saves Lives,” was tested in common areas and patient rooms at 17 Catholic Health Partners hospitals; the research was coordinated by the Premier Healthcare alliance. The video encourages patients, family, and visitors to play a role in their own care by helping health care professionals remember to clean their hands before and after touching patients. After the video

Key Points

- Video uses a “real-world” clinical setting.
- Patients are encouraged to overcome reluctance to question providers.
- Creating a safety culture will make any initiative more successful.

was shown, patients were twice as likely to report reminding nurses to wash their hands, and doctors were twice as likely to report being asked by patients to wash their hands.

In addition, after watching the video, the majority of patients:

- reported that the video increased their knowledge about hand hygiene;
- reported that the video is a useful tool to educate patients about hand hygiene;
- recommended that the video be shown to other patients.

“We know that hand washing is less than optimal; on average, providers wash their hands 50% of the time,” notes **Gina Pugliese**, vice president of the Premier Safety Institute. “People say they wash more than they really do, and we support anything that can appeal to them and help them remember.”

Different types of appeals can be made, she continues. “You can appeal to the left brain with facts, or the right brain with emotions — whether you use posters, stickers, patient reminders, peer pressure from colleagues, or the convenience of hand hygiene containers,” says Pugliese. “A video is one more tool to help empower patients to feel comfortable about reminding the provider to wash their hands. This is one more way to empower them to feel it is OK to remind the caregiver.” In addition, she says, “The majority of doctors and nurses felt comfortable being asked, and it did not bother them at all.”

The intervention, she explains, was implemented over a period of a several months. “There was a month where the patients were pre-tested to get their opinions — what they thought of hand washing, how comfortable they would be about asking the caregiver if they had washed their hands, and so forth,” Pugliese shares. “The next month we watched them in the treatment rooms via closed-circuit TV. The month after that we asked if there had been any change.”

Interventions such as these can be even more successful if the proper foundation has been laid, says **Ann Marie Pettis**, RN, BSN, CIC, director of

infection prevention at the University of Rochester Medical Center. “We ran campaigns prior to the video,” she says. “Several years ago, we had providers wear a button saying ‘Ask me if I washed my hands.’ We did hand wash observation and documented how much of the unit was using the hand washing dispensers and it spiked, so we were already messaging that clearly to our providers. When the video came out, it reinforced the message.”

The video, she continues, “is short, which is important, and it actually shows the clinical setting, which makes it more effective.” The most unique part of the campaign, she says, “was the idea the patient or family was being encouraged to advocate for compliance on the part of providers. The whole idea is that we’re all in this together, and it’s OK to ask the provider if they are not seen doing what they are supposed to be doing.”

Pettis says there was some “initial timidity” on the part of patients and family to question providers when the original campaign was launched, “but there’s been some cultural shift and now, three years later, we don’t see quite as much,” she notes. “In general, the older patients are a little more uncomfortable than the younger ones — to them it’s not unusual to expect to be part of the health care team themselves.”

She says she now shows the video as part of the admission procedure. “What we plan to do soon is start a survey with patients asking them four very simple questions: ‘Did you see your health care professional sanitize their hands before touching you? After touching you? If you did not see them wash, did you feel comfortable reminding them? If you didn’t, please share why not.’ Then we end with ‘Thank you for helping us protect you from infection!’”

[For additional information, contact:

Gina Pugliese, vice president of the Premier Safety Institute. Phone: (704) 733-5874.] ■

Compliance rates low on egress, fire safety

For the first time in several years, The Joint Commission standards and goals with the lowest compliance rates are not directly related to the delivery of health care. In its annual listing of the standards or goals with the highest rates of

noncompliance for the first six months of 2009, The Joint Commission listed the following:

- **Life Safety (LS) 02.01.20:** The hospital maintains the integrity of the means of egress, 45% noncompliant;

- **LS.02.01.10:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat, 43% noncompliant;

- **Record of Care, Treatment, and Services (RC) 02.03.07:** Qualified staff receive and record verbal orders, 40% noncompliant;

- **Environment of Care (EC) 02.03.05:** The hospital maintains fire safety equipment and fire safety building features, 38% noncompliant;

- **National Patient Safety Goal (NPSG) 02.03.01:** The hospital measures, assesses and, if needed, takes action to improve the timeliness of reporting and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver, 38% noncompliant.

With ED managers often playing a key role in disaster planning, and with EDs particularly susceptible to the spread of fires due to their design, observers agree these are important areas on which to focus. This focus is particularly needed for the standard on egress, because there might be some misunderstanding about what constitutes compliance.

The egress standard is a double-edged sword for the ED, notes **George Mills**, MBA, FASCFE, CEM, CHFM, CHSP, a senior engineer with The Joint Commission. The good news is that most EDs are considered “suites” by The Joint Commission, he says. “As a suite, the egress corridor is considered an ‘intervening room,’ so the criteria we normally use for egress corridors do not apply,” Mills says. “That’s why in the ED, you can do patient care in what looks like a corridor.” So, for example, if you walk through this intervening room, he explains, you might see several triage bays on one side, with sliding door for entry. “That is not compliant in a normal patient care unit, but in a suite, it’s OK,” says Mills.

The 8-foot-wide clearance requirement also does not apply, he says. “If you have a Pyxis machine or a food cart in that area, it’s OK. The only thing we ask is a requirement to maintain a 3-foot path of egress, so you can always get out of the area from all the different rooms,” says Mills. Normally in the ED, most of these things are kept to one side of the space to provide a path of egress, he says.

The other requirement is that there must be

Key Points

- Hospitals still showing noncompliance with standards: LS.02.01.20, LS.02.01.10, RC.02.03.07, EC.02.03.05, NPSG 02.03.01.
- Egress standard a “double-edged sword.”
- There must be two “separate and remote” doors in and out of the ED suite.

two “separate and remote” doors in and out of the suite. “Most EDs are shaped in a horseshoe, so the two ways to get out are separate and remote from each other,” Mills says.

Where EDs can run afoul of the standard, he warns, is when they arrange to have patients boarded in hallways (in other departments) to manage patient flow. “It’s not compliant to be treating patients in hallways, say, in the med/surg area, because you have corridor clutter,” says Mills. “If you have a separate observation area, then that’s egress to an intervening room, but if you push them out of the ED early and board your patients in the hallways [in other departments], you have to be aware that’s a violation.”

The only exception is in an emergency situation, says **Kathy John**, MSA, ARN, CHSP, CHEP, chairwoman of the Atlanta Metropolitan Medical Response Healthcare Section. “If they activate their surge capacity plan, it’s just like converting other spaces such as outpatient spaces, auditoriums, and conference rooms to short-term usage for surge capacity,” John says.

Mills concurs. “If there is a surge situation, you have no options,” he says. “If you have to board patients upstairs as part of surge response, that’s acceptable.”

Some EDs aren’t ‘caught’

If boarding patients in other departments is a violation of Joint Commission standards, why are so many EDs doing it?

“They get around it because they haven’t been caught,” says **Mike McEvoy**, PhD, REMT-P, RN, CCRN, EMS coordinator, Saratoga County, NY.

“Here’s the problem: What The Joint Commission is telling you is that there are two different standards, and they do not treat the ED as a ‘floor,’ but it’s important for ED directors to know that what’s perfectly acceptable for them is not acceptable when a person goes to a floor,” McEvoy says.

It’s quite natural for ED managers to reason that if it’s OK to do it in their department, it must

be OK to do it upstairs in another department, he says. “Unfortunately, they don’t think of the ED as being any different from the rest of the hospital, but if a Joint Commission person tells you it is, then, oh yeah — it is!” McEvoy says.

Probably the most important consideration when you think about egress and evacuation is that typically you evacuate “at the wall,” he says. “So, keep in mind when you think about emergency planning to remove the curtains from your ‘picture’ of your department and use the walls as borders beyond which you have to move everybody,” McEvoy advises. ■

Fire standards are key for EDs

The fire safety standards set forth by The Joint Commission, which have low compliance rates, should receive special attention from ED managers. Observers note that the ED is a frequent site for unexpected fires, especially when set by patients. In addition, smoke moves quickly through an ED because of the open architecture, and many of the patients are very sensitive to smoke, so it is not tolerated well.

“That’s an accurate statement,” says **George Mills**, MBA, FASCHE, CEM, CHFM, CHSP, a senior engineer with The Joint Commission. “There is much less ‘compartmentation’ in the suite-like ED. If there is a fire in a room with four walls, it will be contained.” If patient rooms are not defined, you lose the ability to compartmentalize, he says.

Given this added danger, what are the responsibilities of the ED manager? **Mike McEvoy**, PhD, REMT-P, RN, CCRN, EMS coordinator in Saratoga County, NY, says, “I would say two things are important to do: One, have someone in the ED who is responsible for surveying these sorts of compliance issues — what are the standards, are the fire extinguishers where they need to be, are exits blocked?” This individual should check these items on a routine basis, he adds.

“The second thing, which is really hard to do — but very important — is to periodically conduct a drill where you actually practice evacuation and move large numbers of patients,” he says. McEvoy recognizes this practice is difficult to do with live patients, but says all EDs have quiet times when there are opportunities to prac-

tice moving simulated patients with ventilators and multiple IVs. "When you do that, you gain comprehensive appreciation for what would happen," he says.

Even the ICU had a drill

For ED managers who question the practicality of doing this type of drill, McEvoy has the following response: "We even did it in an ICU. We evacuated an entire portion onto another floor just to see if we had the equipment and supplies available to do that."

Kathy John, MSA, ARN, CHSP, CHEP, chairwoman of the Atlanta Metropolitan Medical Response Healthcare Section, says, "You may be able to reduce supplies in the hallways if there are too many, so there's less in the way if you need to quickly evacuate." In addition, she notes, "It's a requirement that the fire extinguishers be checked monthly and annually, so the ED manager needs to be aware of the location and who is responsible to test the equipment according to the [standards of the] National Fire Protection Agency."

The ED manager "needs to know and understand what the requirement is and who is responsible for it," John says. "They also need to understand the storage requirements around sprinkler heads. For example, they must make sure not to store anything too close to the sprinkler heads, because it makes them less effective."

Finally, she says, the manager needs to educate staff about the hospital fire plan as well as the evacuation plan: meeting places inside or outside the department in case of a fire; who turns off the medical gases; what to bring with them in case of evacuation (i.e., charts, medications); and how to do it. "I'm big on the team approach and everybody knowing their role, such as taking a head count when everyone gets outside, because the fire department will need to know if everyone got out," John says. ■

Quality Check measures added by Joint Commission

As of January 2010, The Joint Commission has incorporated into its Quality Check web site (www.qualitycheck.org/consumer/searchQCR.a.spx) the Centers for Medicare & Medicaid Services' (CMS') 30-day readmission rates for heart attack, heart failure, and pneumonia

Medicare patients.

Quality Check displays data on National Quality Improvement Goals for hospitals on selected performance measures in six treatment areas: children's asthma care, heart attack, heart failure, pneumonia, pregnancy, surgical care, and pregnancy. The ED's performance in all of these areas becomes part of the hospital's data submission to Quality Check. That information then can be accessed by consumers as part of their search for hospital care.

Bruce S. Auerbach, MD, FACEP, vice president and chief, emergency and ambulatory services at Sturdy Memorial Hospital in Attleboro, MA, says, "Once a person has been admitted to the hospital, the ED really has no further involvement in what goes on while in they're in the hospital or upon discharge." However, he notes, "Some EDs have instituted programs that process or provide more care in the ED or through which patients are overseen in adjacent areas — like observation or clinical decision units — as a means to manage those individuals they think they can take care of within a 24-hour-period and not admit them." These patients, he continues, will be discharged from the ED or the other units, in which case the ED staff that oversee that unit will provide discharge instructions, he says.

In addition, he notes, some institutions will put case managers in the ED. "Because they have so much to do with discharge planning, they will use them in the ED even for patients who are being admitted since they can start work early on discharge planning so that when they're discharged there are no obstacles in the way of going home," Auerbach explains.

Margaret VanAmringe, vice president of public policy and government relations in the Washington, DC, office of The Joint Commission, says that in addition to accreditation status and performance data, the Quality Check site also indicates "merit badges" for organizations that meet certain criteria for recognition, such as the Malcolm Baldrige National Quality Award. That annual award recognizes U.S. organizations in the health care, business, education, and non-profit sectors for performance excellence.

Why were these particular measures added? "We're trying to follow what is going on at the Hospital Compare web site [www.hospitalcompare.hhs.gov] so that people who got to ours do not have to go to another site just to get a couple of measures that are part our core measures set," VanAmringe explains. "We really had to be careful

about these three because they are only for Medicare patients, while all the others are for all adult patients." That presents the need to identify for consumers that the cohort is narrower, and that by and large it only represents the elderly, she says.

The need to show "good" numbers in these areas has taken on increased importance with the emphasis placed by national organizations on limiting preventable readmissions. The need for positive numbers might increase soon, warns VanAmringe. "Everybody right now, from a public policy and quality and safety standpoint, is looking at preventable readmissions, and if Congress passes a health care reform bill and it has a penalty for high readmission rates, then it becomes a monetary incentive as a quality and safety issue," she notes. ■

Data hold the key to low readmit rates

With The Joint Commission incorporating the Centers for Medicare & Medicaid Services' (CMS) 30-day readmission rates for heart attack, heart failure, and pneumonia Medicare patients into its Quality Check web site (www.quality-check.org), the performance of individual facilities will come under greater scrutiny. Additionally, health care reform legislation might include penalties for poor performance.

As a first step toward decreasing readmission rates, examine your data, says **Margaret VanAmringe**, MPH, vice president of public policy and government relations in the Washington, DC, office of The Joint Commission. "Look at readmissions and discern whether there are opportunities to reduce the number," she advises. "That will, of course, depend on disease category, population, age, and many different factors."

It will behoove you "to really analyze readmissions, assess these data, use a random sample of charts, and look to see if there is a certain group of patients in these three areas where you feel there could be the potential to prevent readmissions," VanAmringe says.

Michael C. Choo, MD, MBA, FACEP, FAAEM, ACHE, president and CEO of Clinton Memorial Hospital in Wilmington, OH, says, "It's always been very important to evaluate the data on a monthly basis and find solutions." Choo, who served for 10 years as the ED medical director at

Dayton Heart Hospital, is bringing what he learned there to his new position. "Congestive heart failure is the most difficult of the three because it's especially problematic in [the Medicare] population," he says. "Initiatives we've used include trying to identify at the time of discharge those patients who need extra support at home or additional education." For those patients who are identified as high-risk, arrangements are made for intense home health care followed by outpatient therapy sessions, he says. His current health system has congestive heart failure clinics, where patients' status is monitored to make sure they stay stable and don't return to the ED or the hospital, he says.

Myocardial infarctions and pneumonia are much easier, he says. "At the time of discharge, we make sure to assess the risk for return, such as home situation compliance probabilities, and communicate those risks with the primary care physician," Choo says. If the patient qualifies, he adds, home health care is recommended.

In the end, says Choo, "it comes down to how well you work with case managers. They identify the risks and coordinate discharge planning, education, and follow-up so the condition does not exacerbate." He has become "much more aggressively proactive in managing these issues," and, in fact, has begun placing case managers within the ED.

With sites such as Quality Check and Hospital Compare, VanAmringe adds, there also is a definite opportunity for benchmarking and for contacting facilities that are performing well and comparing notes. "Health care providers are very interested in comparing how they're doing, and what percentile they're in, compared either with similar facilities or those, say, in the same state," she says. "Being able to benchmark and compare is a very important aspect of quality improvement." ■

Flow strategies cover processes in and out of ED

Door-to-doc time drops 16 minutes

Because many throughput problems experienced by EDs are not caused by EDs, those managers who find themselves operating in a vacuum have little chance of success. Cincinnati Children's Hospital Medical Center can point to a comprehensive approach to improving flow that

addresses ED-specific issues and hospitalwide issues — and to an effective partnership between the ED manager and the hospital's patient flow expert.

"We look at flow from two different perspectives: flow through our department and flow out of our department," says **Julie Shaw**, RN, MSN, MBA, CEN, senior clinical director of the ED. "Our pediatric ED admits fewer patients [into the hospital] than an adult ED would, so internal flow is important to us, and of course, when we do decide to admit and send children to the inpatient area, external flow becomes important, so we've had some efforts in both areas."

Shaw has been working with **Pamela Kiessling**, RN, MSN, director of patient flow & clinical integration, clinical & business integration, and patient services. "Our goal throughout all of this is that patients should not experience delays," says Kiessling. "We want to deliver timely, efficient, effective care."

Although the changes have been in place for only about six months, the hospital already is seeing results. Comparing the May-July period, door-to-doc times have dropped from 61 minutes in 2008 to 45 minutes in 2009.

The ED has tried several strategies to address internal flow and had to abandon some of the earlier attempts, says Shaw. "We tried the idea of having a physician in triage, as well as a nurse whose main assignment was managing flow," she says. "We used those two in tandem with each other, but it was not sustainable in terms of personnel. The ED docs were not able to keep staffing levels high enough."

One of the more important initiatives implemented began in January 2009, Shaw says. "Under our old system, when the patient arrived, there was a clerical person who was the first person the patient saw when they came in the door," she says.

Now, Shaw says, every patient is seen by a nurse immediately upon arrival for a "quick look." "She asks a few questions, such as if they are in pain," says Shaw. "She also determines if they need immediate help, such as resuscitation, and if so, they move them into the resuscitation area." If they don't require such immediate help, they then go through a more complete triage process.

Shaw says the changes have ensured a safe flow as well as a smoother flow. "We do a high-level immediate sort before triage — meds, allergies, history — so patients with significant

respiratory distress, bad fractures, those requiring pain management, all those get recognized right away," she says.

Data on door-to-doc times and length of stay still are being formalized.

Addressing external flow

Ironically, one of the greatest challenges to external flow grew out of an effort to improve safety.

"We developed safe handoff care with the three general care units that represent the greatest 'exports' from the ED, but when we put it in place, ED wait times grew exponentially," says Kiessling. "Handoff was blamed, and the thought was that we just had to accept it, but we couldn't. For us, two hours is a really long time."

So this year, an interdisciplinary team of test units and involved departments have been "mapping" the entire process, Kiessling says. "We looked at nonvalue-added steps and tried to eliminate those," she says. "We tried to decrease redundant or unnecessary communication points." Thus far, one of the steps that seem to have made a difference is removing the nurse-nurse verbal report and replacing it with a faxed report, Kiessling says. "The opportunity to question and clarify is still there, but it is positively impacting wait times: In our small tests of change, we reduced the bed request to occupy time by as much as 40 minutes," she says. "It eliminates the whole telephone-tag situation you get with two people who are busy."

This was "a major culture change," says Shaw. How was it accomplished? "First, we had significant support from leadership on those three units as well as the lead level above them, the assistant vice president to whom they all report," she says. "Everyone wanted to make the process better."

The initiative advanced incrementally. First, it was tested on one nurse and one patient. Next it was tested on one team, then on the entire unit, then for a whole day, then on two units, then for 16 hours a day with two units, and so forth. "It's the whole PDSA [plan-do-study-act] quality improvement process," says Shaw. "We went back and did daily huddles, saw where we were failing, and made changes. For example, we learned we had to pull the patient escort folks in as part of the group."

The patient escort staff move the patient from the ED to the floor, notes Shaw. "We might be working to handoff and transfer in a timely manner in the ED and on the receiving floor, but if the

patient escort department is not focusing on the same need for timely response when a transport was requested, it can erase the gains made in other parts of the process," she says. "The patient escort leadership was able to educate their staff, change some supervision patterns, and change the priority of ED transport calls in our electronic system that handles requests for patient transports to ensure priority was given to ED requests. This helped us with consistency in response time and maintaining and sometimes improving on gains made with other parts of our improved process."

For the first couple of weeks, says Shaw, "we had handwritten data collection forms, and the leadership in all units was very involved talking to the nurses about how things were going, what was working, and what wasn't." When you start with small tests, "you can talk and bring information back to the table every single week," she says.

The units still meet weekly in an ongoing improvement effort, Shaw says.

The testing started last summer, she continues, "and we've had some success with decreasing [the handoff] piece of the transfer time."

The H1N1 outbreak ironically helped engender the needed culture change, Shaw says. "Our clinics expanded hours," she says. "We were running an overflow clinic to funnel off patients who were not high-level emergencies, and it kind of pulled the whole organization into thinking about what kind of things they do in their areas to support patient flow time in this area." They now understood that they were an important part of ED flow, because it was affecting them and their families, she says. "I couldn't have planned it, and I certainly wouldn't have asked for it, but we tried to optimize the opportunity to have everyone be involved," Shaw summarizes.

Overall, she says, "Our LOS actually holds steady across the past three years, which probably makes sense since the triage flow processes that we changed are very early in the patient encounter, and many other things would affect overall LOS," Shaw says.

What's most important? "The patients are getting where they need to go in a more reliable manner," Shaw says. ■

Predicting admits, discharges vital

The numbers don't lie, and having a handle on the numbers is a critical part of developing effective strategies for improving patient flow, says **Pamela Kiessling**, RN, MSN, director of patient flow & clinical integration, clinical & business integration, and patient services at Cincinnati Children's Hospital Medical Center.

"We knew that we were not as efficient as we could be with the whole process around discharges," Kiessling recalls. "For those who just needed antibiotics to take at home, for example, we did not plan in advance sufficiently to discharge them as soon as they were ready to go."

To improve in this area, you have to be able to predict discharges, she says. "The adult world has been doing this for a long time because of their payer structure. Pediatric facilities are paid differently [i.e., in terms of DRGs], so we have not been driven to be as proactive," Kiessling says. "But now we're doing it for the right reasons: to have the patients leave on time and have no delays."

Discharge prediction is a two-level process, Kiessling explains. First, the patient has to have discharge criteria. Goals need to be specific and well communicated to the entire team, including the patient and family. The second level of readiness has to do with the team tasks that need to be completed, such as home care arranged, prescriptions written, and orders written. "The goal is to have the team tasks completed prior to the patient's readiness for discharge whenever possible so that there is no delay for the patient once she or he is ready to go home," she explains.

Communication regarding the predicted discharge date and time is critical so that the entire

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team can execute the plan in a timely manner. For the ED, this timely discharge means a greater likelihood of a bed on the appropriate unit when it is needed and that any delay would be intentional and predictable and only to allow the right bed to be available.

In the absence of the ability to build new beds, Kiessling summarizes, timely discharge is a legitimate way to increase capacity in a hospital that operates with very few open beds at any given time.

In developing the predictive process, says Kiessling, “you have to build in the factor that you’ll be wrong some percent of the time — anywhere from 20%-30% — not because you’ve not planned well, but because the child may not progress as well as you’ve planned.” Still, she insists, “for any given unit, we can be right seven times out of 10.” When planning for beds, then, you should look at your predictions and build in processes to account for the “unpredicted” beds that will be needed.

Where appropriate, you can write conditional discharge orders, i.e., when the patients meet these criteria, they can go home, she says. These criteria must be patient-specific, Kiessling emphasizes. Discharge medication orders and discharge summaries are among the things that can be done ahead of time, she says.

At this point, says Kiessling, some units are

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80% correct in their predictions, while others are closer to 50%. While the discharge predictions are mainly done on the inpatient side, she notes, it still benefits the ED. “Oftentimes there are delays in the ED because of bed availability,” she observes. “In order to set the stage for improvement, we had to have beds.”

It’s difficult to track time saved by this process, she says. “Some patients may meet the criteria at 2:30 in the morning,” she explains. “Should we tell them to get up and leave because our numbers need to be good?”

At the same, says Kiessling, she began to look at how to predict admissions. “We have three kinds of admissions: scheduled, ED, and direct,” she notes. “The trick is to know what’s going on in the population you are looking at.”

In January 2009, she says, a math formula was developed that allowed the ED to predict its admissions. The formula takes into consideration admissions from the ED “yesterday,” “same day last week,” “two weeks ago,” “three weeks ago,” and “four weeks ago,” she says. These data are averaged. “We then look at trends for the last month in terms of percentage of ED visits admitted to the hospital and adjust accordingly,” she notes. “It isn’t an exact science yet, but we’re working on it.”

“We are within 90%-95% accuracy most of the time,” Kiessling says. “Folks in my department and the ED clinical manager figured [the formula] out, and it’s pretty good.” ■