

# Healthcare Benchmarks and Quality Improvement

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## Collecting, sharing data tops list of challenges for quality managers

*How quality is defined, measured seen as more vexing than ever*

What keeps quality managers up at night? What do they consider their greatest challenges? A survey of quality professionals indicates a decided commonality, with concerns centering around how quality is defined, measured, and shared with national organizations and the public.

"One area we all struggle with is defining what quality is," says **Tom Knoebber**, CPHQ, Six Sigma Black Belt and director of performance improvement for Mission Hospitals in Asheville, NC. He notes that quality managers are besieged by a host of quality "definers" — "from the many public vendors announcing their new awards for excellence to CMS with their top performers, as well as hospital boards that want a high-quality, low-cost hospital but are unable to define a problem beyond anecdote."

"We are faced with requirements from our regulatory agencies, payers, purchasers, and the public," adds **Kathy Schumacher**, MSA, CPHQ, director of quality, safety, standards, & outcomes, William Beaumont Hospital, Royal Oak, MI. "They all want many things from us as a health care system, and we have an obligation to be responsive to those needs — like the need for more transparency for our data and outcomes. That's one of our greatest demands."

**Sandra Trotter**, MBA, MPHA, CPHQ, patient safety program director, Lucile Packard Children's Hospital, Stanford University Medical Center, Palo Alto, CA, agrees. "The greatest challenge fac-

## Key Points

- Quality departments should be positioned as "in-house consultants."
- Culture change can lead to greater transparency.
- Annual assessment of all public databases, internal rankings, and projects can help you rate your hospital's quality.

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ing us at Packard is the increasing number of regulations that are sometimes at counter purposes," she notes. "There are a large number of regulatory, accreditation, and other organizations with hospital guidelines and requirements — many of which don't align."

All of this pressure for providing more and more information in an atmosphere of economic woes and downsizing makes the challenge all the greater, notes **Patrice L. Spath** of Brown-Spath & Associates, Forest Grove, OR. "The challenge is how to maintain a quality department in a downsizing environment and maintain viability," she asserts.

For many of these challenges, quality professionals have discovered at least partial answers.

For example, Spath notes, the answer to succeeding in a downsizing environment is to create a quality department as an "internal consultant," as opposed to one that does all the data-collecting work for all the hospital departments.

"The hospital departments and process owners have a lot of ownership for collecting their *own* data," she asserts. "That is one of the keys in being successful in spreading the wealth. Of course, everybody else is very busy, so there will be a lot of push-back from department managers, which means that leadership has to intervene and create that environment."

That can be a challenge, she concedes, and involves knowing just what it costs to collect a data element, "so when they make decisions about data to collect, they're able to equate it with the resources needed to collect it, and the decision can be made at the leadership level as to which is the most efficient place from which the data should be gathered."

The quality department, Spath continues, should have a keen understanding of all the information sources in the hospital, so if someone asks, for example, for data on CT scans, you can tell them that the radiology department routinely collects those data, and they should tap into *their* resources.

"The quality department should act as an internal consultant not just for the collection of data, but also to help people design data collection in other departments or to help people formulate the study question they are looking at," Spath says. "So, for example, when physical therapy decides they want to monitor patient outcomes relative to pain, they should be encouraged to meet with the quality people to help them design that study. In general, I don't think many organizations regard the quality department as a resource they should tap into."

### **Culture change required**

Schumacher takes a slightly different approach. "A lot of what we are doing is becoming much more transparent with data and outcomes; we are very open about outcomes and performance data," she notes. "These data are out there, and as an institution and as a leader we have the obligation to provide them."

How does she do that? "Not with more staff — just a change in culture; a change in the way we do things," she responds.

"We've been on this mission a number of years and we continue to work on it," Schumacher

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#### **Editorial Questions**

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adds. "It's not so much a focus on individual blame but on redesigning processes and systems factors. We've instituted a lot of collaboratives to help us do that."

For example, she notes, "We're very integrated into the work of the Michigan Health & Hospital Association's Keystone initiative's ICU program to reduce infections. We're a beta site for the surgery initiative and also very engaged in their HAI [hospital-acquired infection] program."

Beaumont also has focused on outcomes as well as PI initiatives, she says. "For that we've participated in a lot of national programs like NSQIP (the National Surgical Quality Improvement Program); and we're focused on bariatric outcomes as a bariatric center of excellence. It's great to initiate PI programs, but if you do not have a way to measure outcomes they almost become just something else you're doing," she says.

### **Defining quality**

"It is difficult to find that one measure that would define a quality hospital," notes Knoebber. "If you choose to focus your efforts on what you internally believe are quality metrics and a new study comes out citing a new outcome, hospitals are forced to react to the public and media to ensure they are 'on the list' if it's a new measure of quality."

Knoebber says that internally his department has tried to address "this constant diversion" by providing an annual assessment of all public databases, internal rankings, and projects by providing a score similar to an FMEA Risk Prioritization Number.

"We ask an objective team to rate an assessment of these macro measures or projects — this past year we had 52 — individually using three questions on a scale from 1-10," he shares. The questions are:

**1: Value** — Its importance or relevance to employees, the system, or patients? (10 high, 1 low)

**2: Opportunity** — Do we have opportunity; are we at risk? (10 high, 1 low)

**3: Cost** — What resources are required to achieve the goal or attain high performance? (10 low-cost, 1 high-cost)

"The product of these three numbers lets us rank where we should focus," Knoebber explains. "Within this model, we are able to include mandatory items, and public reporting tends to score high as a value to the system. We can then use this to communicate what our priorities are, or where their individual projects fit."

Having said this, Knoebber adds that "there is

always 'executive privilege,' and as new things do pop up we always work them through — but this at least helps us defend or justify the resources needed to support our defined quality focus."

### **Does coding determine quality?**

Unfortunately, some challenges don't lend themselves easily to solutions — take coding, for example. "I think probably the biggest challenge from a quality perspective is how we are going to manage being paid for quality based on coding," says **Bev Cunningham**, MS, RN, vice president, clinical performance improvement, at Medical City Dallas Hospital. "What concerns me is that the decision on mistakes is based on ICD-9 coding originally designed for billing only. Now what's happened is that it's being attached to quality."

The good news, she says, is that coding appears to be "catching up a little bit." For a long period of time, she notes, pressure ulcers were covered by a single ICD-9 code, "so you couldn't tell if a patient came in with one." Now, says Cunningham, "You can indicate if they are present on admission or not, and pressure ulcers are divided into four stages, so there is a little better definition." Unfortunately, she adds, "A lot of other conditions are not defined like that."

Re-admissions also are problematic, she says. "If a patient goes home and chooses not to follow the physician's directions, there's really no ICD-9 code that describes that," she observes.

The move to ICD-10 coding may help, says Cunningham, "but everything goes so slowly, and I'm not sure that will answer all our questions."

There's not much quality managers can do if coding is not fixed, Cunningham notes. "I wish we had an answer, but I don't," she says. "Being verbal through our hospital associations and even aligning with physicians might help, because physicians will be graded the same way. Wait until they figure *that out!*"

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## Interdepartmental team earns leader quality award

*Average length of stay is reduced significantly*

An interdepartmental quality improvement team at Norwalk (CN) Hospital has developed and implemented strategies that led to a reduction in the average length of stay for all patients from 5.54 days in 2007 to 4.1 days in 2009. The figure for Medicaid patients, which had been as high as 7 days, is down to 4.8 days.

In recognition of these accomplishments **Claire Davis**, RN, MHA, CPHQ, FNAHQ, vice president of quality, was presented the Luc R. Pelletier Healthcare Quality Award for Improving Organizational Performance given by the National Association for Healthcare Quality.

"The most important step we took was that we determined that length of stay [LOS] reduction for the hospital should be a strategic initiative, and that it required a strategic team," she recalls. "The initiative was chosen first."

Senior leadership, she continues, recognized that the hospital was starting with a very strong base in terms of patient quality and safety. "We had a record of which we could be proud, but our average length of stay was one of the five longest in the state; we felt this was a significant opportunity for improvement," says Davis.

Another important decision, Davis notes, is that even though LOS impacts finance and efficiency, it was determined that the initiative should reside within the quality sector. "Leadership felt that clinicians would appreciate the fact that LOS is first and foremost a medical decision, and that it's best for the patient to be at

## Key Points

- Identifying issues as strategic initiatives can enhance likelihood of success.
- Interdepartmental quality improvement team includes director of case management and medical director of hospitalist program.
- Clinicians appreciated the fact that LOS was seen first and foremost as a medical issue.

the appropriate level of medical care," she explains. "If you talked to nurses and doctors and said you wanted LOS down because it would save money, they'd get a bad taste in their mouths and ask about the patients."

The fact is, she notes, when people are kept in the hospital their opportunity for *not* being healthy is greater. "Older people face changes in mentation, and they do not move as much so they are more prone to skin breakdown and circulation issues," Davis observes. "Most of us recover faster functionally in our own safe environment with nutrition and lifestyle patterns we are used to."

Finally, she observes, InterQual and Medicaid "tell us there's no reason to be in the hospital unless you meet acute care standards, and we knew this was not always the case."

### Selecting strategies for improvement

In order to determine strategies for improvement, "sponsors" were placed in the interdepartmental team at the senior leadership level. "I led the team for quality, and we put the CFO as a sponsor, too, to show the relationship between quality and finance," says Davis.

They then appointed two team leaders — the director of case management and the medical director of the hospitalist program, who was also an internist and medical vice president of integration. "These are the two major groups that work on LOS every day — the hospitalists treat 60% or more of our patients," Davis explains.

Then Davis and the two team leaders sat down and looked at the data and the history and used root cause analysis and Pareto charts to identify the largest trends, conducting interviews in areas where they saw numbers that were "out of whack." "We spoke with key clinical and non-clinical people and asked what barriers they had experienced, and identified eight areas we felt we needed to approach," says Davis.

Out of those eight, the top four priorities were

determined, and targeted for 2008.

The first issue addressed was the case management department itself. "Hospital senior leadership had not given them the resources they needed — they did not have Midas software, they did not have integrated InterQual material (which they do now) and they did not have enough staffing," says Davis. "We felt it was critical to put two case managers in the ED to help identify inappropriate admissions before they even came in the door, because when a social admission gets through the door they are very hard to move out."

Physician barriers also were addressed. "We developed senior medical leaders through their own customary chain of command to back up and champion the case managers on their authority," says Davis. "It was their responsibility to give the case managers access to the doctors every single day."

Multidisciplinary rounds, or MDRs, were instituted. "The hospitalists and hospitalist residency program really helped us," says Davis. The daily rounds included dietitians, nurses, and case managers, and met for over an hour and one half. "Teams of doctors would come in four at a time and review every patient under their service," Davis notes.

If patients were not being discharged, the barriers were explored. "If they still needed an MRI, radiology was called," says Davis. "If a patient was not clinically acute, the decision was made to discharge. We really identified what was stopping us from discharge and then got it in motion — forcing efficiency."

The final first-year priority involved working with the ED to reiterate criteria for acute admission and placing the case managers in the ED. "A) they acted as consultants, and B) they have better resources to find safe places to discharge people to," Davis explains.

### ***New programs in '09***

This year, one of the areas of focus has been rehabilitation. "We own a unit here at the hospital, and we found that our patients with rehab DRGs had longer lengths of stay before being transferred," says Davis. "The doctors let them sit on the acute side, thinking they were doing the right thing, but it is *not* a transfer to move them to our rehab facility. It is a discharge, and then an admit. We were seeing unnecessary two-day delays."

In surgery, daily rounds were instituted to help bring down LOS. The nursing role in LOS

throughout the hospital was also addressed by working on ambulation and nutrition and bowel routine. "We explored what they could do to help ensure their patients would not lose mobility," Davis notes.

Finally, a culture of change among all physicians is being sought. "We have to go out to private physicians in the community and change the way they look at LOS," says Davis. "Our physician leader will also be going out to departments and sections and providing actual clinical data on LOS and its relationship to cost and quality, how their department has looked over time, how it looks when benchmarked against other facilities, and how their individual data compares with that of their peers. He will also let them know the resources we have to help remove barriers for them."

### ***Gaining support not a problem***

While staff buy-in can be a problem with such ambitious initiatives, Davis says that in this case it was not. "Before leadership made this a strategy and supported the grassroots, the staff frustration was that they knew the right things to be done but they did not have the resources, the authority, the equipment, or the people," she shares. "It wasn't rocket science because they all knew what was needed."

One of the other keys to success, she continues, was the strategic approach. "When you do not approach this as a strategy, you do not have the whole hospital working on it," she explains.

Finally, she says, the team used a no-nonsense, business-like, rapid-cycle approach to their meetings. "We assigned a limited number of people to the monthly meetings and said that if they had an hour to sit, great, but if they were busy we'd give them a five-minute slot to share their baseline data, discuss what they did to improve, what barriers remained, and how we could help." If the presenter said they had not worked on the project for the past month "we did not accept their presentation," Davis says.

As the meetings unfolded, "once they really started catching on, clinicians liked to sit and hear other clinicians present when they could," says Davis. "When you bring forth a CQI story it holds peoples' attention."

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# Safety and ‘silos’ don’t mix TJC says in new alert

*Involve nurse, physician, administration*

“No unit is an island” might be the theme of a new Sentinel Event Alert from The Joint Commission (TJC).

“Health care leaders can . . . break down the barriers between clinical, operational, and financial ‘silos’ by developing and recruiting leaders who understand the importance of all three areas working closely together in order to create safety,” says TJC in its Alert. (For more excerpts from the Alert, see box below. To access the complete Alert, go to [www.jointcommission.org](http://www.jointcommission.org). Under “Sentinel Event,” click on “Sentinel Event Alert,” then “Issue 43: Leadership committed to safety.”)

ED managers agree that such silos, whether between different areas of the hospital or differ-

## Key Points

- Hold regular meetings involving representatives from all units and departments.
- Ensure adequate input from frontline staff; avoid a “top-down” approach.
- Within your department, hold joint meetings between physicians and nurses on an ongoing basis.

ent disciplines within the department, are barriers to the successful creation of a safety culture. “You have to have representatives [from every unit] at each other’s meetings, as well as a [hospitalwide] quality meeting that focuses on safety every month,” says **Kevin Klauer, DO, FACEP**, director of quality and clinical education for Emergency Medicine Physicians, Canton, OH, and a staff emergency physician at Barberton Citizens Hospital and Lodi Community Hospital, both in the Akron/Canton area. “You’ve got to make sure safety is institutionalized into one sys-

## Joint Commission suggests patient safety actions

The following are some of the actions suggested by The Joint Commission directed to senior leadership: the governing body, the chief executive, senior managers, and medical and clinical staff leaders:

- Define and establish an organizationwide safety culture that includes a code of conduct for all employees, including contract workers.
- Institute an organizationwide policy of transparency that sheds light on all adverse events and patient safety issues within the organization, thereby creating an environment where it is safe for everyone to talk about real and potential organizational vulnerabilities and to support each other in an effort to report vulnerabilities and failures without fear of reprisal.
- Make the organization’s overall safety performance a key, measurable part of the evaluation of the CEO and all leadership.
- Ensure that caregivers involved in adverse events receive attention that is just, respectful, compassionate, supportive, and timely. Also, make sure they have the opportunity to fully participate in the investigation, risk identification, and mitigation activities that will prevent future adverse events.
- Create and communicate a policy that defines

behaviors that are to be referred for disciplinary action; include the time frame that the disciplinary action should take place.

- Regularly monitor and analyze adverse events and close calls quantitatively, and communicate findings and recommendations to leadership, the board, and staff. Conduct root-cause analyses of adverse events. Look for patterns in root causes that identify latent hazards and weaknesses in the defenses against errors — the holes in the slices of cheese — and make sure they are addressed.
- Regularly hold open discussions with risk management, performance improvement, physician, nursing and pharmacy leaders, and with physicians and staff caring for patients, to develop a true, unvarnished view of the safety risks and barriers to safety facing patients and staff. Patient safety rounds at the point of care could provide the ideal opportunity for these discussions, which should focus on learning and improvement, not blame or retribution.
- Prioritize and address safety risks and barriers to safety according to a timeline, with the highest priority items getting immediate attention. Make a visible commitment of time and money to improve the systems and processes needed to defend against hazards and minimize unsafe acts. For example, some organizations create an emergency patient safety fund. ■

tem design — not 30 different ideas of what it is and what it means.”

**India Owens**, RN, director of emergency services at Clarian West Hospital in Indianapolis, says, “I think that most of the things we do, most of the processes we use, cross every one of our disciplines. This central approach is important because more often than not what you have difficulty with, I have difficulty with.” (The multidiscipline approach is reinforced at Clarian West by its Safe Passage Committee. See the story to the right. For additional information on creating a safety culture, see the story on p. 140.)

Accordingly, while there are corporate goals around safety, each department keeps a “scorecard” of its performance, and every department has its own goals to feed into the overall corporate goals, Owens says. The system is totally transparent, so the ED can view the scorecards of all the other departments in the hospital. “If I have a goal to reduce labeling errors and I wonder what kind of approaches should be used, I can go and look at what other units have done,” she explains. “If another unit has a higher score in this area, I can review and discuss their tactics with them.”

Methodist Hospital in Sacramento, CA, held collaborative meetings between the physician staff and nursing. “You need the support of both to be effective,” says **Cindy Myas**, RN, MSN, director of emergency services. At Methodist, the triage process recently was overhauled to enhance patient safety. The triage nurse was put in the waiting room to serve as the “greeter.” She quickly determines if a patient should go home, requires further diagnostics and should be placed in the waiting room, or if they require an ED bed.

“If we were not all working in the same direction, this would not have worked,” Myas says.

During a series of meetings, both groups voiced their concerns, and everyone had to agree on the new processes, she says. “Our motto was, ‘If you come to the meetings, you get to make the decisions,’” Myas shares.

Administration also was a critical element, she says. “They had to be supportive,” Myas says. “They actually needed to sign on to what the leadership in the ED recommended because this hit our bottom line.” More staff were required to make the new process work, she explains. Administration approved the addition of two RNs to each shift, a midlevel physician’s assistant, and another physician for the busiest times in the ED. ■

## Multidisciplinary group provides ‘safe passage’

At Clarian West Hospital in Indianapolis, the ED participates in a multidisciplinary group that processes all safety issues. Called the Safe Passage Committee, it is led by the vice president of quality and safety.

“Frontline staff [members] attend the meetings and report back to leadership,” notes **India Owens**, RN, director of emergency services. Issues can be brought forward by staff or leadership. They are discussed, and an approach is decided upon. Meeting minutes are distributed throughout hospital and also are available to any staff member online.

Many times, she notes, the decisions involve changing or creating a policy. At Clarian West, however, processes are part of the safety policies. “For example, in the ED, we have a policy for determining if a pregnant patient who presents should be sent to OB or stay in the ED,” Owens explains. “We have an algorithm embedded in the policy that outlines the steps a staff member goes through to make that determination — the key decision points.” The advantage to this approach is that ED staff members don’t have to go to two places (policies and processes) to find out what to do, she says.

Having all safety issues go through the committee ensures that safety practices unfold the same way in the ED as they do in other departments, Owens notes. Consider a hypothetical example in which there are three needlesticks in the ED related to a new product, she says. “It would go to that committee, and the vice president of quality and safety could make the decision to pull the product and communicate it to the entire hospital,” Owens says. “The product would be pulled, and we’d revert to a prior product.”

However, she adds, the process doesn’t stop there. At the next committee meeting, the group would discuss whether this was truly a product failure or whether there was another factor involved. “Even if the product was pulled, we’d try to figure out the root cause,” Owens explains. “Maybe we did not educate the nurses well enough, or maybe the nurses were not used to the way the product was designed. We never just pull a product.” ■

## A safety culture key to reducing errors

ED leaders agree that creating a safety culture that reaches across all hospital departments is the key to improving safety in any department. **Kevin Klauer**, DO, FACEP, director of quality and clinical education for Emergency Medicine Physicians, Canton, OH, and a staff emergency physician at Barberton Citizens Hospital and Lodi Community Hospital, both in the Akron/Canton area, has identified several key elements of such a culture.

“Everyone talks about safety, but people do not always do what they say,” he says. “The organizational values are not matched by the operation of the institution.” Patient safety should be the first priority, Klauer adds. “The translation is, it has to be an agenda item on everyone’s meetings.”

What’s more, he adds, “Your culture has to be blameless — and not just for doctors or nurses. Errors are going to happen.” Those errors do not make someone a bad doctor or a bad nurse, Klauer adds. “It’s how we handle them that make us different,” he says.

So, as an ED manager, the approach to staff who commit errors is to tell them you know they are committed to doing their best, and it is important to examine the incident to learn how to prevent it from happening again. That attitude must be reflected by upper management as well, Klauer says. “Your administrator has to say that ‘we understand there is rarely an error made that is one-dimensional — that they are multifactorial,’” he says.

The final element — a patient-centered culture — is closely linked to having a consistent approach to safety throughout the institution. For example, notes Klauer, procedural sedation is an important issue for The Joint Commission. “My understanding is that they are concerned that it may be occurring in environments made unsafe by providers who are not properly trained,” he says.

So, for example, procedural sedation is part of an ED physician’s training, board certification, and standard of care. However, for some other departments, “It is a good idea to make sure the staff are trained and credentialed properly, so if you are going to do an endoscopy, you will not have a bad outcome,” says Klauer.

That’s where a single hospitalwide approach becomes critical, he says. “If you have 15 departments saying they do not need oversight, you can

have a huge breakdown, which can result in bad patient care,” says Klauer. “Some patients may be getting a shoulder reduced without sedation in some institutions. You can’t have 15 different definitions of what quality and safety are.” ■

## Deadline nears for HAI NPSG

*ED managers suggest doing a final checkup*

While The Joint Commission has not introduced any new National Patient Safety Goals (NPSGs) for 2010, that doesn’t mean the clock has stopped on the implementation of earlier goals. In fact, three requirements under Goal 7 relating to the prevention of health care-associated infections (HAIs) will go into effect Jan. 1, 2010. The requirements — NPSG 07.03.01, NPSG 07.04.01, and NPSG 07.05.01 — address, respectively, multidrug-resistant organisms (MDROs), central-line bloodstream infections, and surgical-site infections (SSIs). (*Editor’s note: The Joint Commission also has revised some of the 2010 National Patient Safety Goals, including the Universal Protocol. For more details, see Joint Commission Online — Sept. 9, 2009, which can be found at [www.jointcommission.org/Library/jconline](http://www.jointcommission.org/Library/jconline).*)

A specific series of steps was laid out by the commission to help lay the foundation for compliance, notes **Kelly Podgorny**, RN, MS, CPHQ, a project director in The Joint Commission’s Division of Standards and Survey Methods. These included oversight, coordination, ensuring there are adequate resources, assigning accountabilities, and developing a timeline. They were set out in specific milestones, with the final one being a pilot test in at least one hospital unit by Oct. 1, 2009.

Assuming your department has been following this roadmap, however, there still are steps you can take in the next few months to give your ED a final “check-up.” In fact, say ED managers, these practices can be implemented for any requirement or standard. “We have a nurse who is specifically assigned for process improvement and constant ongoing surveillance of this nature,” says **Tim Almquist**, MD, FACEP, medical director of the ED at St. Mary’s Medical Center in Evansville, IN. “She is involved with retrieval of records, making sure that the staff are well educated; so it’s a top-of-the-mind awareness to make sure we have taken care of issues related to infection.”

For example, he says, his ED inserts central lines, and there are procedures in place for making sure conditions are as sterile as they can be, including sterile draping, cleansing of the skin with antiseptic solution, and having a minimal number of people in the room (usually just the patient, the doctor, and one assistant). When using ultrasound guidance, the probe is covered with a sterile probe cover or a sterile glove. "We do this as an ongoing procedure, but there will certainly be an extra emphasis now to continually remind people that this is necessary," says Almquist. As the deadline date comes closer, he says, there will be an even greater emphasis on education: peer review, trauma morbidity review, nursing review, and roundtable meetings. "These will occur repeatedly and frequently," he says.

**Bruce Auerbach**, MD, vice president and chief of emergency and ambulatory services at Sturdy Memorial Hospital in Attleboro, MA, says, "There has to be retrospective monitoring of performance or, if you have a formal checklist, reviewing that." Auerbach says his staff are creating such a checklist for the new goal. "We did the same thing with conscious sedation," he says. "The checklist included such elements as vital sign monitoring and oxygen saturation monitoring."

The checklists are reviewed by Auerbach or the nursing director. "Where there are deficiencies, we address them," he notes. "If something was getting in the way of us being able to comply with the process, we'd find a workaround that would appropriately address the issue." For example, Auerbach's department already has redesigned how patient rooms are set up. "We found we had needle boxes too far from the bedside, and doctors and nurses were sticking themselves walking those four steps to the sharps," he says. "Now we have them stored at arms' reach."

Communication with physicians who are failing to follow proper procedure also is important, says **Bruce Jones**, DO, medical director at Doctors Hospital in Columbus, OH. As in other EDs, quality assurance nurses track data. "If we find certain physicians falling out with any of our measures, we go back and report to them," he says.

The discussion is not accusatory, says Jones. In fact, most discussions are generic. He might say, "We had two parameters that fell out." The talk is more informational, "so that this issue will be on their radar," Jones says. "We just keep reinforcing the message, if need be, and eventually they catch on." ■

## Keep communication open to keep pharmacy priority

*Show you've made money to receive money*

There are many strategies and details pharmacy leaders can employ to help maintain their department's staffing and resources. But arguably one of the most important is to create and maintain a solid line of communication with hospital leaders, physicians, and staff.

"We need to make sure everyone understands that the services pharmacists deliver on a day-to-day basis have a return on investment," says **Michael D. Sanborn**, MS, RPh, FASHP, corporate vice president for cardiovascular service at the 3,000-bed, multisite Baylor Health Care System in Dallas. Sanborn was scheduled to speak about proving your return on investment through clinical services at the 14th Annual American Society of Health-System Pharmacists' (ASHP's) Conference for Leaders in Health-System Pharmacy, held Oct. 19-20, 2009, in Chicago.

Pharmacy directors need to keep their hospital administrations informed of how pharmacy is doing, says **Billy W. Woodward**, BS, RPh, executive director of Renaissance Innovative Pharmacy Services in Temple, TX. Woodward was scheduled to speak about strengthening core pharmacy services at the ASHP's conference in October.

There are seven areas of accountability for each hospital pharmacy, and pharmacy directors must keep in mind three overarching principles for each area, Woodward says.

They must make certain everyone in their department feels some level of responsibility, ensure there is a culture of leadership and top-down guidance, and maintain a proactive communication plan in dealing with hospital leadership, Woodward advises.

"The information needs to be put upfront on a regular basis," Woodward says. "And it should be hand-delivered so it doesn't end up in the inbox and never gets read."

If the pharmacy director is not regularly letting hospital leaders know what the pharmacy department is doing, there could be problems where cutbacks impact the hospital pharmacy's resources and ability to provide quality care, Woodward adds.

"Even if you're doing a first-rate job, you could have problems," he says.

## Key Points

- Build trust with hospital leaders through open lines of communication.
- Provide data on successful quality and safety projects, as well as cost-savings in pharmacy.
- Use hallway chit-chat time to let other hospital staff and leaders know about your small successes.

"I've seen departments that were doing an A-plus job, but the bosses upstairs didn't know that, and the pharmacy department was on the verge of having positions eliminated," Woodward explains.

Even when a hospital system is not making across-the-board cuts, it is financially sensible to keep pharmacy's economic and quality successes on the leadership's radar screen, Sanborn notes.

"A hospital pharmacy might want to obtain funding for a big project one day, and the director brings the idea forward," Sanborn says. "But the project is turned down, and one reason why the department is not successful is likely because the pharmacy hasn't created an identity of fiscal value in the first place."

If the pharmacy director had been consistently providing information about the pharmacy's outcomes, including cost savings through clinical pharmacy programs or changes, top leadership will clearly understand that the pharmacy department provides significant value, Sanborn explains.

Then it would be a much shorter leap for the hospital leadership to agree that a new pharmacy project would provide value over the long run and be worth the initial investment, he adds.

Pharmacy directors need to remind hospital corporate leaders that cutting labor rarely is the best way to cut costs in the pharmacy department, Woodward says.

Labor is the biggest expense in overall hospital costs, but this isn't true in the pharmacy department, he explains.

"In the inpatient, acute care setting, 70-75% of the costs for the pharmacy is drugs," Woodward says. "Manpower might be 5%."

So when a hospital cuts pharmacy staff, they're making a big mistake because they could cut 20% of the pharmacy staff to have an impact of cutting only 4% of the pharmacy budget, Woodward says.

"Then the drug budget will start to go up 18% a year because there are no employees available to take care of reducing it," he adds. "And things suffer from a quality standpoint too."

If the bosses above the pharmacy head don't understand how this scenario will play out, then it's because the pharmacy director hasn't done a good job of communicating with them, Woodward says.

"By the time you have a consultant upstairs looking for ways to cut costs, then it's too late to convince the administration that you need enough resources to do the things you do to keep the hospital safe and control costs," Woodward adds.

It might not be possible for hospital pharmacies to avoid all job cuts during an economic

downturn, Sanborn notes.

"But the more everyone realizes that every pharmacist delivers value, the less likely you will be to experience some cuts," Sanborn adds.

Here are some strategies that will help improve communication between pharmacy and the top brass:

- **Speak at department head meetings:** "You should make a periodic presentation to the department head meeting about what pharmacy currently is doing, such as using dashboards and metrics and other methods to demonstrate how pharmacy is creating value," Sanborn says. "Show how managing the formulary and other clinical programs impact the budget."

- **Position pharmacy at the hospital leadership table:** It's important for the hospital pharmacy leaders to be well-positioned in the hospital's organizational structure, Woodward says.

"ASHP has talked about having a chief pharmacy officer," he adds. "This can work, but regardless of what the position is called, it's critical for pharmacy to be positioned at the table to talk with the right people at the right time."

If pharmacy leaders aren't present at hospital corporate and leadership meetings, then it will be much more difficult for them to be heard and to maintain pharmacy as a priority.

Pharmacy heads can help encourage the hospital to include them in the leadership structure by developing relationships through communication about the size of the pharmacy department's budget, its manpower, and the safety issues and their consequences, Woodward says.

Baylor Health Care System has a corporate director of pharmacy who attends senior leadership meetings and most major meetings, Sanborn says.

The corporate director of pharmacy oversees the health care system's 13 hospital directors of pharmacy, and the position has evolved over the past few years, he adds.

"Pharmacy directors at sites have a direct line of reporting to the corporate director of pharmacy,"

Sanborn says. "That way, once we all agree on what the goals are for pharmacy, the corporate director drives the performance against those goals."

Baylor's pharmacy department was the first clinical department to have system-wide leadership, he notes.

"All of the clinical departments now have a corporate leader," Sanborn adds.

• **Submit quarterly reports to administration:** "We've been sending quarterly reports of our overall pharmacy performance to the administration for at least five years," Sanborn says.

"They're short and sweet," he adds. "We used to do a six-slide PowerPoint presentation, summarizing our performance, and now we have consolidated it down to a one-page dashboard that we can also e-mail and review with senior leadership."

• **Create a dashboard to describe expenses and progress:** The Baylor pharmacy dashboard includes specific labor and drug expense benchmarks that have to be hit by all of the hospitals, Sanborn explains.

"We provide an easy-to-read, one-page summary of where the department is with respect to those benchmarks, in addition to including progress initiatives that we should be working on," Sanborn says.

"For instance, there's a therapeutic interchange summary with year-to-date fiscal information about what we focus on," he explains. "There's also an Excel spreadsheet with two graphs that summarize where our labor and drug expenses are, followed by a table that shows which initiatives the department is working on and what we're doing."

The dashboard might also measure output based on pharmacists per adjusted patient day ratios and show whether the department is hitting a particular target, Sanborn says.

"We also have FTE measurements based on doses dispensed, and all of those metrics vary by facility," he adds.

• **Provide anecdotes of successes:** At the Baylor hospital emergency department, there's a pharmacist who works full time, and there have been documented savings since that position was

created a year ago, Sanborn says.

"The savings are well above the pharmacist's salary, but more importantly, the pharmacist has had an impact on throughput in the emergency department and has helped a lot with triage," he explains. "We've been able to adjust the triage process."

For example, ED patients often need to be sent to the intensive care unit (ICU) because of their need for IV medications.

"If the pharmacist can adjust those IV drips so they're no longer necessary, then the patient can be transferred to a lower level of care, and that has a big financial impact on the hospital," Sanborn says. "The ED pharmacist also can have a big impact on antibiotic streamlining."

This is the type of anecdote a hospital director should be pointing out with hospital leadership, showing how just one clinical pharmacist program can positively impact both quality of care and the financial bottom line.

"An ED pharmacist also can standardize the ED's protocols, looking at medication use and monitoring to see if there are ways we can function more efficiently," Sanborn says. "That's a project that will last a year or two, and the physicians and nurses are very excited about it."

• **Market pharmacy's successes with all staff:** "You can do this in a variety of ways," Sanborn says. "Whether you're at a department head meeting or just a meeting with your supervisor or administrator, you can discuss the department's accomplishments."

If something significant has happened, then put it in an e-mail.

"Say you have numbers for a particular project and it looks like you've saved \$30,000 over the past six months," Sanborn says. "Craft a short e-mail to your boss, saying, 'We just got the numbers in, and we've saved \$30,000 over the past six months.'"

Even a brief walk down the hall with the hospital's chief executive could be an opportunity to reinforce pharmacy's value.

"I was recently talking in the hall with our CEO about our success with bedside barcode scanning, and he complimented the department

## COMING IN FUTURE MONTHS

■ CQI effort gets hand washing compliance from 33% to 95%

■ Federal government puts millions behind prevention efforts

■ Hospital improves hand hygiene compliance by 300%

and said, 'When you focus on patient safety, the finances take care of themselves,'" Sanborn says.

Pharmacy staff should receive the same pharmacy reports sent to hospital leaders, and hospitals should have communication boards with charts and graphics that display the pharmacy's progress on various metrics, Sanborn suggests.

These simple, persistent communications help build the understanding that pharmacy adds value, he says.

"Pharmacists understand much more now than they did 4-5 years ago that while clinical practice is very important, they also have stewardship responsibility to the organization," Sanborn says. "We recognize that the more efficient we can be from a financial standpoint, the more likely it is that our service capabilities will increase." ■

## CDC updates H1N1 infection control guidance

The Centers for Disease Control and Prevention has updated its H1N1 infection control guidance for health care settings, including use of N95 respirators. The agency continues to recommend that health care workers who are in close contact

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with patients having suspected or confirmed H1N1 flu use N95s, but acknowledged supply concerns.

Where a shortage of respirators exists despite reasonable efforts to obtain them, hospitals may prioritize use of the N95 respirators, especially for aerosol-generating procedures and for health care workers who are at higher risk for H1N1. Hospitals with insufficient supplies of N95 respirators that demonstrate "good faith" efforts to acquire N95s and follow the agency's hierarchy of control recommendations may use surgical masks.

During a CDC call, a representative from the Occupational Safety and Health Administration (OSHA) said OSHA will not deem these hospitals to be out of compliance with its standards, and is preparing a detailed compliance directive outlining how OSHA will enforce the CDC guidance. The CDC also released a document to help health care facilities optimize the implementation of H1N1-related infection control recommendations within the context of equipment shortages. (The document can be found at: [www.cdc.gov/h1n1flu/guidelines\\_infection\\_control\\_qa.htm](http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm).)

The guidance also updates how long health care workers should stay away from work if they develop a fever and respiratory symptoms. Under the new recommendation, these workers should be excluded from work for at least 24 hours after they no longer have a fever without the use of fever-reducing medicines. ■

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