Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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MAY 2009

VOL. 16, NO. 5 • (pages 49-60)

Montana RHIO seeks to improve patient safety and efficiency

Organization will help link some distant facilities in rural region

Members of the Health Information Exchange of Montana (HIEM), a Regional Health Information Organization in the northwestern part of the state, have begun using a computerized system that will help them integrate patient data across hospitals and clinics in the region. So far, Northwest Healthcare and Family Health Care has been using the technology, but by the end of this summer most members will be online.

"We are made up of hospitals and clinics from five communities in northwestern Montana. That includes the integrated network here in Kalispell of Northwest Healthcare, which is two hospitals, a nursing home, and a number of private practice clinics," explains **Kip Smith**, executive director of HIEM. "The outlying communities have four critical access hospitals and their medical providers in different kinds of clinical arrangements, plus two federally funded community health centers in rural communities."

HIEM's service area is 45,000 square miles, Smith continues. "While two communities are only 15 miles apart, the furthest facility in the membership network is 135 miles away and on the other side of the mountains," he notes. "They are very remote, rural, and mountainous, and present some unique challenges in terms of just the geography."

The organization was formed a few years ago, with the closest

Key Points

- Hospitals receiving transfers will be able to avoid conducting redundant tests.
- Rural practitioners will receive updated records from urban facilities that treat their patients.
- Quality leader will be monitoring new system for accuracy in medication reconciliation.

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hospitals (Northwest's Whitefish and Kalispell Regional Medical Center) leading the way. "Kalispell had a lot of patients being referred, and providers generated these questions: 'Is there a way we can share patient records in any kind of expedient manner, have more complete information, and not repeat tests that do not need repeating?'" Smith shares. "What came out of these initial discussions was that those two facilities agreed to pursue the same platform for hospital records."

However, he notes, the clinics' records continued to be on different platforms — some electronic and some paper. "Over time, the other facilities began saying the same thing — that it would be really nice if when they got the patients' records back from the hospitals, the home provider there would have a more complete record," says Smith.

Choosing a vendor

Ultimately, HIEM selected the Informatics Corporation of America (ICA) of Nashville, TN, to provide the necessary technology. "Probably the biggest challenge that our group was trying to address was the fact that we have a variety of electronic records already in place in these facilities and doctors' offices — and they're not all the same," Smith explains. "So HIEM started exploring the options of an overlay model. This involves buying and installing a software system that allows the matching and extracting of patient information from disparate systems so the provider could pull those records forward and see all the information — labs, X-rays, clinic data, and so forth — without ever having to convert to the same platform." The ICA software, Smith adds, was developed at Vanderbilt to answer internal questions they had about disparate medical records and having different systems "talk" to each other.

As with all conversions, says Smith, HIEM is using a phased approach. "We did a pilot here in Kalispell, tying together the records of the two Northwest hospitals; they're up and running," he reports. "Starting next week and through the end of the summer we will be bringing on three of the remote hospital sites and several of the physician clinics, then the two community centers. By the end of this summer, we hope to have most of the facilities online and able to share records."

Laying the foundation

As the system was being installed and training was under way, **Jere Schaub**, RN, clinical informatics supervisor at Kalispell Regional, who is leading the quality metrics initiative, began laying the foundation for measuring performance. "We wanted to try to be reasonable about expectations, but we did want to show improvement," she shares. For instance, she notes, she wants to see improved access to information for providers in Kalispell Regional, in the ED, and for smaller rural communities getting patients back from Kalispell. "The other things we are looking at are medication reconciliation, being able to track the ongoing meds a patient is on regardless of where they are being seen, and vaccination information," Schaub says.

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.

Subscriber Information

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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As HIEM was established, and later as ICA was brought on board, "we worked with them for help in looking at some metrics for success," Schaub recalls. "We formed a clinical working group made up of members from each organization, and we meet on a regular basis to discuss not only metrics but other things that may come up as we are reviewing the data."

The group has been meeting at least a couple of times a month for the past half year or so, she reports. "We started the pilot project in November and are still refining the data, and we're working with some target physicians to learn about the improvements they see."

How were these "target" physicians selected? "We started with our IT medical director and also chose inpatient hospitalists and ED physicians, as a few had expressed interest," Schaub says. "We also have a physician IT advisory group, and we involved them as well."

As for the data being reviewed, "we tried to pick data that were already being collected for other reasons — like hospital quality measures," Schaub notes. "In our smaller organizations they just do not have enough resources, so we wanted to choose metrics that made sense for them."

Schaub adds that individual facilities will be able to develop their own quality metrics. "Some may look at visits across the board — at issues like drug-seeking patients," she notes. "Others just want to be able to check if a patient claims they already had a certain procedure somewhere else."

Another significant metric Schaub plans to follow is physician satisfaction.

"We have surveyed our doctors around their satisfaction with the current means of data collection to establish a baseline," she notes. "We also want to see if they are utilizing online resources, and we want to make sure they're available through ICA."

Access is secure

Providers who use the system access it through a secure web site by entering a user name and password, explains **Candy Deruchia**, director of health care IT at Northwest Healthcare, who adds that a firewall has been created and other security measures have been taken as well.

The type of information the user can access varies with his or her role, she notes. "A physician can have a patient list and the patient's history," Deruchia explains. "Since more than one hospital is participating, they will get the whole picture — labs, radiology, history, EKGs, meds, problem lists, allergies, and so forth."

Not much staff training was required, she says. "You sit down with a doctor, and within a couple of hours, they're on the system," she claims. "It's very user friendly."

The real benefit of the system, she continues, "is that you can see what you want without needing to see multiple screens and getting lost; you can see the big picture in an easy format."

The key to optimal use, she emphasizes, is realizing the system is what she calls "patient-centric." "You concentrate on the patient, *not* the event," she explains.

The network will become even more robust in Phase II, says Deruchia, which will unfold over the next 12-18 months. "We will eventually have clinical messaging, a clinical dashboard, forms and notes in the system will become bi-directional, and we will be able to send data to statewide exchanges," she says.

A boon to rural facilities

Having a network like this is especially beneficial in a rural area such as northwestern Montana, notes Smith. "Given our geographic and distance barriers, this is huge," he says. "If we can share records back and forth, in some cases we may even avoid a patient being transferred."

What's more, he adds, continuity of care should be vastly improved. "I've seen so many times in the past where patients were referred from a rural to an urban facility, and the urban facility just has basic information and they turn around and repeat a test that may have been done a week ago," he notes.

The proof of success, he concludes, "will be providers telling us that this gives them much better information on which to make patient decisions."

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'Clinical triggers' program cuts cardio arrest rate

QM finds alternative to rapid response team

Rapid response teams, in the classic sense, may not be the best option for all hospitals, as a recent article in *The Joint Commission Journal on Quality and Patient Safety*[1] clearly shows. A "clinical triggers" program at the Denver Health Medical Center (DHMC), which did not involve the creation of a separate team to handle typical "RRT" situations, was able to reduce the cardiopulmonary arrest rate by 39% and significantly decreased the number of ICU "bouncebacks" within 48 hours or transfer from the ICU, from 4.62 to 3.27 per 100 ICU transfers.

"Before we started down the road of rapid response process, we were looking at some of our outcomes and in-depth case reviews, and four things jumped out at us: failure to recognize clinical deterioration; failure to communicate and escalate concerns; failure to physically assess the patient; and failure to diagnose and treat appropriately," recalls **Kendra Moldenhauer,** RN, BSN, director of patient safety, quality, and regulatory compliance, and lead author of the article. "As we looked at the situation and read more about rapid response teams, we thought that for us it might be more important to do some education with nurses and residents, and set up a process as opposed to a team, because we do have the necessary resources in our organization."

Departing from the model

In what ways, then, did the DHMC model differ from a more familiar RRT model? "The use of clinical triggers is similar, and having someone at the bed is the same, but not having a separate team — that's the core difference," says Moldenhauer. "The other thing we accomplished is not having to hand off to people who may not have any familiarity with the patient and their condition."

In addition, she says, "we felt we had a real opportunity to sharpen the nurses' clinical skills using this other process."

This was accomplished through two main initiatives, Moldenhauer continues."One was by developing the clinical triggers and getting them out there," she says. Dr. Phil Mehler, chief medical officer "and I spent a lot of time going to staff meetings, nurse educator meetings, and so forth, talking about the clinical triggers and how to make nurses aware of them, and we also made sure new nurses were educated."

The other initiative, she says, was a project using Lean methodology. "We did a rapid improvement event around nursing recognition of clinical deterioration," Moldenhauer explains. "We conducted education sessions with techs and CNAs [certified nursing assistants], and developed laminated prompts for those folks that were at the same location as the flow sheets, so they would have a list of the values that required notification."

In addition, she says, "we did lots of auditing." Not only did her team look at all the rapid response calls, but each nurse audited records on his or her floor to make sure that if there was a change in condition a physician was notified. "They were given immediate feedback," Moldenhauer adds.

One of the key messages of the entire program was "vitals are vital," and this was communicated on an ongoing basis through staff meetings, utilized by physicians in resident training and at different outcomes conferences and during "M&Ms," — "where the attendings were sure they made residents aware of that message," says Moldenhauer.

Promoting empowerment

In the article, the authors also emphasized the importance of empowering the nurses to communicate their concerns. "This was initially done by developing the [clinical triggers] form and the process for them to escalate, and telling nurses that they *had* to act on these clinical triggers," says Moldenhauer. "Then, you need to call someone to get help using SBAR [Situation-Background-Assessment-Recommendation] communications, and if you do not get help you are not only empowered, but *required* to escalate to the next level of care."

The physicians, she says, have responded very favorably, and now better relationships are developing, and feedback is positive.

As for the project's success, Moldenhauer also credits the involvement of leadership. "Having Dr.

Key Points

- No separate team required for rapid response.
- Nurse education critical to success of initiative.
- Model is more readily implemented in academic facilities.

Mehler involved in the project and helping to drive this, as well as having support from directors of service from get-go was very important." she says.

Moldenhauer is not prepared to say her facility's approach is superior to an RRT approach. "I think that it's better for *our* facility," she explains. "Some people have been very successful using rapid response teams; what works for you and improves outcomes is the way to go."

She reiterates that teaching facilities have the resources necessary for her model. "Because we are a level I trauma center, we have a surgical attending in-house and anesthesia here all the time, as well as critical care attendings and hospitalists," she points out. "In a community hospital, you probably could not do this."

Moldenhauer says she remains open-minded, and is willing to change the process if need be. "But it does improve communications, it sharpens nursing skills, and has improved outcomes without adding one more handoff."

Reference

1. Moldenhauer K, Sabel A, Chu ES, Mehler PS. Clinical triggers: an alternative to a rapid response team. *Jt. Comm J Qual Patient Saf*, 2009;35:164-174.

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Tumor registry aids in ongoing QI efforts

Data used to benchmark, meet practice guidelines

At the Cleveland Clinic Cancer Center at Fairview Hospital, "quality" is more than a word, says **Susan Dunson**, MSN, RN, OCN, administrator of oncology services. "Our mission statement includes the word 'quality,' and we're always looking for ways to measure it," she says.

That measurement, she continues, starts with benchmarks and national standards. "We use the National Comprehensive Cancer Network's [NCCN] practice guidelines," she says. "We have a multidisciplinary committee chaired by a physician that looks at these guidelines for each specific tumor site bi-monthly."

Key Points

- Reporting of cancer data is mandatory in all 50 states, but this facility uses same data for PI projects.
- Data include treatment provided, such as surgery, chemotherapy, radiation, or hormonal therapies.
- Quality leader shoots for "100% compliance" with national guidelines.

In addition to comparing its clinical practices to those guidelines outlined as best practices, other quality indicators are used, particularly from the National Quality Forum and the American College of Surgeons' Commission on Cancer, which have chosen six indicators to monitor.

This naturally requires a lot of data, the collection of which, says Dunson, is enabled by the Cancer Tumor Registry maintained at the hospital. "The data we need can generally be accessed through the general data collection fields of the registry," she explains.

One requirement, different models

Every state, Dunson explains, has mandatory cancer incidence reporting. "The state of Ohio reports through a branch of the Ohio Department of Health called OCISS — the Ohio Cancer Incidence and Surveillance System," she says.

The tumor registry at her facility has many data fields, including demographics, pathology, cystology, grade, size, and lymph node involvement. "It also records the treatment provided, which may include surgery, chemotherapy, radiation, or hormonal therapies," she adds.

A tumor registry, she continues, is a group of individuals "who are hopefully CTRs [certified tumor registrars], who abstract data from patient charts. It is their job to report these data to the state," she notes. While all facilities in the state are required to have a registry, "some hire their own CTRs, while others use a staffing service," Dunson says.

Her registrars sit on the performance improvement committee. "They have a place at the table," she notes. "They also sit on the cancer committee itself, which is the governing body."

The registry data also played a key role in the facility recently receiving a Commission on Cancer accreditation. "We earned accreditation with

commendation, and the registrars were a big part of that team," says Dunson. "That [accreditation] speaks to the quality of a program, as it is recognized nationally and is good for three years."

Outcomes are tracked

The registry is particularly helpful in tracking outcomes, notes Dunson. "Patients are followed for years to provide long-term data — which is wonderful when you want to find survival rates over five years," she notes. It's critical to report these data accurately, Dunson emphasizes. "So if the registry can't find some particular information, we use an RN, who is experienced with cancer treatments to retrieve the data. If the patient did not receive all the elements of care we would expect, we ask an RN to review the chart to find the reason an element was missing. Was the element missing due to patient choice or a system or process issue? Any patient management outliers are discussed at the cancer performance improvement committee, where physicians evaluate the quality of care rendered," she says.

For example, one of the NQF measures is radiation therapy administration within one year of diagnosis for women under 70 years old receiving breast-conserving surgery for breast cancer. "If the field in the tumor registry is not complete, we send a nurse into that chart to find out why it was not given; perhaps the patient moved out of state and we lost the ability to track them; perhaps they refused the treatment for some reason, or they just failed to come in for the treatment." The reason this extra level of research is employed, she explains, is because "our goal is always 100% compliance."

As science and technology develop, Dunson continues, the registrars track new and different elements. "For example, sentinel node breast biopsy was added as a new metric in the standard of care, so we monitor it monthly," she says. "We also monitor breast-conserving surgery monthly — did they have a lumpectomy or a mastectomy? Where we find a system failure, we change policy and educate everyone involved in the care of that patient to prevent it from happening again."

Each unit tracks different metrics, Dunson adds. "For example, nursing tracks pain, radiation tracks treatment accuracy, social workers monitor each support group session with a questionnaire, and breast nurse navigators track the time it takes to get from an abnormal mammogram to biopsy."

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Health care services are becoming more integrated

Experts see greater unity

In some ways, the direction health care is heading could be seen as a back-to-the-future scenario.

Discharge planning may return to its roots as a team process.

"Years ago, when I started out, we worked as a team and met once a week to discuss discharging patients," says **Elizabeth J. Clark**, PhD, ACSW, MPH, executive director of the National Association of Social Workers in Washington, DC. Clark is a member of the National Transitions of Care Coalition (NTOCC) advisory task force.

"We had a nurse, social worker, and sometimes a clergyman," Clark recalls. "That was when length of stay [LOS] was much longer, and you had a full component in the hospital setting."

The discharge team did a good job of returning patients home, she adds.

"Visiting nurses would come in the hospital and meet with us and do a home assessment," Clark says. "Then people would leave the hospital, and their transition was pretty good."

Years of cutbacks at hospitals forced cost-cutting changes, such as putting the discharge planning role on the shoulders of nurses, she adds.

"They decided nurses could do everything, which is unfair to nurses because they have a lot to do," Clark says. "They kept cutting back because of

Key Points

- Cutbacks at hospitals over the years have forced cost-cutting changes, including putting the discharge planning role on the shoulders of nurses.
- Long-term financial efficiency is compromised when discharge planning is not a priority.
- Obama's focus on prevention in health care could increase momentum back to preventive care.

financial efficiency, and that's been a really unfortunate way to focus on good, patient-centered care."

But over time, health care researchers and experts have noticed a trend of patients who are discharged without adequate resources returning to the hospital within weeks. The long-term financial efficiency is compromised by a model in which discharge planning is not a priority.

"I don't think many of us would say it's very efficient to have someone go home today and then be back in the hospital in two weeks," Clark says.

"They don't like to include education and prevention in their efficiency measures," she adds. "But if they don't do a better job of educating the patient and caregiver, then they're not going to be able to stay in the home."

There are models of collaborative discharge planning and transitions of care teams that offer hope, Clark says.

"It's like going back to the future," Clark says. "In my mind, we're going back to the kind of care we used to give, but we're doing it on an outpatient basis instead of an inpatient basis."

What could increase momentum back to preventive care and more focus on the discharge planning process is President Obama's focus on long-term improvements and prevention, Clark says.

"The new president has come out very strongly in favor of prevention, and that's the first time we've heard a president talk about prevention in terms of their mandate," she says. "We have always known how to do good health counseling and prevention, but nobody has ever been interested in it."

Medicare's reimbursement style should be changed to make it easier on patients and providers, as well as to make the process more efficient, Clark suggests.

For instance, one current barrier is a reimbursement system that allows only one provider to be paid per patient per day, she says.

"If you come in to see one doctor in a day, then if you want to see a dietitian, you'll have to come back another day," Clark says. "It places a tremendous burden on the patient."

These types of barriers make it more challenging for health care providers to collaborate.

Another change that could cause care collaboration and integration involves pending health care workforce shortages.

There are workforce shortages in health care across the board, and as those shortages become more critical, there will be more health care integration, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America in Little Rock, AR. Lattimer also is a member of the NTOCC advisory task force.

"I honestly believe our shortages will drive us to unite," Lattimer says. "We see a lot of case management teams where nurses and case managers work together."

And the next push will be to increase the involvement of families and caregivers in the whole process, she adds.

Discharge planning teams will need to improve patient and family education and learn more effective communication strategies, Lattimer says.

Communication issues to consider

They'll have to consider these communication issues, she adds:

- What is the health literacy of the patient and caregivers?
- Do the patient and family understand medical terms?
- Is English their primary language?
- Can they comprehend English?
- Did we write the discharge plan patient literature in medical jargon?

"There's a significant recognition of what's good communication and how we can develop that," Lattimer says. "The patient and family might never ask questions while they're in the hospital, and then they might miss their follow-up doctor visit and end up back in the emergency room." ■

Scribes help ED avoid expense of hiring PAs

'Clinical information managers' mostly pre-med

The hiring of physician scribes, known as "clinical information managers," has helped Saddleback Memorial Medical Center, a five-hospital system based in Laguna Hills, CA, to save a significant amount of money by avoiding the hiring of physician assistants (PAs) for its two EDs.

"PAs cost at least $50 an hour, and we're spending $15 an hour on the clinical information managers and still surviving and getting the job done well," says **Marc Taub,** MD, FACEP, medical director at Saddleback Memorial ED and vice chief of staff.

This strategy was implemented several years ago, he notes. "We put it in place to try to free up physicians to have more time at the bedside and spend less time on documentation — being stuck charting," he explains. Most of the scribes are local pre-med students, Taub says.

The system has two campuses — one in San Clemente, the other in Saddleback-Laguna Hills — and those individuals are used differently in each ED, he says. In the smaller department in San Clemente, which has 15,000 annual visits, they use them to help track labs, X-ray results, and also monitor documentation to make sure they meet Centers for Medicare & Medicaid Services' requirements, core measures, and Physician Quality Reporting Initiative (PQRI) measures, says Taub. But in the larger Saddleback-Laguna Hills department, which has complete electronic medical recordkeeping for its 36,000 annual visits, "it's more about managing the electronic documentation phase."

Managing the chart and the information coming into it is especially important if you don't have good interfaces with other systems, says Taub. "For example, if the lab is not automatically populating the chart, they can bring that information in," he explains. "They can also watch the trackboard."

The scribes will ask nurses about labs that are not back, so the doctor will understand the reason for the delay, says **Kim Hogerson**, RN, CEN, ED manager at Saddleback. "They run around from place to place while the doctors are concentrating on the patients," she explains. "The nurses can do the same, rather than trying to track down the doctors." **(This strategy has yielded more than financial benefits. See the story, below.)** ■

ED leader: Scribes have many benefits

When Saddleback Memorial Medical Center, a five-hospital system in Laguna Hills, CA, hired scribes for its two EDs and eliminated the need for physician assistants, it saved a significant amount of money. However, that's not the only financial benefit the EDs have realized, says **Marc Taub**, MD, FACEP, medical director of the Saddleback Memorial ED.

"They allow our physicians to see more patients per hour, which means more revenue," Taub says. He points out that his physicians probably see at least one more patient per hour each since the addition of the scribes.

What's more, he adds, his facilities' performance outshines some of the others in his organization. "We serve with over 50 hospitals in a large physician organization [California Emergency Physicians], and we have some of the lowest levels of down-codes in the entire organization," Taub notes. "That's definitely dollars saved."

While the scribes are used for a variety of tasks, Taub makes one important exception. "We do not use them for CPOE [computerized physician order entry]," he says. "That would probably not be the safest option."

An added benefit is that this approach provides valuable experience for the pre-med students who fill the positions, Taub says. "It's an amazing experience for them. They learn about labs and disease processes," he states. "It's a huge win-win." ■

Redesign helps EDs improve patient flow

The ED managers and administrators at Cuyahoga Falls (OH) General Hospital and the Greater Baltimore (MD) Medical Center agree that careful attention to design considerations in their new departments significantly improved patient flow and communications among staff members.

"We measured operational and patient satisfaction outcomes, and you could easily say embedding radiology [in the ED] helped take us from an average time of 60 minutes to 20 for X-rays," reports **John Wogan**, MD, chief of the ED at Greater Baltimore.

In addition, the department had been going on diversion about 200-300 hours a month, and that number is down to 15-25 hours a month, he says. "Diversions had been a real problem, and that's a metric that works for us," he says of the reduced times. In addition, he notes, door-to-doc times in the department (when all operations were housed in a single unit) were 60-70 minutes prior to the redesign. Now, they are at 50 minutes in the urgent care portion of the department, and 20-30 minutes in the pediatric section.

The "circumscribed" footprint of the new ED, as Wogan describes it, was designed to accommodate a change in flow. "We wanted to trifurcate

the ED into three areas [the main adult ED, the urgent care center, and pediatric ED], and create a different operational model in the triage process," Wogan explains. The reception area was designed to help move registration from the waiting room to the bedside. They set up a triage reception area where the receptionist cohabitates with the triage reception nurse, he says. It's "where they do a 'quick look' — name, date, chief complaint — and if there is a room available in the back, they can get there quickly," says Wogan.

There are effectively three nursing pods that are on the interior of the department and patient rooms circling around on one continuous track, he explains. This setup provides for maximum flexibility, Wogan says. "Even though urgent care has a designated eight rooms, if there is overflow from the main ED, we can use that space," he says. "We can easily co-opt three rooms for either of the two other units."

Kathy Rice, president and CEO at Cuyahoga Falls, where the new ED also has a circular design, says, "the redesign has not only made us more efficient, but the staff can work more effectively in teams, and it provides a more closed setting for patients. The great advantage is having staff and physicians in one [central] block of space so they can communicate verbally easy and take visual cues from the computer tracking system, so everybody has the same information at the same time."

What's more, the department was created by remodeling an existing clinic, which was much less costly than it would have been to build an entirely new ED, says **Frank Zilm**, DArch, FAIA, president of Frank Zilm & Associates, Kansas City, MO, and the architect for both facilities. "We did it all for under $2 million, and it probably would have cost about $5 million to build a new department," he says. "It shows you can work within existing walls to create operational improvements. It would have been a very difficult site to expand on." ■

Patient education program slashes ED readmissions

Patients taught about disease and meds, follow-ups

A new initiative at Boston University Medical Center called the Re-Engineered Hospital Discharge Program (RED) has significantly reduced additional ED visits and readmissions. Thirty days after their hospital discharge, the 370 patients who participated in the RED program had 30% fewer subsequent ED visits and readmissions than the 368 patients who did not.

In addition, 94% of the patients who participated in the program left the hospital with a follow-up appointment with their primary care physician, compared to 35% for patients who did not participate. Also, 91% of the participants had their discharge information sent to their primary care physician within 24 hours of leaving the hospital.

The program used specially trained nurses to help one group of patients arrange follow-up appointments, confirm medication routines, and understand their diagnoses using a personalized instruction booklet. A pharmacist contacted patients two to four days after hospital discharge to reinforce the medication plan and answer any questions.

"Everyone wants patients to be safe and prevent them from coming back to the ED when it may be unnecessary, and giving them the tools they need to take care of themselves when they are home is huge," says discharge nurse **Lynn Schipelliti**, RN, one of the "discharge advocates" on the project. "This [instruction booklet] is a great tool and reminds us as well to do things that sometimes we as clinicians forget to do," she says.

Brian Jack, MD, head of the project and associate professor and vice chair, clinical director, Lesotho Boston Health Alliance Department of Family Medicine, Boston University School of Medicine/Boston Medical Center, says, "The program is successful because, in a nutshell, we prepare people for discharge and teach them about their diagnosis. We review their meds and how to take them, when their follow-up visit is scheduled, what to do if there's a problem, and then we test their competency."

How is that testing done? "For example, if they have been taught about three or four different medications, we mention one of those drugs and ask them, using a customized booklet we created for them, to show us how many of those pills they take each day," Jack says. This "open-book test" lets the discharge nurse know whether additional education is needed, he explains. The same test can be used, for example, to confirm that the patient knows when, where, and with whom their follow-up appointments will be. ■

ENA study cites barriers to NPSG compliance

Culture must change to engender safer processes

While the response rate (4.6%) was small, the message delivered in the results of a survey by the Emergency Nurses' Association (ENA) was huge: Significant barriers still remain to compliance with National Patient Safety Goals (NSPGs) in the ED.

The survey, which went out to 28,000 ENA members and 2,800 ED managers, was based on replies from 2,200 ED nurses and 129 ED managers, The results were published in the January 2009 issue of *The Joint Commission Journal on Quality and Patient Safety*.[1]

In the case of many of the NPSGs, respondents indicated that while policies were in place that reflected the goals, compliance still was being hindered. For example, while 85.7% of the EDs had universal timeout policies, only 23.2% reported no barriers to implementation. Regarding having at least two patient identifiers, while 96.9% of the EDs had a policy in place, only 46.3% reported no barriers to implementation. In some cases, even policies were lacking. For example, only 33.8% of EDs said they had a readily available and visible list of "Do Not Use" standard abbreviations, acronyms, and symbols.

While conceding that the current working environment in the ED — overcrowding, insufficient treatment space, boarding, longer wait times, and patients leaving without being seen — mitigates against compliance, the authors say there are steps ED managers can take to address barriers to implementation. "The first thing an ED manager has to do is look at where they stand on these findings. Some folks do not have as many barriers as others," notes **Susan Paparella**, RN, MSN, one of the paper's authors and vice president of the Institute of Safe Medication Practices in Horsham, PA. Send the right message and set a culture of shared responsibility for safety, she says. "Safety is not a project, but should be a thread running through all the things we do."

Debby Rogers, RN, MS, vice president of quality and emergency services for the California Hospital Association in Sacramento, agrees. "What I was struck by in reading about barriers is the culture," Rogers says. "For example, while most hospitals used two unique patient identifiers, 19.5% of the nurses said the bracelet was not always available [when meds were ordered], and yet they probably gave the meds anyway."

Changing the culture in the ED could be one possible solution, she suggests. "What if it becomes the culture of the ED that meds are never given without a bracelet?" Rogers poses. "Then that becomes the acceptable practice." Culture change drives the change in practice, she says. "You might look at the list of National Patient Safety Goals and assess the culture in ED around these areas," Rogers suggests.

To address culture change, the California Hospital Association is developing a California Hospital Patient Safety Organization. "The Association for Healthcare Research and Quality has a culture survey that hospitals can give every member of their staff," Rogers points out. "We have automated it, and we will try and get all the hospitals that want to, to use the survey."

The timing couldn't be better to revisit your compliance with National Patient Safety Goals: No new goals will be added this year, according to The Joint Commission.

Reference

1. Juarez A, Gacki-Smith J, Bauer MR, et al. Barriers to emergency department's adherence to four medication safety-related Joint Commission National Patient Safety Goals. *Jt Comm J Qual Pat Saf* 2009; 11:49-59. ■

New ED processes remove barriers

While removing the many barriers to National Patient Safety Goal compliance that exist in the ED is not always easy, it can be done, as demonstrated by some of the safety improvement processes instituted in the ED at the University of Kentucky Medical Center in Lexington.

For example, in order to improve patient identification, you've got to introduce a standard method, notes **Mary Rose Bauer**, MSN, quality compliance coordinator for emergency trauma services and a co-author of a recent article in T*he Joint Commission Journal on Quality and Patient Safety* that addressed many of these issues. "Since we're communicating across an entire system, it's

important not only for the staff to understand what the identifiers are and when to use them, but to provide scripting," she says. "This is most important, so when the staff approach the patient, they have a standard way of talking to them so they get the correct information."

In her ED, for example, every staff member says, "Tell me your name, and tell me your date of birth." "You do not want some people walking up to a patient and saying, 'Hi, Mrs. Smith, I see your data of birth is such and such,'" Bauer offers. "This tends to lead to problems in patient safety."

Here are some other methods used in the ED to ensure safe practices are followed:

• A pharmacist has joined the ED staff and works during the busiest times for the department. The pharmacist reviews medication reconciliation, standardized drug concentrations, and look-alike and sound-alike drugs. "We have totally reorganized our Pyxis so that we do not have look-alike drugs in areas right next to each other," Bauer notes.

• Standardized abbreviations are displayed on posters in the department and also are listed on the medication reconciliation form. "We also have audits performed by a pharmacist so that everyone knows where the problems lie and what needs to be done in terms of staff education," says Bauer. The ED is more than 97% compliant for physicians and nursing staff, she notes.

• The SBAR (Situation, Background, Assessment, Recommendation) system is used to improve the effectiveness of communications. "We have not only educated the staff, but every staff member has a little card they keep on their ID badge that spells out specific information you need to give in a handoff — certain things we must do before the patient is passed on to the floor," says Bauer.

Finally, she says, "during every staff meeting we have some form of Joint Commission training. We review all the National Patient Safety Goals and look at our compliance rates." ■

Understand the intent of NPSGs

One of the keys to improving your ED's adherence to the National Patient Safety Goals is to "appreciate their intent," says **Susan Paparella**, RN, MSN, vice president of the Institute of Safe Medication Practices in Horsham, PA, and one of the authors of a recent article in *The Joint Commission Journal on Quality and Patient Safety* that addressed many of the reasons EDs have difficulty complying with the goals.

"We found that there wasn't a clear understanding of the intent and how to work with staff to implement the goals in a safe way," Paparella says.

Often ED nurse managers and nurses approach them "as another set of new rules," rather than trying to better understand the evidence behind their creation and then going back to their own practice setting and seeing where the gaps are, she says. This approach can present a challenge for some ED nurses, she notes. "ED nurses are very capable of changing on a dime, but without coaching on risky behaviors, they may do what they have always done and without realizing it they may be adding risk," Paparella says.

How can an ED manager gain a better understanding of the intent of the goals? "They're got to read up on them, and not just take them on face value," she says. "They also need to feel comfortable about accessing the requisite [hospital] resources in terms of their risk managers and patient safety officers." The goals are not limited to the ED, so talking to these individuals can be very beneficial, Paparella says. "The applications they use may require some re-analysis by the ED, but you should go to those folks because we all want to see these goals accomplished," she concludes. ■

COMING IN FUTURE MONTHS

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■ Task force offers new guidelines for preventive use of aspirin

■ Touch-screen check-ins put smiles on patients' faces

Know CB requirements when referring to PA care

Discharge planners and others might find the rules confusing with regards to consolidated billing (CB) under the Balanced Budget Act (BBA) of 1997. This may be particularly true when patients are discharged to skilled nursing facilities (SNFs) and home health services.

The Centers for Medicare & Medicaid Services (CMS) has provided descriptions and clarifications about how CB works for these post-acute services at these web sites:

- www.cms.hhs.gov/SNFPPS/05_Consolidated Billing.asp;
- www.cms.hhs.gov/HomeHealthPPS/.

Here is a summary of what CMS says:

Changes were made to original CB legislation: The original CB legislation in the BBA was modified over the years. Now the provision regarding SNFs applies only to services that a skilled nursing facility resident receives during a covered Medicare Part A stay. The only exceptions include physical, occupational, and speech-language therapy, which remain subject to CB regardless of whether the resident receiving the services is in a covered Part A stay.

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Excluded services are billed separately to Part B: Services excluded from SNF CB are billed separately to Medicare Part B, but the bills still must contain the SNF's Medicare provider number. The services that are excluded include these:

- Physicians' services that include furnished to SNF residents, although the technical component of physician services is subject to CB and must be billed to and reimbursed by the SNF;
- Physician assistants, nurse practitioners, and clinical nurse specialists working in collaboration with a physician or under a physician's supervision;
- Certified nurse-midwives, qualified psychologists, and certified registered nurse anesthetists;
- Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Part B coverage of epoetin alfa (Epogen) for certain dialysis patients;
- Hospice care, an ambulance trip that conveys a beneficiary to the SNF for the initial admission, and physician "Incident To" services.

Some specific outpatient hospital services also are excluded: Some hospital services are so intensive and costly that CMS has excluded them from SNF CB.

Also, durable medical equipment is excluded from CB. ■