

# Healthcare Benchmarks and Quality Improvement

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## AHA survey: 'Most wired' hospitals achieve higher patient satisfaction

*Experts say interactivity is most appreciated by patients*

Patient satisfaction is higher at hospitals that embrace technology, according to the 10th Annual Most Wired Survey and Benchmarking Study of *Hospitals & Health Networks* magazine, which is published by the American Hospital Association. These hospitals scored significantly higher in patient satisfaction in a number of areas, including: admission process, room, nurses, tests and treatments, visitor and family interactions, and services.

"That doesn't surprise me at all," says **Brent James, MD**, vice president of medical research at Intermountain Healthcare in Salt Lake City, which has been on the "Most Wired" list for 10 years.

There is "most definitely" a correlation between a hospital's use of technology and patient satisfaction, adds **Penny Smith-Horton**, patient and family satisfaction coordinator for Memorial University Medical Center in Savannah, GA, which has been on the list for nine years.

"We use Press Ganey for patient satisfaction surveys, and we've found it was one of the areas that patients rate higher and made them more likely to recommend us," she continues. In the data Memorial reported for publication on the HospitalCompare web site, 71% of its patients said they would "definitely recommend" Memorial. "This is higher than both the state and national averages," says Horton. "We think there's a connection [with technol-

## Key Points

- Technology can help patients become more involved in their own care.
- Put yourself in patients' place when planning how systems will operate.
- Don't stand on your laurels; look for ways to continually improve your service.

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ogy] to the high score; our patient satisfaction is steadily increasing on the inpatient side.”

“I think it does improve satisfaction, as well as quality,” notes **David Erickson**, MD, chief medical officer for Avera Health, a Sioux Falls, IA-based system that has been on the “Most Wired” list for 10 years. “We have been very pleased.”

### **What the ‘most wired’ use**

The “most wired” facilities use a variety of technology to provide services and interact with patients. All three of the aforementioned organizations, for example, say they have an EMR (electronic medical record) system.

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#### **Editorial Questions**

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“On our web site we have transparent data on quality measures from a clinical standpoint,” notes **Deanna Larson**, RN, Avera’s vice president of quality. “When patients come in they are given a brochure on how they can connect. And in one facility, we have a system that looks like a hotel TV connect monitor; if a patient has concerns, they can click and someone will come to see them.”

“We have a Meditech EMR at various stages of implementation, depending on the facility,” adds Erickson. “At one of our clinics, you can go online and schedule an appointment, which I think has been very successful.”

In addition, Larson says, “some patients are in the initial stages of e-prescribing — and that helps a lot.” She adds that all nurses have pagers and phones on their belts, which enable them to respond to patient calls more quickly. And, most of the facilities’ ICUs are linked to outside intensivists 24/7 through an e-ICU system. “The patients actually hear that voice come into the room,” she notes.

At Intermountain, “we have a fully protected health portal,” says James. “When patients log in, they can see what is being covered by insurance, and they can look at their EMR.” It also has particular applications for chronic diseases, with advice about care; the system also can alert a clinic if you start to have problems. “On top of that, we have a [public] web site where you can get access to health care information,” James says.

In the outpatient setting, a clinical desktop system is used, “and we see the phenomenon where patients sit shoulder to shoulder with the doctor and can see their record and participate in their care,” notes James.

“We added a solution a year ago called Relay Health, by McKesson, which gives patients interaction with their physician,” says **Chris Leggett**, director of technical services at Memorial. “They can e-mail the provider with questions, ask to schedule appointments, pay bills online, and get their prescriptions renewed.”

The system, which is totally voluntary, enables patients to put in their demographic information, and is password protected.

The Memorial Health web site has other interactive options for patients, he continues. “They can look up their illness and get information, look up referring physicians, and obtain patient education,” he says. “They also can pre-register for services, such as X-rays.”

Quality professionals at highly “wired” hospitals look to satisfaction surveys and anecdotal

comments from patients for hints as to which services are the best satisfiers — and patients are not shy about letting them know what they think.

### ***What do patients say?***

“Our patients like the ease of making their own appointments, and those who are used to online access say they like it and use it,” says Larson.

“Part of our standard satisfaction survey has to do with information transfer — and we got a bump in patient satisfaction in that setting,” says James.

Horton says the pre-admission option is a big satisfier for her patients. “One obstetric patient wrote, ‘Good option to have on web site,’ on our satisfaction survey,” she reports.

However, insists Larson, “it’s not the machines; it’s really the people. The machines support the care we deliver.”

Regardless, says Horton, your facility can increase satisfaction by making it easier for patients to interface with your technology. “Read your patients’ comments, listen to what your patients have to say, and then use those comments to determine where you need to make improvements,” she advises. “And communicate what you do well to the rest of the organization.”

“It’s too easy for the person on the technical end to lose sight of what they are after,” adds Leggett. “We constantly have to put ourselves in the place of the patient.”

James also warns against expecting too much. “When we first gave patients access, we did a trial of 60,000; it was pretty easy to use, but we got very low uptake,” he reports. “The reason is that people do not want to see their record unless they are actively sick; out of sight, out of mind.”

What works well, he continues, is interaction, such as information about health care coverage, or sitting next to your physician and reviewing your case.

“For years we had ‘ask a nurse’ using a computer, as well as for post-surgical and ER follow-up information, and that was quite popular because the patients had a compelling current problem,” he explains.

It’s also important to continually explore new ways of expanding your technology and related services, say the experts.

“We have experimented with a touch screen, but it has not been deployed broadly,” notes James. “We’re exploring different ways to give people access to their information.”

“Part of what we’re wrestling with going forward is to provide access and care for the elderly in rural locations,” says Erickson. “Any time we can use this technology to support nurses, pharmacists, and physicians, it is invaluable.” He adds that his system is currently looking at several other pilot projects, such as e-pharmacy and e-ED.

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## **‘Long journey’ to establish a culture of quality**

*‘You don’t just turn on a switch’*

Quality managers agree that establishing and maintaining a culture of quality and safety is one of the toughest challenges they face. One facility that appears to have successfully met that challenge is Munson Medical Center in Traverse City, MI, which recently received the 2008 AHA-McKesson Quest for Quality Prize.

According to AHA, the award was “based on its culture of quality and efforts to achieve the Institute of Medicine’s six quality aims for health care.”

“We started down this journey way back in 1996,” recalls **Terry Haslinger, RN, MA**, the administrator for patient safety and performance improvement. “You can’t just one day turn on a switch and have everybody talking about quality.”

The “journey” began with training by Philip Crosby Associates of Winter Park, FL, and Boston (Crosby is the author of *Quality is Free*).

Every employee in the hospital took part, says Haslinger, with vice presidents and the hospital president serving as the leadership team. There were two-, four-, and eight- hour programs, depending on whether the individual was to facilitate a team or be a member of a team. “This gave a message to our organization that this was not a ‘flavor of the month’ program,” says Haslinger.

It also began a pattern of reliance on outside

## Key Points

- Reach out to quality, safety experts and participate in collaboratives with other hospitals.
- Be sure to get your board invested in quality programming by sharing results with them.
- Evaluate your programs, and when necessary re-design them and implement them again.

experts by Munson, particularly the Institute for Healthcare Improvement (IHI), with which the facility was a “pioneer” participant in its collaboratives.

Haslinger says she and the vice presidents of medical affairs and nursing went to a gathering of small hospitals and learned about measurement tools, data collection, and rapid cycle improvement.

When they came back, they decided to launch a pilot program on adverse drug events in two nursing units. “Every two weeks we had assignments, sent data back to IHI, worked with other hospitals and benchmarked, learned different tools and how to apply them,” says Haslinger.

Another significant step was taken in the early 2000s when Munson board members began going to the IHI meetings. “They were very willing to go,” says Haslinger, noting how important it is to have board support for QI.

Now, she says, there are monthly meetings in which the board reviews a matrix of quality measures to see how improvement is progressing. “They drive the organization to do better,” Haslinger says. “They ask us for benchmark data.”

### **Improvement is ongoing**

Munson, it seems, never stands still on its journey. “In the last few years we’ve been transitioning to an even greater emphasis on patient safety,” says Haslinger, noting that the hospital’s president indicated that as many resources as possible should be dedicated to that issue. “He is the chairperson of the patient safety committee, and he and I put the agenda together,” she explains. “We have now put two board members on the committee, so that the board will be sure to know what’s going on.” Not only is the board well informed, she continues, “but when the staff hear the board is asking about falls and how to prevent them, it’s different than having a peer ask about them.”

Technology has also helped improve quality. “For the past few years we have used the ‘PEERS’ reporting process for errors,” says **Lori Kirkey**, RN, BSN, CAN, a nurse manager on a Munson heart unit. “Staff at the bedside level can enter an error, and it is processed immediately through risk management.” In the “old days,” she notes, these would be reported on paper and it might have been a week or two before a root cause analysis could have been started.

Staff who report errors can identify themselves

if they wish, but they do not have to. “We have a non-punitive approach,” Kirkey explains.

The team also adapts its approach when things don’t go as planned. For example, a few years ago, Haslinger, several Munson physicians, and the president attended an IHI presentation where Sorrel King told the emotional story of her two-year-old daughter, Josie, who died while a patient at Johns Hopkins. “We bought the video, brought it back, and said we wanted every employee at Munson to see this,” says Haslinger.

But the initiative, she admits, “did not exactly have the effect we expected.” The staff felt that the tragedy occurred at Johns Hopkins because it was a teaching institution, and that it could not happen at Munson, she explains.

“We realized we had missed a teaching opportunity to share with the employees,” says Haslinger. So, her team took an adverse event that had occurred at Munson and made a video called ‘It happens here.’ “It told stories of errors we had made, and we showed it to every employee,” says Haslinger. “Then we followed up every month with a newsletter called *It Happens Here*, which talks about near misses that were caught. If we have found a root cause, we share that and discuss what people can learn.” Printed copies of the newsletter are sent to all departments, she says, and also is e-mailed to the board.

Two years ago, another video, called *It Still Happens Here*, was created, but this one also told of successes. “We constantly keep the staff educated about what’s happening here, and what we need to do to improve,” says Haslinger.

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# Study: Patient satisfaction not what it could be

*Yet programs have positive impact on outcomes*

There's good news and bad news in a new study just released by the Health Research & Educational Trust, an affiliate of the American Hospital Association, and the Boston University Health Policy Institute: Of 470 hospital chief quality officers surveyed, 97% reported that QI activities had a positive effect on patient care outcomes. However, when that same group was asked about patient satisfaction, only 28% agreed it was at the level it should be.

In addition, they found, hospitals in which the chief quality officers perceived high levels of patient care quality were more likely than others to have embraced QI as a strategic priority, fostered staff training and involvement in QI methods, and engaged in an array of QI activities and clinical QI strategies.

"The overall picture is that there is a lot of progress being made, but we still have a long way to go as far as moving in the direction of high-performing organizations and a high-performing national health system," says **Alan B. Cohen, ScD**, professor of health policy and management and executive director of the Boston University Health Policy Institute, and one of the study's principal authors, who noted that the respondents came from hospitals of all sizes and types. "We have a long way to go, and a lot of work to do."

While more than 80% of the respondents said they had seen important gains in quality in the three years prior to the survey, he continues, they did believe their hospitals were "falling down in the area of increasing patient satisfaction."

In this particular study, he adds, the respondents we not asked to identify potential causes. "We hope to do that this fall with a small set of

institutions," Cohen says. "We'll go into some high-performing organizations to see what it is they do to improve patient satisfaction and quality of care in general."

## **Hospitals still 'falling short'**

Although hospitals have continued to improve in terms of complying with certain recognized quality and safety strategies, says Cohen, there are other areas where the results are still disappointing.

"We found a number of clinical QI strategies that are being used, many of which follow on the recommendations of the IHI [Institute for Healthcare Improvement] — such as preventing surgical site infections, central line infections, and ventilator-associated pneumonia," Cohen notes. "They really have gotten hospitals focused on preventing these things. But a sizable majority of the institutions surveyed show there is not the desired level of diffusion of other things that IHI, the IOM [Institute of Medicine], and the Leapfrog Group have been talking about for a long time." For example, he says, the survey indicated that:

- Only 47% of the respondents reported that they use evidence-based practice guidelines widely;
- Only 52% said they use standing orders widely;
- Only 62% said they use medication reconciliation widely.

"If left to their own devices, many hospitals will likely fall short," says Cohen. "The IHI has been pushing the notion that there really is some value to using reminders and setting up systems with prompts and alerts and reinforcing the notion that these are things you have to do."

Compliance, he continues, also comes down to checklists. "These are busy professionals, and they constantly have to be reminded of certain routines that are important in terms of reducing medication errors, wrong-site surgeries, and so forth," Cohen says. "We constantly have to stay vigilant."

One key problem, he acknowledges, is that such vigilance can be costly. "The question is, how do we define optimal levels and when do they become too burdensome from a cost standpoint?" he poses. "Some will say we can never do enough, while others will say there are limits to what institutions can afford to spend."

## **Some surprises**

Cohen says that not all the survey results were what he and his colleagues anticipated. "We were

## **Key Points**

- Fewer than half of the quality managers surveyed said their facility uses evidence-based guidelines.
- Checklists, other reminders are key to staff compliance with best practices.
- The jury is still out on the benefits of rapid response teams.

surprised that almost half of the hospitals did not monitor wait times for outpatient services," he says. "There is much evidence that if people do not have access to good outpatient or primary care it will most likely lead to serious illnesses and conditions that result in avoidable hospitalization. It makes sense from a QI and cost perspective to prevent this from occurring."

The bottom line, he says, is that hospitals "Should be vigilant about how long it takes to get a patient a clinic appointment because delays can lead to adverse outcomes."

Another survey finding, he says, is that the jury is still out on the issue of rapid response teams. Noting conflicting evidence in the medical literature, Cohen reports the following: "We found that two-fifths of all the hospitals said they were using rapid response teams widely, and another two-fifths said they were using them minimally or not at all.

"We surmise that some hospitals might have been convinced by the weight of evidence that [rapid response teams] made sense, and they had the necessary resources to use them widely, while the others probably adopted a 'wait and see' attitude concerning whether they proved to be both clinically effective and cost-effective. If more positive evidence is produced, these hospitals will be more likely adopt rapid response teams and make them part of their QI plans."

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## Exactly where are you with overall NPSG compliance?

*'Use the time wisely' before new goals are surveyable*

With the 2009 National Patient Safety Goals (NPSGs) just announced, it's an ideal time to perform a self-assessment for all of the existing goals, including the requirements for improving recognition and response to changes in a patient's condition and improving safety of anticoagulation medications, which are being phased in right now, says **Paula Swain**, MSN, CPHQ, FNAHQ,

director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC.

Swain recommends using a "quick and easy" matrix to track current compliance. "You need to determine your progress to date, as well as get your staff ready for the next onslaught," she says. "It's a moving target with data collection."

One of the first steps is to embed the new elements of performance into the existing NPSGs your facility is tracking. Swain recommends using one of the popular examples from the public domain, such as The Joint Commission's own web site ([www.jointcommission.org](http://www.jointcommission.org)).

"This shows what has changed, with very little labor on the facility side," says Swain.

When this task is finished, the organization can see that there are no new NPSG goals, but there are significant expansions in goal numbers 1 (patient identification activity), 7 (infection control efforts), and 8 (medication reconciliation).

"However, rewording in many other goals will cause tightening of patient education, documentation, and additional angst for the Universal Protocol," says Swain.

Next, use the strategies that your organization already has developed for your anticoagulation and rapid response team work plans. At Presbyterian, a matrix was created that color coded each of the quarter performance expectations, as described by The Joint Commission.

"Create the same type of matrix for the new goals. The quarterly matrix that is required to keep a facility on track needs to be replicated for the new infection control goals," says Swain. "Those goals will go through the implementation phase in 2009 and be surveyable in 2010. So, use the time between now and actual survey of the new items wisely."

**Kathleen Catalano**, RN, JD, director of health-care transformation support for Perot Systems Corp., agrees that your first step should be to make a list of all changes and additions to the NPSGs, and the data that are currently being tracked.

"A task force, or some other committee familiar with the work already performed on NPSGs at

### Key Points

- Create a 'quick and easy' matrix to track current compliance.
- Look throughout facility to see what's being tracked and by who.
- Alert staff at all levels about changes in the NPSGs.

the facility, should be convened. Based on the organization's practices, a determination should be made as to how the collection of data will be altered," Catalano says.

If the required data have changed or are no longer applicable, the organization should shift its energies to other NPSG requirements. "In many instances, organizations will be *adding* to what is being collected, not deleting," says Catalano.

Next, look throughout the organization and determine exactly what is being collected and by whom. "Is everyone doing the same thing? This may not be the case," says Catalano. "Many times, even though there's been a directive on what data to collect and how to do the data collection, it is not followed. Try getting everyone on the same page."

At University of Pittsburgh Medical Center, each facility in the 20-hospital system has "adopted" a goal and acts as the system resource and content expert for that goal, says **Kathy Hale**, director of patient safety. "The information is shared among patient safety officers at a monthly forum."

This past year, Cincinnati-based Catholic Healthcare Partners implemented TeamSTEPPS in many of its facilities, Patient Safety WalkRounds in all, and launched a professional behavior initiative. "All of these actions are intended to improve the care and safety of our patients and compliance with national standards and NPSGs," says **Jana B. Deen**, patient safety officer. "Each of our facilities has teams committed to constant readiness for The Joint Commission and compliance with NPSGs."

NPSG compliance is monitored at the local level at individual sites. "We provide resources and support system initiatives that promote safety. For example, our professional behavior initiative was intended to improve compliance with the Universal Protocol," says Deen. "And as a system, we have endorsed SBAR to improve communications."

### **'Share the wealth' throughout facility**

Swain recommends "keeping a campaign going" to alert staff at all levels about the NPSG changes. Be sure every meeting, from the unit level to the quality council and the medical staff, keeps staff up to date on what is being done. "None of the National Patient Safety Goals are conducted in a silo. Share the wealth as information on changes and improvements is known," says Swain.

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## **Proven strategies for tough-to-measure NPSGs**

*Tips for handoff communication, hand hygiene*

Some of the Joint Commission's National Patient Safety Goals (NPSGs) are easier to monitor than others, such as reducing the likelihood of harm associated with the use of anticoagulants, which can be tracked electronically.

"If you have physician order entry, you can put in computer logic that says you cannot order Coumadin unless there is an INR available in the lab system. That is something we have tested and are in the process of implementing," says **Charles Emerman**, MD, associate chief of staff in charge of quality and chair of the department of emergency medicine at The MetroHealth System in Cleveland.

Here are some proven strategies for three NPSGs that are especially difficult to monitor, shared by quality professionals:

- **Implementing a standardized approach to handoff communications, with an opportunity to ask and respond to questions.**

"We can have checkboxes to say that people did this, but I can't always be sitting there listening while people talk to each other," says Emerman.

At University of Pittsburgh Medical Center, the "Ticket to Ride" program is the mechanism used to comply with the handoff goal. The program provides standardization of communication

among caregivers at all handoff points, with the goal of reducing serious events related to patient transport and handoffs.

“The program started as a pilot in one hospital and is now being spread throughout our system,” says **Kathy Hale**, director of patient safety. “We monitor compliance through our event reporting system, by investigating and tracking events that occur during patient transport or that are in some way a result of a hand-off.”

- **Hand hygiene guidelines.**

Just as you can't listen to everything staff say when they are handing off a patient, you can't watch everybody washing their hands, says Emerman.

At MetroHealth, spot checks are done by staff to observe hand washing, but this system isn't foolproof, says Emerman. “We have a nice process where everybody takes ownership of watching everybody else wash their hands,” he says.

“But it's hard to implement that. It's hard to get a 20-year-old care associate to go up and tell a physician to go back and wash their hands, even though we tell them it's OK to do that. I wish I had the magic bullet for this, but I don't. It won't be a permanent fix. It will be something that you have to constantly monitor.”

- **Universal Protocol.**

At University of Pittsburgh Medical Center, measuring compliance with the Universal Protocol requirements to prevent wrong-site surgeries is a challenge, says Hale.

“To measure accurately, there needs to be an observer to verify that each step in the process took place at the right point in time and that the appropriate staff were involved, rather than just verifying that the appropriate paperwork was completed,” says Hale.

At Presbyterian Healthcare, the “timeout” process was analyzed over a one-year period, listing all the elements one should consider just prior to the beginning of a procedure.

“It was determined that there was so much

‘noise’ imposed over the timeout process,” says Swain.

The entire organization, including operating rooms and procedural areas, decided to include only those elements critical to the prevention of wrong-site surgery and other procedural mishaps caused by preparation steps. “It was felt there were other processes and policies in place to manage the antibiotic and consent issues,” says Swain.

At UCLA Medical Center, a process was implemented where the orderly coming to move the patient had to verify with the nurse the existence of the order for the procedure.

“Even though doctors were not active participants, they had to be permissive for it to occur,” says **Thomas Rosenthal**, MD, chief medical officer. “They had to be tolerant of the two extra minutes for the handoff to occur correctly, instead of saying, ‘I don't want any delays, just get my patient down here.’”

“It was difficult to get all those pieces in place, and furthermore, it was difficult to measure whether we were accomplishing anything,” adds Rosenthal. “We had to find a way to measure that this handoff was actually occurring. You couldn't have that be self-supported.”

A novel program was created where undergraduate students were trained to observe the handoff procedure. The student checks to see that the transporter provides a written document for the nurse, the nurse checks for an order in the chart, and both the transporter and nurse check for two patient identifiers.

“You would think if you are being observed, you would be compliant 100% of the time, but that was not the case,” says Rosenthal. “When we started, our compliance was 40%. That confirms for me that people don't always do it perfectly just because they know they are being watched.”

Observed compliance with all measures is now greater than 95%, but this took two years to achieve. “For me, that illustrates that asking for a change of this magnitude is not trivial,” Rosenthal says.

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## Key Points

- Implement standardized approach for handoff communication, with opportunities to ask and respond to questions.
- Constantly monitor hand hygiene and encourage staff to monitor each other.
- Try an observer to verify each step is taken to prevent wrong-site surgeries.

# Data overload isn't a good thing

*Identify a small number of important metrics*

Dealing with too much data is “like drinking from a fire hose,” says **David A. Snyder**, MD, vice president of patient care quality and safety at MCG Health in Augusta, GA.

“Sort out what things are particularly hot right now,” he advises. “We’ve done a data inventory and have identified over 4,000 metrics that we track regularly related to the processes of care at our hospital.”

As a physician, Snyder says he would find it very difficult to deal with 4,000 metrics. Instead, he says, “identify ones that have shown up again and again.” He gives the example of three metrics involving antibiotics for surgical cases: the timing of preoperative administration, the choice of antibiotics, and the time it takes to discontinue them after surgery.

“We have asked our surgeons to focus on those three things and a handful of other metrics associated with actions that have been shown to improve surgical care, not the literally thousands of others that aren’t necessarily relevant or actionable for them,” says Snyder. “Sorting through all the background noise to find those pearls is another way that quality professionals can help staff.”

Your data must make sense to the people who receive them and be considered valid. “That point is more important than how much data you give them,” says **Kevin Tabb**, MD, chief quality and medical information officer at Stanford (CA) Hospital & Clinics. “If they don’t trust the data are correct, then it doesn’t matter whether you provide a little or a lot.”

Also, physicians want to see that the data focus on things that will truly impact patient outcomes. Some medical staff members may think that some of The Joint Commission’s National Patient Safety Goals, for example, don’t affect patient outcomes.

“Some of these things just don’t make much sense,” says **Charles Emerman**, MD, associate chief of staff in charge of quality and chair of the department of emergency medicine at The MetroHealth System in Cleveland.

He gives the example of a requirement for educating patients and families about central line-associated bloodstream infection prevention. “What is the patient going to do? How is that

## Key Points

- Identify a small number of metrics that you track repetitively.
- Get physicians to track these items.
- Physicians are interested in hearing practices that affect patient outcomes.

going to help?” he asks. “It’s just one of those things that somebody will do a checkbox for, but it won’t have any effect.”

Instead, he says, physicians are interested in hearing about practices that will affect patient outcomes. “You get overwhelmed by meeting all of these goals that don’t focus on actually improving things,” says Emerman. “With everything else that physicians have to address in their day, you can’t do 12 things at once. You need to pick high-impact things.”

Chart audits and gathering data must be done for compliance, but Emerman argues it’s also important for quality professionals to step back for some portion of their day or week and ask, “What is really going to impact patient care here, who do I need to involve, and how do I make this a priority for the decision makers?” ■

## Is your process for ID’ing disruptive docs complete?

*What your peer review process should contain*

Organizations are taking a close look at their policies for addressing disruptive physicians, in order to comply with new Joint Commission standards for 2009 that will require accredited health care organizations to create a code of conduct and formal process for managing unacceptable behavior.

In addition, a Sentinel Event Alert was just issued by The Joint Commission to call attention to this topic. Rude language and hostile behavior among health care professionals can threaten patient safety and quality of care, warns the alert.

The alert recommends organizations educate all health care team members about professional behavior, develop a system to detect and report unprofessional behavior, and take a comprehensive approach to intimidating and disruptive behaviors that includes a “zero tolerance” policy

and strong support from physician leadership.

Your peer review process for a disruptive provider should include the following, says **Douglas L. Elden**, chairman of the Northbrook, IL-based National Peer Review Corp.:

- A review of the hospital records relating to the professional conduct of the physician, including the credentialing file, staff complaints, and records of investigation, committee minutes, and other relevant information. The investigation should not be limited to the latest incident or incidents.

- An on-site investigation to gather information on the physician's professional conduct through interviews with the physician's peers, patient care professionals, managers, administrators, and technical and support personnel.

- The information gathered from the records and site visit should coalesce to create a solid record detailing any disruptive conduct incidents, as well as their causes, targets, and the circumstances surrounding these incidents.

- The information should then be analyzed to determine the impact of the physician's conduct on patient care.

- A report should be generated setting forth the unbiased conclusions and recommendations necessary for the hospital to determine if peer review action is appropriate.

- If the hospital and medical staff are concerned about a physician's clinical competence, as well as disruptive conduct, the peer review activities for each issue should be conducted as two separate tracts.

"Hospital decision makers often hesitate to initiate a review of a disruptive physician," says Elden.

In addition to internal political considerations, this reluctance arises, in many instances, because the evidentiary basis for the review may appear too subjective to support a peer review action.

**Alice Gosfield**, a Philadelphia-based attorney and consultant specializing in quality improvement, points to a case involving a complaint of the patient against the hospital for failure to take definitive action when complaints were made against the physician (*Copithorne v. Framingham, Supreme Ct. MA 1988*).

"Despite concerns, a hospital cannot ignore its legal obligation to take action to protect the safety of patients and the hospital staff from the disruptive conduct of a physician," says Elden. ■

## Rural hospital adopts Planetree model

*MCMC uses art, music, integrative therapies*

The Planetree model is almost 30 years old but its essence is timeless, says **Janet Powell Morin**, RN, chief culture officer and former vice president, patient care services at Mid-Columbia Medical Center (MCMC) in The Dalles, OR.

"It is timeless and timely and one of the reasons patient-centered care around the country is what all hospitals are working toward," she asserts. And she should know. Since the mid '90s, the 49-bed rural hospital has had visits from more than 2,000 hospitals seeking to learn how MCMC does it.

"For a small community hospital, we really have a progressive board of directors and really forward-thinking," she says. "It frequently surprises people when they come to visit us."

The Planetree methodology was born in 1978 after a patient, Angelica Thieriot, dissatisfied with the care she received while in the hospital, sought to change the way hospitals approach care. Thieriot envisioned a hospital environment that promoted communication, making patients and their family members partners in the care they receive in a healing, nurturing environment.

One of only five designated Planetree patient-centered hospitals, the hospital first learned of the model in the late '80s when its then-president Mark Scott attended a conference with Tom Peters, a writer, business guru, and management consultant who espouses the Planetree philosophy. One of the speakers was an administrator with the Planetree organization. She related the story of a model patient care unit in San Francisco where the rooms are muted in soft colors and embellished with pleasing artwork and the smell of fresh-baked cookies emanates from the kitchen on the unit. MCMC's Scott was so taken with the concept, he rallied to adopt such a model.

After that, Morin recounts, the hospital sent an exploration team to Pacific Presbyterian Hospital in San Francisco to visit the first Planetree-modeled unit. "We took what we saw and modified it for what made sense in our community. We made a decision," she says. "Rather than having just one 11-bed unit or one 40-bed unit, we would implement the Planetree philosophy throughout the whole organization."

Since the facility already was invested in the

process of remodeling and upgrading patient rooms, it was a perfect time, Morin says. "Literally, the architect spent the night in the patient room right across from the nurses' station so he could experience what they heard, what they saw, what they felt."

In preparation, MCMC held multiple focus groups with patients, family members, physicians, and nurses. This first step involved "a real good cross section of individuals that experienced what it felt like to walk into these patient rooms or in the hallway free of clutter with a real focus on making the environment healing, trying to decrease noise, having a real focus on making the environment healing," Morin says.

The primary lesson learned from the focus groups was that people needed space — space for families to gather for quiet times or for time to be together or time to listen to music or watch television. In response, the hospital created a solarium as a quiet room that overlooks the Columbia River gorge, taking advantage of the natural wonders that surround it, Morin says.

One of the questions posed to the focus groups was: "If you could have anything, what would it be?" Morin says physicians wanted quiet places where they could speak with patients and their families about confidential issues without worrying about anyone overhearing, without answering questions in busy hallways. Another item was storage spaces that were easily accessed by staff, having plenty of them, and placing supplies such as linens near patient rooms. Oak shelves were put at the feet of patients' beds so they could see any items they viewed important — cards sent by families, flowers, mementos from home. Each room now also boasts a DVD player and a television with access to more than 60 channels. Patients are also empowered by choosing when and what they'd like to eat.

### ***Catering to specific populations***

Because The Dalles has a large Spanish-speaking population, the hospital began offering a Spanish and an English menu. Now they are

combined into one "so everything is available to everyone," Morin says. She says they also have a lot of Samoan patients. "We know that they like to gather in the atrium and play the piano and sing. If the patient is able, we'll put him in a wheelchair and take him down to the atrium. Sometimes the singing is just done around the patient's beds. For Native American patients, it's often important that they be placed near open windows, and staff are quick to help."

Other offerings include a number of "soothing and aesthetic" gardens used by cancer patients, inpatient rehab guests, and even members of The Dalles community. Yoga and tai chi classes are offered regularly. "In our Center for Mindfulness, which is a part of our cancer center, there is a wonderful meditation room, and we have regularly scheduled relaxation opportunities, meditation with guided imagery, and aromatherapy," Morin says.

### ***Windows more important than you think***

In redesigning patient rooms, one of the most significant yet understated changes, Morin says, was windows. Though it's "something the common person might not think of," she admits, it's one of the things that "just made a huge difference." Windows make the space more inviting, she says. Fish tanks also were placed in "strategic spots, so that really draws you into the rooms. One of them is in our main lobby, and it's really a focal point."

Besides expansive windows, all patient rooms now have large digital clocks, at patients' request, displaying the date, day, time, and temperature. Carpet buffers the hallways, Morin says, lending to the quiet that guests appreciate and find soothing. Patients are encouraged to invite family members; there are kitchens in each of the resting units for home cooking. "It's a very welcome environment," Morin says.

One of the most popular provisions is massage. "Literally every patient that is going in to scheduled surgery is offered a massage," she says, "and it's rare that they don't take them up on it." In the cancer center, radiation patients are

## ***COMING IN FUTURE MONTHS***

■ HHS finally moves on proposed rule for ICD-10 code sets

■ Disruptive behaviors cited as a threat to patient safety

■ NQF endorses national accountability/reporting consensus standards

offered a head, neck, and shoulder massage before they go in for treatment. Roving therapists visit patients in the acute care nursing department. Doctors can request massages for their patients and often do.

Morin says it's a rigorous process to be designated a patient-centered hospital by Planetree, and to maintain the designation is a continuous practice. MCMC has a Planetree advisory council comprised of various staff members and a Planetree action team. "We have several systems in place to really involve the staff and keep the staff informed and active in furthering each of their departments — how we can further implement human interaction and access to information and be very cognizant of the healing environment."

In order to maintain the designation, MCMC has to maintain records of what it's doing and what it's offering and continue to have focus groups. One of the things emphasized to nursing staff is to always ask the patient before leaving the room, "is there anything else I can do for you?"

What about the financial implications of offering more amenities to uphold the patient-centered philosophy?

"You're going to have to paint the wall, so you might as well have a beautiful color. When you see things that remind you of pleasant thoughts

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or memories, it's just healing. Yeah, maybe some things cost a bit more, but if it helps the patient feel special and helps with their feelings, they're going to recover faster.

"Our sense is that [the cost] really balances out."

She acknowledges that resources are now much tighter than when MCMC began implementing Planetree practices, and they were lucky to begin the process when they did. But "it really doesn't matter what your environment looks like. The basic tenets of the Planetree philosophy are within each employee and that's the compassion and personalizing the experience, remembering people's names and what's special about them, and the relationship between employees and the patients and families. Helping them be as comfortable as possible, helping them understand what's going on, answering their questions and fears, and using staff as instruments of love and compassion." It all starts at hello.

"Over the years since we implemented Planetree," Morin says, "just as we went to the model site in California, hospitals all across the country come here to spend the day at our hospital to learn from us, and we know we have impacted health care — not just in our community, but hospitals all across the country."

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