INSIDE

BECKER'S

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7 Steps to Better Quality Control at Orthopedics & Spine Surgery Centers

By Laura Miller

Diagnostic and Interventional Surgical Center, the ambulatory surgery center arm of DISC Sports & Spine Center in Marina del Rey, Calif., has done over 7,000 cases since it opened its doors in 2006 and reported a zero surgical site infection rate during that time.

"Patients should be able to leave without an infection and have a great experience," says Karen Reiter, administrator at both Diagnostic and Interventional Surgical Center and DISC Surgery Center at Newport Beach.

Ms. Reiter discusses seven steps to better quality control at orthopedic and spine surgery centers.

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5 Key Areas CMS Looks At in ASC Surveys

By Carla Daley Shehata, RN, BSN, vice president of operations for Regent Surgical Health

With the implementation of the Centers for Medicare and Medicaid Services 2009 Conditions for Coverage, numerous new standards were mandated for ASCs to follow in order to maintain compliance. In recent surveys, the surveyors have seemed to focus on five key areas.

These five areas are: Governing Body and Management (416.41), Quality Assessment and Performance Improvement (416.43), Environment (416.44), Infection Control (416.51), and the Safe Surgical Checklist (mandated by CMS as of January 2012). Even though we will be focusing on these five areas, it is important to remember that ASCs must follow all standards within the Conditions for Coverage in order to be compliant with CMS.

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6 Important AAAHC Accreditation Updates to Know

By Heather Linder

As many ambulatory surgery center administrators prepare for initial or renewed ASC accreditation, two industry professionals weigh in on recent updates to AAAHC standards — and what you should know about the process.

Mary Wei is the assistant director of accreditation services at the Accreditation Association for Ambulatory Health Care in Skokie, Ill. Sandy Berreth, RN, is the administrator of Brainerd Lakes Surgery Center in Baxter, Minn., and a surveyor for AAAHC.

Ms. Wei and Ms. Berreth answer six questions about what has changed with AAAHC's certification and how administrators can stay on top of regulations.

1. How did the accreditation process change in the last year?
AAAHC released this year's standards March 1, and one major change was the length of accreditation terms.

Previously, ASCs could opt for three-year, one-year or six-month accreditation periods. However, now the accredit-

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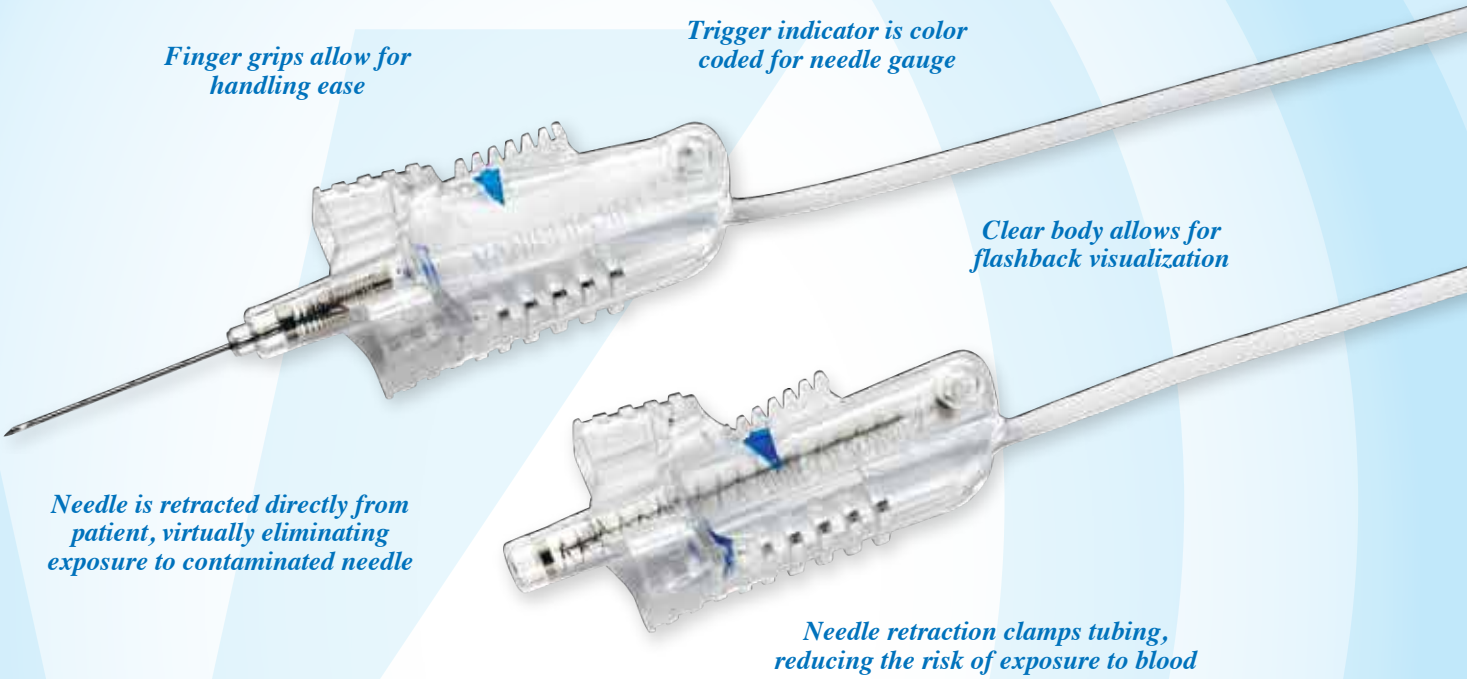

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FEATURES

7 Steps to Better Quality Control at Orthopedics & Spine Surgery Centers
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1. Limit the risk upfront. The surgeons and staff at DISC work hard to keep the risk to a minimum, and have been very successful by implementing several protocols. As a routine part of pre-op, DISC staff members ask all scheduled patients if they have had exposure to MRSA or a history of a skin infection that was difficult to heal. It is surprising how many patients (athletes and non-athletes alike) say they do. When appropriate, the staff also do a preoperative baseline screening. If patients test positive, they are encouraged to see their internist or an infection control specialist for preoperative treatment, and none of their patients have denied this treatment.

"Much of our care and staffing are directed to avoid cross-contamination, and prevent infection. In the environment of the surgical center, we can significantly limit the contacts of the patient," says Ms. Reiter. "At a hospital, on the other hand, there are multiple contacts through admissions, preoperative surgery and postoperative floor, as well as all the ancillary services. At our center, a patient is admitted to a room, the preoperative admitting nurse is usually the same nurse that cares for the patient after the procedure, and contacts are significantly limited. This dramatically lowers the rate of cross-contamination, as essentially every patient is treated in an isolated fashion."

DISC is an official medical services provider for the U.S. Olympic Team, Red Bull's North American athletes and the Los Angeles Kings.

2. Emphasize hand washing for everyone on the same level. DISC emphasizes the importance of hand washing from the medical director down to the newest employee; everyone is responsible for following the hand washing policy and speaking up when they see someone else who hasn't.

"We embrace a 'don't be afraid to speak up' culture. At our surgery center, it's not that the surgeon is the leader and everyone else is underneath," says Ms. Reiter. "It's a collaborative environment. In some cases, physicians may not be aware of the right hand washing techniques. They know to wash between patients, but they don't know that touching a patient's chart is the same as touching the patient, and they need to wash again."

Ms. Reiter has an anonymous person do a "hand washing blitz" to watch whether everyone is washing their hands appropriately. "At first people didn't like this, but now they accept it," says Ms. Reiter. "It helps when the medical director or predominant users of the facility are also supportive of the 'I just noticed you missed a great hand washing opportunity' discussion."

3. Install an advanced air purifying system. Infections can travel as easily through the air as they do on our clothes from one room to the next. DISC has installed an air purifying system so that air from each room goes through a filter to be cleaned constantly and isolated from the rest of the building.

"This is something unique to the DISC facility," says Ms. Reiter. The surgery center installed a $950,000 environmental air conditioning system that provides a HEPA and UVC filtered air to all areas, including preoperative recovery and patient waiting. Each operating room has individual units keeping high volumes of air flowing through the HEPA filter and high-intensity UVC emitters to eliminate airborne germs, bacteria and microorganisms.

4. Enhance patient education on wound care. An important part of the patient's experience extends beyond their time at the surgery center to taking care of the surgical site once they've returned home. There are steps they can take to avoid infecting the surgical site when they are changing wound dressings, and it's important for each patient and family member to understand this process.

"Surgery centers should do a good job with patient and family education in terms of wound care," says Ms. Reiter. "We, as an ASC, send patients home with wound care supplies, so they are able to cover their wounds during a shower and understand how to do the dressing. We want them to be able to take care of it."

5. Adhere to strict surgical attire policies. DISC has strict policies about its surgical attire. For instance, no surgeon or employee is allowed to wear their scrubs outside of the facility. If the staff leaves for lunch, they must change out of their scrubs. While in the center, no personal garments may hang out from underneath the scrubs. Masks must be worn correctly, and cloth hats are not allowed in the facility without a cap on top of them.

"You need a strong buy-in from physician owners and medical directors on this," says Ms. Reiter. "Staff members will do what they are told, but physicians need other physicians to police them."

6. Conduct bladder scanning. One of DISC's policies is to conduct bladder scans on all patients, both preoperatively and post-operatively, to make sure the bladder is working properly. The center also encourages early discontinuation of catheters and use of medications to enhance voiding and reducing residual urine, which is essential to preventing urinary tract infections.

"One of the ongoing quality assurance studies we are now conducting involves looking at how post-operative voiding can impact readmission or risk of infection," says Ms. Reiter.


Karen Reiter

7. Embark on performance and quality-improvement measures. Every facility can work on programs to improve quality of performance. These are going to be important as carriers begin pay-for-performance instead of necessarily fee-for-service reimbursement models. DISC conducts improvement meetings, quality-assurance protocols and ongoing studies to benchmark against national standards.

"Our quality-improvement meetings — like staff meetings — include everyone. We go around the room to see what others are doing differently," says Ms. Reiter. "This openness helps find best practices. We are also running a lot of quality-improvement projects, and have compared our measures to those the hospitals have to follow to verify we are meeting and exceeding them."

Ms. Reiter recommends surgery centers aggressively research hospital quality measures and published benchmarking data and make sure their numbers exceed them. The ability to report these numbers to potential patients will help attract them and drive patient volume in the future.

"It is our goal to deliver a high-quality product that exceeds all national standards, while still providing a personal environment and a great experience for our patients," says Ms. Reiter. ■

4 Approaches to Implement Evidence-Based Care Practices

By Sabrina Rodak

Larry Burnett, RN, MS, a managing director of Huron Healthcare's clinical performance improvement solution, has recommended four approaches for engaging care teams in implementing evidence-based care pathways on the Huron Healthcare website.

Implementing evidence-based care practices can improve quality, reduce care variation and lower costs.

Here are Mr. Burnett's four recommendations:

1. Form collaborative, focused work teams. Multidisciplinary teams of clinicians can develop evidence-based care guidelines for specific diagnosis-related groups or conditions.

2. Plan for proactive change management. A physician change management strategy should include credible data with benchmarks illustrating comparisons between cost and quality outcomes of different physicians.

3. Create an accountability structure. An accountability model should include metrics for expected utilization of pathways, order sets and protocols.

4. Remove barriers to coordinated, interdisciplinary care. Daily interdisciplinary care team meetings and other processes can support a collaborative approach to care. ■

6 Questions Hospital Leaders Should Ask When Managing Care Variation

By Sabrina Rodak

Huron Healthcare, part of Huron Consulting Group, has shared six key questions hospital executives should ask when implementing care variation management.

Managing care variation includes standardizing evidence-based practices across an organization to improve quality and efficiency.

Here are the six questions Huron Healthcare recommends hospital leaders consider when managing care variation:

1. Do you have a reliable and regular way to compare current practice patterns to benchmarks and evidence-based guidelines?

2. Is there a culture of collaboration and accountability among your clinicians?

3. What care pathways or guidelines are currently in place, and are they used to drive decision making at the point of care?

4. Do you have an effective process for concurrently monitoring adherence to the pathways and guidelines, and an escalation process to address non-compliance?

5. Where is your performance on the diagnosis-related groups that fall under the current value-based purchasing program, and on those DRGs that are likely to be added to the program in the future?

6. What tools are currently in place for tracking and reporting quality performance? ■

National Association for Healthcare Quality Offers 5 Recommended Practices for Quality

By Jaimie Oh

The National Association for Healthcare quality has issued a call to action, urging stronger safety cultures to help healthcare professionals feel empowered and protected when reporting potential risks and adverse events.

NAHQ's call to action provides detailed recommendations to enhance provider institution quality, improve ongoing safety reporting and protect staff. NAHQ collaborated with several national healthcare professional organizations to develop the recommendations, including the American College of Physician Executives, American Medical Association, National Association of Public Hospitals and Health Systems, National Patient Safety Foundation and The Joint Commission.

The recommended practices included in the call to action are:

- Create a focus on accountability for quality and safety as part of a strong and just culture.
- Ensure that protective structures are in place to encourage reporting of quality and safety concerns.
- Ensure comprehensive, transparent, accurate data collection and reporting to internal and external oversight bodies.
- Ensure effective responses to quality and safety concerns.
- Foster teamwork and open communication and ensure effective oversight. ■

Promoting Hand Hygiene Through Electronic Monitoring: Q&A With DebMed

By Rachel Fields

These questions on hand hygiene compliance were answered by leaders with DebMed, part of Deb Group, LTD.

Question: What are the current problems with hand hygiene compliance? Why do healthcare facilities still fail in this area?

DebMed: Proper hand hygiene is the number one way to prevent healthcare-associated infections, yet the typical rate of hand hygiene compliance is estimated to be only 40 to 50 percent.

The most commonly used method to track rates of hand hygiene compliance is called direct observation, which involves someone watching and recording the hand hygiene behavior of healthcare workers.

It is not only costly and time-consuming to conduct direct surveillance, but the observation itself is likely to change behavior, as people behave differently when they know they are being watched. This is known as the Hawthorne effect, which artificially inflates hand hygiene rates as the clinicians clean their hands more frequently than they normally would because they know they are being observed. In fact, a study done in Germany and published in the *American Journal of Infection Control* in December 2009 showed a difference of almost three times (2.75x).

Based on the low compliance rates and inaccurate tracking methods, there is clearly a need for a better way to monitor and improve hand hygiene compliance. New advances in technology have resulted in electronic monitoring systems, such as the DebMed GMS, which offers a more accurate, cost-effective and reliable way to measure healthcare workers' hand hygiene compliance than direct observation.

Q: Some employees may not take hand hygiene seriously — how can they be convinced it's important?

DebMed: Hand hygiene is simple, but improving compliance requires leadership, collaboration, accessibility of hand hygiene products, feedback on compliance and infection rates and individual accountability.

Hand hygiene compliance programs that have been successful include a multi-faceted approach that includes providing real-time reports on compliance performance, reminder tools such as posters and making a priority of increasing the availability and convenience of hand sanitizer and soap. A key factor in success is the hospital administration making hand hygiene compliance a hospital-wide priority through dedicated funding, encouraging the participation of senior staff, administration participating in meetings and voicing support for the program.

Accountability, feedback on compliance rates and collaboration can be addressed through an electronic monitoring system. For example, the DebMed GMS encourages higher compliance by monitoring groups instead of individuals. Group monitoring is recognized by industry experts as being more effective than other monitoring systems that track individuals' actions and can be seen by staff as punitive or as an invasion of privacy. Providing reports at the group level encourages collaboration and teamwork to improve compliance.

In addition, the DebMed GMS system includes an online toolkit with educational materials designed to help change behavior, ultimately creating a safer environment for the patient.

Q: What adverse effects can hand hygiene non-compliance have?

DebMed: Loss of life and loss of revenue are the serious consequences resulting from HAIs, which account for nearly two million infections, 99,000 deaths and up to an estimated $45 billion in costs annually in the U.S alone. In 2006, an analysis of 1.69 million admissions from 77 hospitals found that patients with HAIs reduced overall net inpatient margins by $286 million.

The good news is that up to 70 percent of infections may be preventable. Preventing an infection is much less costly and easier than treating one, and saves patient's lives.

Q: What steps can be taken to ensure compliance and involvement from team members?

DebMed: Studies have shown that providing feedback to healthcare workers on their compliance rates in a timely manner, as well as organizational characteristics such as leadership involvement, reminders, and convenient availability of products have a big influence on hand hygiene performance. Healthcare organizations need to integrate hand hygiene into routine procedures and have in place strong systems to support, monitor and promote the correct behavior. ■

Want to learn more about electronic monitoring? Stop by booth #116 at IHI in Orlando December 9-12th.

Respecting Sterile Processing for Their Role in Patient Safety

By Sabrina Rodak

While surgeons, operating room nurses and anesthesiologists have more visibility in providing safe and high-quality surgical care, central sterile processing staff also plays a critical role in delivering excellent patient care. Without sterilized instruments, properly organized and available in trays, patients would be at risk for surgical site infections, and cases would be delayed as nurses search for the appropriate tools.

Alecia Cooper, RN, BS, MBA, CNOR, senior nursing consultant at Surgical Directions, and Valeria McAfee, MBA-HCM, a central sterile processing consultant for Surgical Directions, say proper recognition and appreciation for the sterile processing department and its staff is long overdue. They explain how hospitals can treat sterile processing with more respect to empower staff in patient safety efforts.

Respecting the sterile processing department and staff

"In years past, central sterile processing staff have been looked down upon as employees who exist on a lower level or as an uneducated group who do not know what they were doing," Ms. McAfee says. "The old stigma needs to go away. [They should be treated as] great partners and team players who are part of giving the best surgical care in the hospital."

Job rotations

One of the reasons for this stigma may be a lack of visibility in the OR. Hospitals can break down barriers between the sterile processing department and OR staff by cross-training staff members through different areas of responsibilities that others face on a day-to-day basis.

"The surgeons can really help by visiting the [central sterile] department and providing in-services on their specialty," Ms. McAfee says. This practice not only helps people understand the role of sterile processing in the OR, but it also promotes a collaborative relationship between the OR, the surgeons and the sterile processing team, which is crucial for a safe and efficient OR.

Involvement in committees

Another way to eliminate silos and recognize sterile processing is to involve sterile processing staff in committees that make decisions about OR policies and infection control practices. For example, the central sterile processing manager should be included in infection control meetings, Ms. McAfee says. Including sterile processing staff in OR and safety initiatives can yield significant benefits in the quality of care delivered.

Ms. Cooper says an Illinois facility with one of the lowest infection rates attributed their success in large part to the sterile processing department. "It really does make a huge difference," she says.

Support from leadership

In addition, a hospital can show respect for sterile processing by providing support from key leaders. "The directors of perioperative service need to understand the role this department plays in performing quality outcomes and make sure that they have the necessary resources to do their job properly," Ms. Cooper says.

Overcoming resistance to change

Giving sterile processing staff the respect they deserve is also a step in gaining their buy-in for new projects or other changes. Resistance to change is one of the greatest challenges in maintaining a successful sterile processing department, according to Ms. McAfee.


Alecia Cooper

She says one way to break down resistance is to use a technique called Appreciative Inquiry, in which the perioperative director, central sterile or sterile processing department manager and other leaders seek out the best in people, their organizations and the world around them.

"You have to motivate [central sterile/sterile processing] staff and respect them. You assist them in understanding that their job is of [the] utmost importance," Ms. McAfee says.

One of the effects of the longstanding stigma attached to sterile processing is that many staff in this department feel disconnected from patient care and underappreciated, according to Ms. McAfee. Perioperative leaders need to convey to sterile processing staff members that they are appreciated and that their involvement is critical for meeting overall goals of patient safety and quality outcomes.

Ms. McAfee suggests having staff members verbalize what they do to help them understand their role in patient care.

"Everything they do touches another human being's life. If they understand that what they do touches that person and the quality of care is affected by what they provide, it [helps them buy in to change]," she says. "I have a motto 'One team — one goal!'" ■

4 Strategies to Boost Hospitals' HCAHPS Scores

By Sabrina Rodak

Hospitals' scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey are becoming increasingly important for hospitals to maintain market share and avoid losing reimbursement. Under the value-based purchasing program, hospitals could be financially penalized for low HCAHPS scores. In addition, hospitals' increased transparency and patients' greater involvement in choosing their hospital will force hospitals to provide a positive experience to attract patients. Here are four strategies hospitals can use to increase HCAHPS scores.

1. Communicate clearly and often.

One of the foundations of a positive patient experience is communication — both between providers and patients and among providers. Several questions on the HCAHPS survey address communication. For example, the survey asks patients:

- How often nurses and physicians listened carefully to them.
- How often nurses and physicians explained things in a way they could understand.
- If hospital staff told them what their medicine was for.
- If hospital staff described possible side effects of their medicine.
- If physicians, nurses or other staff discussed whether they would have the help they need after leaving the hospital.
- If they received information in writing about symptoms or health problems to look out for after leaving the hospital.

In a blog post titled "Simultaneously Enhance HCAHPS Scores and Patient Flow," Darin Vercillo, MD, a co-founder and CEO of patient flow software firm Central Logic, wrote, "In medicine, good communication is the action most highly praised by patients and families. 'My nurse explained to me…' and, 'the doctor sat and talked to us…' are phrases associated with high HCAHPS scores. You never see a comment card saying, 'my nurse ran that infusion so well,' or 'my doctor picked the perfect antibiotic.'"

In today's healthcare environment, safe, quality care is expected from hospitals; the experience at the hospital may be what differentiates one hospital from another for patients.

Communication tools

There are many tools and tactics hospitals can use to improve their communication with patients. Hospitals should use multiple modes of communication to emphasize important information and help patients remember key instructions. "To reinforce important information to patients, staff should both write instructions and repeat them verbally, giving patients time to respond with questions," says Elizabeth Chabner Thompson, MD, MPH, a patient advocate and founder and CEO of Best Friends for Life Co., which makes products for patients recovering from various conditions.

At South Nassau Communities Hospital in Oceanside, N.Y., each patient's room has whiteboards to help physicians, nurses and staff communicate with patients, according to Ruth Ragusa, RN, vice president of organizational effectiveness and performance improvement at the hospital.

Another tool hospitals can use to ensure effective communication is interpretation services. Providing interpreters for patients who do not speak or understand English is crucial for communicating information about medication and discharge instructions.

Follow-up calls

Hospitals are also conducting follow-up calls to patients after discharge to answer any questions, ensure discharge instructions are followed and solicit feedback on their experience. Zach Silverzweig, a co-founder of healthcare solutions company CipherHealth, says one of the benefits of asking patients about their experience post-discharge is that patients feel the hospital is really listening to and cares about the patient.

2. Collect and act on data.

As in most improvement initiatives, lasting improvement in HCAHPS scores requires hospitals to collect, analyze and act on data about the patient experience. At the basic level, hospitals can examine HCAHPS surveys to identify trends and problem areas. However, one of the weaknesses of the HCAHPS survey is its low response rate, according to Mr. Silverzweig.

"You get a lot of squeaky wheels. People who are very satisfied and people who are very unsatisfied want to tell you about their experience." Mr. Silverzweig says hospitals can avoid this issue by communicating with every patient about their experience. A larger response rate will ensure hospitals receive data about universal problems in the patient experience. "You need to get a


Darin Vercillo


Elizabeth Chabner Thompson


Ruth Ragusa

consensus view of how patients feel," he says. "Understand what changes are important for all patients because that's what drives the most valuable improvement."

Target specific drivers of satisfaction

Data, whether from HCAHPS surveys, follow-up calls or other tools, can help hospitals determine what is most important for patients to experience and then create projects to target these areas. "People think about patient satisfaction as this big, amorphous problem, but if you can think of a few key small micro-projects, you will be able to move the needle," Mr. Silverzweig says.

For example, he says one hospital found through follow-up calls that some patients were complaining that the beds were uncomfortable. As the hospital had recently brought in new beds, it determined staff were not adequately trained on using the beds. After additional staff training, complaints on the comfort of the beds dropped off, according to Mr. Silverzweig.

3. Educate patients.

Another key strategy in improving HCAHPS scores is to educate patients throughout their hospital stay. "Start teaching and educating people from the day they come in, making sure they are prepared to take care of themselves at home," Ms. Ragusa says. In addition to speaking with patients one-on-one, Ms. Ragusa says hospitals can educate patients through videos at the bedside and written instructions.

Every interaction with patients is an opportunity to educate patients — about their condition, medication, post-discharge plans and follow-up plans. Patients that understand more about their condition and their care will feel more involved in their care process and less detached.

Educating patients during transitions of care, such as from the hospital to a long-term care facility or to home, is especially important for the patient experience because understand what to do post-discharge eases patients' anxiety. "A 'cold' discharge process can leave a patient feeling like a number," Dr. Chabner Thompson says. "Empowering the patient with pertinent information and support tools makes a huge difference."

4. Make a positive patient experience part of the culture.

Significant, long-term improvement of HCAHPS will depend on the culture of the hospital. Hospitals where leaders emphasize the importance of patient satisfaction and where staff are trained in patient satisfaction strategies will be more successful in projects to improve HCAHPS scores.

Leadership

Developing a strong culture that values the patient experience begins with leadership. Hospitals affiliated with Franklin, Tenn.-based Capella Healthcare have made significant and sustained progress on HCAHPS scores over the past two years. Michael Wiechart, senior vice president and COO, attributes their success to leadership and accountability.


Zach Silverzweig


Michael Wiechart

"The single most important contributory factor in our success is that the hospital's senior leadership must embrace and drive service excellence for the organization," he says. "They must develop and drive a mature model of accountability that permeates the culture. That accountability must cascade from senior leaders to directors, managers and frontline staff. The culture of service excellence must be continuously nurtured in order to consistently achieve the strong HCAHPS scores and provide the best care for the patients and communities we serve."

To create a culture that values the patient experience, Ms. Ragusa suggests hospital leaders interact often with the patients. "A key function of leadership is to be accessible to patients and families so that you have first-hand feedback from patients and families directly," she says. "We have all of our management staff making rounds, talking with patients, talking with families, so they're close to what the patients are experiencing."

Training staff to adopt a patient-centric approach to patient care can also help hospitals emphasize the importance of patient satisfaction. "The perspective we always try to take is approach each patient as you would like your family member treated, understanding that [the hospital] may be a common place for us as professionals, but it is a unique situation for patients and families," Ms. Ragusa says. In addition, hospitals should acknowledge that treating patients goes beyond one individual, as treatment also affects the patient's family, according to Ms. Ragusa.

Small changes have big effects

Even small changes in physicians' and staff members' behavior can influence patient satisfaction. For example, Ms. Ragusa says sitting to talk to patients and families instead of standing can give a more positive impression.

"Everyone [in the hospital] has so many things to accomplish, and it's easy for patients to feel that they're rushed," she says. "Even something simple like when you go in to speak to a patient, sit down as opposed to standing. It might take the same amount of time, but the impression is not rushed. The impression is that you might have spent more time when really you haven't." ■

6 Step Strategy for Promoting Patient Safety Innovation

By Sabrina Rodak

Following evidence-based practices is critical for preventing harm in a healthcare setting. However, what happens when there are no evidence-based practices? Hospitals are being called upon to innovate and create patient safety protocols to fill gaps in the literature and adapt existing practices to different environments.

Detroit-based Henry Ford Health System has been recognized nationally for its commitment to patient safety and its innovative solutions to challenges. It was awarded the 2011 Malcolm Baldrige National Quality Award and the John M. Eisenberg Patient Safety and Quality Award in 2011 for reducing system-wide harm events by 34 percent and system-wide mortality by 12 percent from 2008 to 2011. William Conway, MD, senior vice president and chief quality officer of HFHS and CMO of Henry Ford Hospital in Detroit, and Sue Hawkins, senior vice president of performance excellence at HFHS, share six steps hospitals can take to drive innovation in patient safety.

1. Create a robust patient safety program. To encourage patient safety innovation, hospitals have to first create a structured program of patient safety and an infrastructure that enables people to test and share ideas. HFHS started the "No Harm Campaign" in 2008 with a goal of reducing harm events by 50 percent by 2013. The campaign has a clear structure, including committees dedicated to different kinds of harm and monthly reporting requirements.

2. Develop a culture of safety. Fostering innovation also depends on a strong culture of safety in the organization. Ms. Hawkins says HFHS develops this culture through educational offerings and training. The system also assesses leaders' and staff members' perceptions of the culture through surveys.

The employee engagement surveys also include questions related to safety assessment, from how leaders promote a culture of safety to how employees address safety concerns that arise. As part of the curriculum, each employee receives a tool kit and individual coaching on communication about safety as necessary. Leaders are expected to improve culture in their areas based on feedback from the survey. All HFHS leaders are also trained in managing a just culture when errors do occur.

3. Hold people accountable. Holding people accountable for patient safety in the organization motivates them to find ways of overcoming challenges to meet goals. In the No Harm Campaign, HFHS' definition of harm includes all types of harm, whether preventable or not. "When you're holding the team accountable for improvement, they have to come up with innovations because if something appears to not be preventable, it's forcing you to fix it, to come up with new approaches," Dr. Conway says.

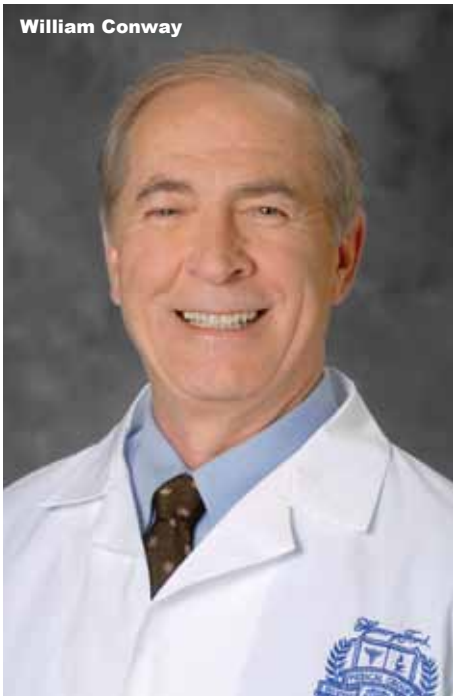
For example, following standard best practices to reduce catheter-related blood stream infections in hemodialysis patients resulted in only modest improvements at HFHS, which motivated the team to develop new best practices. HFHS established an antibiotic lock protocol, in which a solution of gentamicin and trisodium citrate is instilled into the catheter lumen after each patient's dialysis session. This practice has led to a 34 percent decrease in dialysis mortality since its implementation in 2008.

In addition, HFHS was innovative in its approach to managing anticoagulants, which is one of the highest risk medications. The team developed the Pharmacist-Directed Anticoagulation Service in 2008, a practice in which pharmacists direct the dosing of anticoagulants and follow certain protocols to manage the medications.

4. Pilot programs. Specific patient safety protocols don't have to be an all-or-nothing venture. In fact, piloting new projects provides an opportunity for leaders, physicians and staff to innovate, test new ideas and refine practices that can then be shared system-wide. Ms. Hawkins says results of pilots are shared with a steering committee all the way up to senior leadership and the board quality committee to evaluate their success.

5. Partner with researchers. Researchers can support innovation by testing new theories and providing data to support new practices. HFHS has a significant focus on research. "We're a big research organization, so we have lots of physicians and scientists who love to dive into data. If we see blips we don't understand, we take a harder look at what's happening, brainstorm ideas and test them," Ms. Hawkins says.

6. Participate in outside patient safety programs. Participating in regional or national patient safety programs can spur innovation by enabling different organizations to share their successes and failures. For example, HFHS participates in the Institute of Health Improvement programs, which inspired the system to create its own method of measuring patient safety metrics, according to Ms. Hawkins. ■


William Conway


Sue Hawkins

Chuck Lauer: Greater Awareness of HAIs Has Not Translated Into Action

By Chuck Lauer, Former Publisher of Modern Healthcare and an Author, Public Speaker and Career Coach

It's not easy to reach a consensus on a lot of issues, but I think all of us agree that healthcare associated infections are a very serious threat. With this sort of alignment, you'd think hospitals would be doing all they could to eradicate HAIs. Unfortunately, that is not the case.

Part of the problem seems to be that a lot of people don't get excited about fighting HAIs. They should be. An estimated one out of every 20 hospitalized patients in the United States will contract an HAI, at a total cost of as much as $45 billion a year.

Twelve years ago, the Institute of Medicine released its groundbreaking report, "To Err is Human," which got hospital executives all fired up about this issue. In the report's wake, just about every hospital in the country began updating safe practices, rethinking staff training and setting up patient safety committees.

The IOM report found that preventable medical errors were causing 44,000 to 98,000 deaths per year — an astounding figure. In an analogy I remember to this day, the IOM said these deaths amounted to one jumbo jet crashing every single day of the year. If that actually happened, the airline industry would be shut down! But in healthcare, we tolerate this death toll.

A dozen years after that 1999 report, where do we stand? According to some accounts, deaths from HAIs are now much higher than the IOM's 1999 estimate. Basically, we have been treading water. Of all the infections out there, the most difficult one to control is probably Clostridium difficile, a bacteria that can cause severe diarrhea, inflammation and bleeding in the colon, and death. It strikes half a million Americans a year, and more than 9 percent of C. difficile-related hospitalizations end in death.

USA Today recently ran a sobering front-page article on U.S. hospitals' losing battle against C. difficile. It's a stubborn infection. Alcohol-based hand sanitizers and many disinfectants are ineffective in getting rid of the spores. Simply mopping hospital floors just spreads them around. Eight years after "To Err is Human," the CDC reported that the C. difficile rate in U.S. hospitals almost doubled. The rate declined a little in 2008, but the current level is still way above what it was when the IOM report opened our eyes to the enormity of this problem.

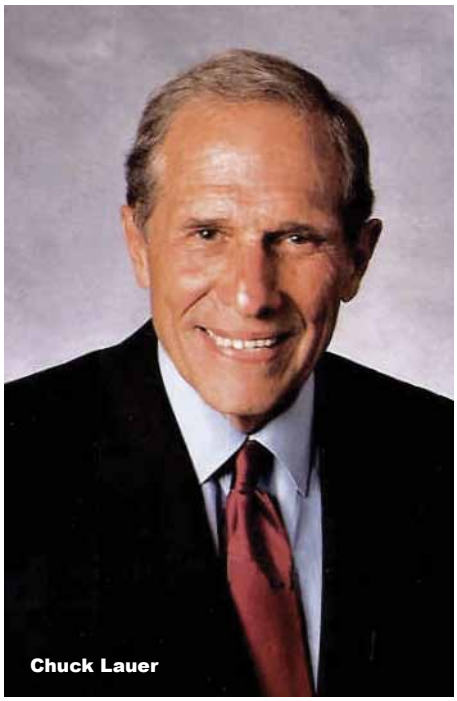
Should we give up? Is it simply impossible to punch a hole in an infection like C. difficile? Absolutely not. A number of hospitals have shown that by applying some imagination, determination and grit, it is possible to cut the infection rate substantially. In 2010, the Mayo Clinic reduced C. difficile acquisition rates by one-third in high-risk units, mainly through daily cleaning of all high-touch surfaces with a disinfectant. This doesn't need to cost a whole lot of money. Jewish Hospital-Mercy Health in Cincinnati, for example, cut its C. difficile rates in half in less than a year, at a cost of just $10,000.

But as hospitals struggle to control their bottom line, that kind of money is, in many cases, apparently too much. Even basic services that help control HAIs have been cut back. A big part of the fight against C. difficile involves maintaining adequate housekeeping staff. According to the Association for the Healthcare Environment, however, hospitals have cut housekeeping budgets by up to 25 percent in recent years. AHE surveys also found that many hospitals spend as little as 18 minutes cleaning a patient's room, well below the optimal level of 25-30 minutes.

One effective way to get hospitals interested in eradicating infections is to lower reimbursements for cases involving HAIs. But these initiatives may simply cause hospitals to shift existing resources around.

In 2008, CMS began withholding additional reimbursement for hospitalizations for just two HAIs: catheter-associated urinary tract infections and central line-associated bloodstream infections. The CMS policy was a success, in that it forced hospitals to redouble efforts against the two targeted infections, and infection rates fell. But in the process, resources were taken away from fighting other HAIs. In a recent survey by the Association for Professionals in Infection Control and Epidemiology, 81 percent of infection preventionists reported that their hospitals had focused more resources on the two targeted infections, but one-third of respondents said resources had been shifted from fighting other infections, including C. difficile.

This is robbing Peter to pay Paul. Fighting HAIs shouldn't be a zero-sum game. It's time for hospitals to take a more aggressive approach against stubborn infections like C. difficile. HAIs accounted for $40 billion in excess healthcare costs in 2009, with the average infection costing $20,000 to $25,000 to treat, according the CDC. As reimbursements move from fee-for-service to bundled payments, hospitals may be forced to swallow the high cost of HAIs or finally do something about them.



Chuck Lauer

In the meantime, hospitals' uninspiring fight against C. difficile has even disillusioned HHS, which in 2008 had established optimistic five-year targets for reducing of HAIs. It slated a 30 percent reduction for C. difficile hospitalizations by 2013, but now, one year before that deadline, HHS concedes there us no way that goal can be reached.

Government must take a stronger stand to eradicate stubborn infections like C. difficile. The British government requires hospitals to report all C. difficile cases — part of a regulatory campaign that has reduced infections by more than 50 percent since 2008. In the United States, a new C. difficile reporting rule for facilities will take effect next year. Thirty-four states now require hospitals to publicly report their rates of infections, but fewer than a quarter of them include C. difficile, according to an analysis by HAI Focus.

For the past dozen years, we have seen greater awareness of the massive destruction wreaked by HAIs like C. difficile. Now we need to finally do something about it. ■

Chuck Lauer (chuckspeaking@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide

Maintaining Quality at Pain Centers: Q&A With Dr. Edward Tavel of Pain Specialists of Charleston

By Laura Miller

On Oct. 6, 2012, the New England Compounding Center issued a voluntary recall of all products after it distributed a contaminated steroid injection to several practices, resulting in numerous cases of meningitis. Since then a nationwide outbreak of meningitis has infected and killed several people who received the injection to ease chronic joint pain.

The Food and Drug Administration issued warnings about several of the company's products and is currently investigating the outbreak. In the meantime, pain management physicians and clinics have notified patients who may have been infected. Others are reassuring patients they didn't use NECC products.

Here, Edward Tavel, MD, founder and medical director of Pain Specialists of Charleston (S.C.) discusses how pain physicians can avoid these problems in the future.

Q: How can surgery centers make sure they are safe?

Dr. Edward Tavel: Compared to inpatient acute care settings, ambulatory care settings are largely responsible for creating their own safety infrastructure and policies.

For ASCs, the first step towards safety should be accreditation. My practice, Pain Specialists of Charleston, is accredited by the Accreditation Association for Ambulatory Health Care. AAAHC accreditors critically examine practice policies, processes and techniques; this includes an examination of medications and devices, assessment of internal policies, review of vendors and evaluation of procedure technique. Pursuit of an AAAHC Accreditation helps ASCs develop best practice, safety-first infrastructures that benefit both the ASC and the patient.

Outside of accreditation, internal and external oversight is critically important. Recent problems with compounding pharmacies are magnified because these pharmacies do not fall under FDA regulation. If a vendor or provider does not fall under federal or state oversight, it is the ASC's responsibility to self-protect. My practice only works with organizations and suppliers that have FDA regulation, quality controls and well-established oversight systems.

Last but not least, ASCs need to establish processes to promote safety from the top to bottom of their organization. For example, physicians operate under the basic expectation of safe injection practices but staff and support staff (Lab, UDS, etc.) may not have or function under that same expectation. Leveraging the CDC's "One and Only" campaign — "1 needle, 1 syringe, 1 time = 0 infection" — is a great way to establish a practice-wide policy. In addition, we train and retrain on infection control, clinical best practices, OSHA, AIDET, etc. ASCs can look to organizations like APIC for great educational materials.

Q: How does your center stay updated with the regulations?

ET: We do quality assessments on the clinical side all the time and infection control is an important part of that. We have a thorough evaluation policy and standard safe injection policies. Most importantly, we are always focused on our affiliation with AAAHC. We had our re-accreditation last week, and that sets the bar.

Q: What do you do to tell potential patients about your accreditation and how do you show them your center provides high quality care?

ET: We have the AAAHC accreditation on our business cards. After the news about the compounding pharmacies, we ran a letter in the newspaper to put patients at ease and sent emails out telling them not to worry. We strive for quality with the accreditation. Our patients aren't at risk at all, and we wanted to make sure we educated our community about that. There are a lot of people who do what we do, and accreditation is a distinguishing factor for our center.

Q: What will it take to prevent another outbreak like this in the future?

ET: FDA oversight. The FDA needs to get involved with compounding companies like they are with major pharmaceutical companies. ASCs should only work with licensed and credentialed companies. ■

Leveraging Technology to Reduce Readmissions: 3 Things to Know

By Sabrina Rodak

Readmissions are becoming a top concern of hospital leaders, not only because readmission rates reflect quality of care and population health but also because they have significant financial implications for hospitals. Under the Patient Protection and Affordable Care Act, hospitals will lose a portion of their Medicare reimbursement for having higher readmission rates for heart attack, heart failure and pneumonia. An analysis by *Kaiser Health News* found that in October, more than 2,000 hospitals will lose a total of $280 million in Medicare funds due to high readmissions.

Hospitals need to employ a variety of strategies to decrease their readmission rates to improve quality and avoid cuts to Medicare funds.

Collaboration is essential for meaningful change

"Collaboration is really at the core of reducing readmissions," says Thomas R. Ferry, president and CEO of healthcare patient-management software-as-a-service provider Curaspan Health Group. Patients most at risk for readmissions are typically those who need additional care after hospital discharge. Hospitals need to collaborate with post-acute care providers to ensure patients receive appropriate care and will not need to be readmitted.

"As hospitals strive to move [patients] outside their four walls, they're going to send them to long-term acute care, skilled nursing facilities or rehab facilities, and so they have to measure the performance of those organizations," Mr. Ferry says. "You have to ensure you're sending a patient to the right level of care and to an organization that can handle that patient and has a track record of managing that patient population."

Collaborating with post-acute care providers through technology and data sharing can help hospitals track patients' progress and avoid readmissions. Mr. Ferry explains three steps hospitals should take to develop a working relationship with community providers to achieve the common goal of reducing readmissions.

1. Ensure the technology is usable and useful. "The tendency of most organizations is to think of the impact [of technology] within their four walls and the users of the technology within their organization," Mr. Ferry says. "But if you're thinking about driving collaboration and the relationship with your external partners, you also have to think about a technology platform that's going to be useful to those organizations as well."

Technology that can work across multiple systems will enable hospitals to more easily share data with post-acute care providers, which can support a strong relationship between the two groups.

In addition to functional concerns, hospitals should consider the benefits of technology for both their own organizations and the organizations they will partner with. "Make sure the technology has utility and provides benefits to your users so they adopt it and want to incorporate it into their everyday life," Mr. Ferry says. The technology should be easy to use to increase the likelihood the post-acute care providers will use IT to share data with the hospital.

2. Collect and analyze data. When hospitals and post-acute care providers implement a shared technology platform, they can collect data on patients discharged from the hospital and their outcomes at the new care provider. For example, hospitals can track data on how many patients are readmitted from each post-acute care provider, and can drill down further to identify readmission rates for different populations of patients — such as cardiac patients — by post-acute care provider.

To pinpoint the source of the problem, hospitals can also track the reason for the readmission from each post-acute care provider. A provider may have a high number of cardiac patients readmitted due to medication noncompliance, for example.

By collecting this data, hospitals can evaluate the appropriateness of different post-acute care providers for specific patient populations. "You can start to use that data to drive the right processes in those organizations that are managing your patients," Mr. Ferry says. "Without that adoption of technology, you don't have that data and can't better manage that process for better outcomes."

3. Meet with post-acute care providers. Once hospitals and post-acute care providers share data and identify trends, they should meet regularly to discuss strategies for improving care. If a hospital notices higher readmissions for patients who went to a certain post-acute care provider, the hospital and post-acute care provider should discuss what the organization's internal processes are for managing patients. The hospital may identify a problem or an opportunity to improve processes so patients receive better care and avoid needing to be readmitted.

Tom Ferry

For example, Mr. Ferry says one hospital realized that a certain skilled nursing facility had a disproportionately high rate of congestive heart failure patients who were readmitted to the hospital. The hospital encouraged the nursing facility to start offering a congestive heart failure coordinator to more effectively manage those patients, and there was a subsequent drop in readmissions.

In addition, the post-acute care provider may realize that it does not have the capability to care for a certain patient population. By communicating this to the hospital, the hospital will learn not to send these patients to that facility and can avoid readmissions.

Mr. Ferry suggests hospitals meet with their post-acute care provider partners quarterly "to continue to cultivate relationships and reinforce proper behavior to best manage patients for the best clinical outcomes."

These collaborative relationships between hospitals and community-based organizations, supported by technology, can help hospitals discharge patients to the most appropriate setting and avoid high readmission rates. ■

Why Providers Can't Settle for "Later:" Tracking Data in Real Time to Reduce Readmissions

By Sabrina Rodak

Demand for instant gratification — receiving responses to questions, gaining access to products and resolving discomfort immediately — is often viewed as a fault of today's society. When it comes to healthcare data, however, instant gratification can become a competitive advantage. Pressure to improve quality and reduce costs is driving hospitals and health systems to adopt new technology, like electronic health records, that can collect useful data about a patient population.

Often, however, actionable data is available only after the fact — after an error has occurred or after a patient has been readmitted. Hospitals today have to work to access concurrent data they can use to proactively prevent readmissions and promote population health. Chris Cashwell, senior director of analytics-based solution marketing for health IT company Nuance Healthcare, explains how healthcare providers can use technology to extract and apply patients' data before they leave the hospital.

Value of "now"

For many hospitals, looking at data retrospectively has been the status quo. Now, however, there are technologies that allow organizations to view patient data in real time and act to prevent readmissions and adverse events instead of making changes after the fact. For example, a technology called clinical language understanding allows healthcare providers to extract important data points from physicians' narrative documentation.

"Capture those patients before they fall through the cracks and [efforts become] reactionary. Now you can do something for patients before they become statistics as opposed to only changing [something] for future patients," Mr. Cashwell says.

For example, Mr. Cashwell says hospitals can determine whether patients have received discharge instructions before they leave the hospital. If the technology does not find evidence that discharge instructions were delivered, an alert can be sent to providers so they can be aware of the situation and talk with the patient before he or she leaves to help reduce the risk of readmission.

In addition to process information, the technology can scan clinical information to tell providers about possible underlying causes of conditions or comorbidities that might otherwise go overlooked.

"Clinical indicators may indicate this patient is leaving the hospital with something they may come back with. [He or she] may be developing pneumonia while in the hospital, and the doctor may or may have not documented the pneumonia. Either rule it out before [he or she] leaves or keep the patient another day to address it," Mr. Cashwell says.

Improving documentation

Another value of collecting data in real time is the ability to identify what additional data is needed and alert physicians, nurses and other providers to collect that data. For example, Mr. Cashwell says the CLU engine may scan information on a cardiac patient and determine there is not sufficient data to calculate the patient's risk for readmission. The system can then request the physician provide more detailed documentation on the patient's diagnosis in real time.


Chris Cashwell

Proactive patient management

In addition to looking at individual patients' data, hospitals can use real-time data tracking systems to analyze data for specific patient populations. Hospitals can filter patients with specific diagnoses to guide strategies for different initiatives, such as reducing falls. Mr. Cashwell says the CLU technology can identify patients that meet certain criteria, such as risk factors for falls.

For example, hospitals can look at patients that have specific neurologic risks for falling, have functional issues, take medications that increase the risk of falling and meet demographic criteria that increase the risk of falling.

"Every patient that fits the criteria will pop up while they're still in the hospital, and you'll be able to see the trends," Mr. Cashwell says. "You can create whatever hypothesis you think meets the readmission focus you're trying to combat, then run that over the entire population and compare it to your last quarter discharges."

By teasing out this information, hospitals can more easily predict which patients are most at risk for different outcomes and implement strategies to prevent adverse events. ■

6 Important AAAHC Accreditation Updates to Know
(continued from page 1)

ing body only certifies centers for three-year periods. The change largely reflects member feedback, Ms. Wei says.

One timeframe should help streamline the process and make it easier for centers reapplying. It can be reassuring for payors, as well. "[Surgery centers] can state to public and state agencies and third party payors, 'We are accredited for three years,'" she says.

Another addition this year was to send updated handbooks to currently accredited organizations to help them stay up-to-date with changing standards. "It gets folks started," she says. "They have an idea of what is changing so they can take the document and compare it to the current year's handbook."

Other modifications were mostly minor and involved making the language more specific. "We had different words mean the same things," Ms. Wei says. "[Words like] providers, practitioners and professionals can mean the same thing or different things according to the situation. We found there was confusion regarding those types of words."

2. What changes can be expected for next year? The public comment period begins at the beginning of September. AAAHC releases potential changes for the 2013 standards and invites administrators, physicians and members of the public to submit comments, suggestions and requests for clarification, Ms. Wei says.

All feedback is analyzed and considered until March 1, 2013, when a new set of standards is released. Ms. Wei says to expect a large overhaul of AAAHC standards in March.

One change will be to eliminate redundancies. Some standards appear in more than one place for emphasis, she says, but some requirements make the process unnecessarily confusing.

Also, members can expect to see handbook chapters and subchapters rearranged or condensed. "It's always more noticeable when we renumber the chapters," Ms. Wei says.

The AAAHC also plans to start giving review guidelines to help people narrow down what they need to be doing and to give ideas for how standards can fit within an organization.

"At first it's going to be general review guidelines," she says. "A number of standards we tried to focus in on are standards that seemed to be the least clear to begin with. We will keep working on developing those in future iterations of the handbooks."

3. What is the biggest obstacle for most applicants? Applicants seem to struggle the most with the quality improvement standards and differentiating between activities and studies, though both have separate AAAHC requirements, Ms. Wei says.

A quality improvement activity involves looking at a center's processes for indicators, such as internal or external benchmarking or links between a peer review and risk management. A study is a written compilation of a center's activities that is determined with a specific goal in mind.

"In order to have a study," Ms. Berreth says, "we have to compile our activities and ascertain what they mean to us. Studies show us how we can improve our activities and what our end result is based on our activities."

To assist in properly meeting quality improvement standards, the accrediting agency developed a worksheet for applicants to help them review required elements. The sheet walks them through how to analyze a study individually and see if their studies meet AAAHC standards.

"A lot of people conduct their studies based on their basics, like cost of care, looking at turnaround times, duration of procedures and implementation efficiencies. What's included in the standards is a requirement for internal and external benchmarking," Ms. Wei says. "They can make great use of benchmarking by seeing where they are in comparison to similar organizations in the region or nationwide."


Mary Wei

4. How can applicants properly prepare for a survey? Ms. Berreth first received accreditation for Brainerd Lakes Surgery Center in 2005 and has maintained it ever since. The simplest step she took to receive and upkeep her AAAHC accreditation was poring over the handbook frequently. She recommends that new surgery centers base their initial regulations on the processes instead of trying to amend processes to fit the rules later.


Sandy Berreth

Separating the chapters out can also make the process seem less daunting, she says.

"It was important for me to make sure my standards and my processes were very much in line with my handbook," she says. "I have three-ring binders that deal with every chapter. If it is required, I have it stuck in those three-ring binders."

Ms. Berreth works to keep her binders updated whenever changes are issued. Her system also allows for any surgery center employee to view compliant processes anytime, even when she is unavailable. Having your entire staff educated on standards and procedures makes implementation more seamless.

"If you take really good care of your patients, if you have high standards of meeting care, you will meet the standards," she says.

5. What does it take to maintain compliant processes? Staying constantly aware of new standards and updating practices accordingly is the best way to retain accreditation and compliance, Ms. Wei and Ms. Berreth agree. Even though new AAAHC policies are released in March, one document — CMS' Appendix A — is online; reading these will keep you ahead of the standards, and will give people an idea of what will be changing, Ms. Wei says.

"Don't wait until March to start acting," she says. "The idea of accreditation is that it's ongoing. Make changes, update programs you put in place at the beginning. Don't set up a program to leave it after you've completed the survey until next time. Prep for your next survey shouldn't start in the three months preceding your application."

Be aware of changes made by CMS and your accrediting body, even if it's not a reaccredidation year. "The standards I had to comply with in 2005 [for my first accreditation] are nothing compared to the standards in 2012," Ms. Berreth noted.

Certification may last for three years, but Ms. Berreth recommends making changes every year to avoid problems with recertification. Quick changes won't stick. Have your governing body meet regularly to ensure standards are discussed and updated.

6. Overall, what does accreditation mean? Accreditation can serve as a signal to physicians and other surgery centers of a facility's high quality assurance.

"If you see the emblem of AAAHC, you know you will receive the best, safest, cleanest possible care in a surgery center," Ms. Berreth says. "Healthcare is constantly changing and technology changes. We as practitioners need to change with it. We have accreditation standards to live up to; this indicates our dedication to quality."

Receiving additional certification also makes a surgery center more appealing to commercial payors. Some third party payors, such as Aetna and Blue Cross Blue Shield programs, require third-party accreditation in addition to Medicare certification. While not all require it, they may reward a center monetarily for achieving accreditation. "I've seen centers get a percentage increase on top of regular rates," Ms. Berreth says of some commercial payors.

Payors also appreciate the assurance that your surgery center is taking care of patients properly, even if certification means little to the patients themselves.

"Patients don't want to see the AAAHC emblem or the CMS emblem," she says. "They want to be taken care of. That's what patients pay attention to, but third party payors want a guarantee we are taking care of their covered lives. Accreditation means we meet the standards; it's proof we are excelling in quality patient care." ■

5 Points on Preventing Injection Errors in the Surgical Setting

By Rachel Fields

Gina Pugliese, RN, MS, is vice president of Premier's Safety Institute and a member of the Premier Safe Injection Practices Coalition, which aims to study and prevent unsafe injection practices. In 2009, a hepatitis C outbreak in southern Nevada was linked to the reuse of propofol vials, leaving patients infected with incurable liver disease.

Drug shortages and low reimbursement for pain procedures mean that providers are often tempted to cut corners, reusing needles and vials in order to save money. But the consequences can be life-threatening — hence the CDC's "One and Only Campaign," which aims to raise awareness about safe injection practices.

Here, Ms. Pugliese discusses five things providers can do to prevent unsafe injection practices.

1. Champion "one needle, one syringe, one time." Premier's Safe Injection Practices Coalition recently conducted a survey to determine how widespread the problem of unsafe injection practices is. Of the 5,500 people who responded to the survey, approximately 1 percent reported re-using single-dose vials on multiple patients. Fifteen percent reported re-using a syringe to enter a multi-dose vial, and 6 percent of that 15 percent saved that multi-dose vial for use on another patient. Ms. Pugliese says these numbers point to a serious problem. "We didn't try to trick them by saying, 'Are you doing this terrible thing?'" she says. "We just said, 'How often do you do this?' And people were very honest."

She says facilities should maintain a zero-tolerance approach to the re-use of single-dose vials or the re-use of syringes on multi-dose vials. "We're bringing together providers from different professional organizations and asking them to educate their professionals," she says. Education has been more difficult in some areas, such as pain, where low reimbursements are a problem for physicians. For example, Medicare reimburses for pain procedures but not for all the medications used for the procedures. "Physicians had a tendency to re-use single-use vials until this campaign started," she says. In your facility, she recommends sitting providers down with a video and an explanation of why this is important. Emphasize that this is not an option. "one needle, one syringe, one time" is mandatory.

2. Empower patients to speak up. Patients need to be educated about unsafe injection practices as well. "Patients are so much more prepared now than they used to be," Ms. Pugliese says. "They're asking questions and demanding information." She says she recommends that facilities post signs that inform patients about safe and unsafe injection practices.

That way, if the patient notices that he physician is re-using a single-dose vial or using a syringe tinted with blood, they can speak up. "If the patients from the terrible outbreak in Nevada had known what was happening, they could have said something," she says.

3. Post signs, slide programs and education materials in your facility. You can't educate too much on a topic that saves patients' lives, Ms. Pugliese says. The One and Only Campaign and the Premier Injection Practices website offer a number of resources for providers, including posters, slides for physicians to browse in their free time, and brochures for patients to read. Make "best practices" visible in your facility to remind providers and patients of the rules.

4. Survey your facility. Ms. Pugliese says the survey conducted at Premier was so effective because it didn't put providers on the defensive — it simply asked, "How often do you do this?" You need to know whether your facility has a problem with unsafe injection practices; the practice may be widespread among your staff without anyone realizing it's a problem. Ms. Pugliese recommends distributing a survey or assigning "secret shoppers" to departments to watch injection practices and determine how often providers are not complying. A survey can be relatively informal and give you an idea of misinformation in the facility.

5. Take extra caution in small facilities. Small facilities may be more prone to these unsafe practices than large hospitals, Ms. Pugliese says. She says this may be because small clinics are staffed by a limited number of people, who pass information from one person to the next with limited oversight from a bureaucratic structure.

"When you work in a hospital, you really have a lot of other people watching you," she says. "In non-hospitals, there's a greater opportunity for improper practices to go on for a long time. It's the attitude that, 'This is the way they showed me, and this is how I'm doing it. Everybody does it that way.'"

She says this means education in small facilities is even more important. You don't want your long-time OR nurse passing on misinformation about unsafe practices to her colleagues because she simply doesn't understand the rules — and is the only source of education for new workers. ■

Inside the Medicare Accreditation Process: 5 Crucial Points From ASC Inspector Dr. David Watts

By Taryn Tawoda

David C. Watts, MD, the vice president of education for the American Association for Ambulatory Surgery Facilities, discusses five key factors in the process of obtaining and maintaining Medicare accreditation in ambulatory surgery centers.

1. The first inspection is typically the easiest one. The first Medicare accreditation inspection may be the easiest phase in the process because the ASC is most likely new and therefore has less opportunity for error, says Dr. Watts. "In the beginning, it's a clean slate — the surgery center is doing it for the first time, so there hasn't been a chance for anything to go wrong. It really is a fairly clean event."

The center is more likely to encounter violations during the re-inspection process, at which point it has been operating for several years, he says. "It's one thing to talk about conducting an infection control meeting when you first start, for example, but over a three-year time period, have you been doing it every quarter like you said you would?"

2. Inspectors classify non-compliance into three categories. A Medicare accreditation inspector identifies three levels of non-compliance/deficient practice when examining an ASC:

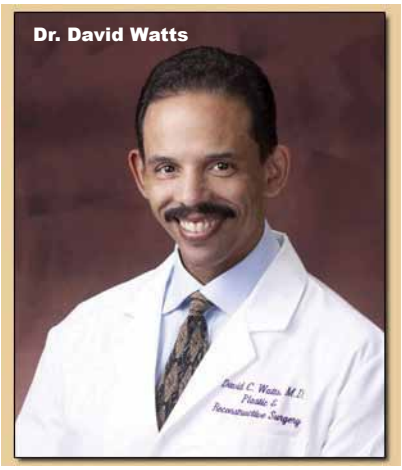
- **Immediate jeopardy.** A deficient practice that falls under this category would likely cause the surgery center to close immediately, says Dr. Watts. "An extreme example would be if a surgeon was operating and eating a sandwich at the same time," he says. "Another example would be if the surgery center didn't have a crash cart, or if all the medications in the cart were expired. CMS would say to shut them down."

- **Condition level deficiencies.** These deficiencies are typically related to infection control, such as when a surgery center does not have a hand washing or sterilization policy in place, says Dr. Watts. There is no set number of condition level deficiencies that must occur in order for an ASC to be closed — the deficiencies are noted and the ASC's Plan of Correction is reviewed by a committee following the inspection.

- **Standard level deficiencies.** The most minor of the three categories, a standard level deficiency, is an error that does not immediately jeopardize patient safety but that must nonetheless be corrected. A tear in an OR table, a lack of eye wash at a sink or an unsigned patient bill of rights all constitute potential standard level deficiencies, says Dr. Watts. As with condition level deficiencies, these deficiencies are noted and reviewed by the accreditation committee at the AAAASF office. An excessive amount of standard level deficiencies in one area such as the OR environment can cause the ASC to be cited for condition level deficiencies, says Dr. Watts.

3. A sufficient number of deficiencies will prompt a re-inspection. AAAASF must inform the ASC of any areas of non-compliance found within 10 business days of an inspection. From that point, the ASC has 10 calendar days to develop a plan of correction to address its deficiencies and an additional 30 days to implement. Every ASC that has even minor deficiencies must develop a plan for correcting them, says Dr. Watts.

If an ASC was found to have only standard level deficiencies, sending a photo or a receipt proving that the problems are fixed may be sufficient, he says. However, if conditional level deficiencies are noted, a focused re-survey will occur for ASCs that are renewing their Medicare accreditation. "They will send the examiners back unannounced to see if the ASC has fixed the problems. New applicants that have condition level deficiencies will not be recommended for deeming and must send a letter of intent to continue the accreditation process once they have made the appropriate corrections if they want to continue to pursue Medicare deeming," says Dr. Watts.


Dr. David Watts

4. The ASC must report bi-annually into an electronic peer review system. "You want to look at how you're logging in and tracking narcotics, handling disciplinary problems, the advanced directives looked at by patients, the bill of rights looked at by patients — this has to happen on a daily basis for every case," says Dr. Watts. "You want to make sure that documents like pathology reports and X-rays have to be signed off on by the physician doing the case. All of this has to be checked."

5. Unannounced quality reviews can happen at any time. Quality measures in the ASC are also closely reviewed, and an accreditation representative can visit at any time to inspect these measures, says Dr. Watts. "When you're moving patients, is it safe?" he says. "Is there any break in sterile techniques during a case? Is the staff wearing protective equipment like glasses and gloves? How are you sterilizing instruments when you wash them?" These quality and infection control protocols are all noted during the inspection and, depending on the severity, could be classified as condition level deficiencies.

Dr. Watts says he sees common errors and deficiencies when examining ASCs, but once they are noted and corrected, the surgery centers ultimately attain a higher level of patient safety and care. "The process requires incredible vigilance to make sure that everything gets done, but once you do it, you will have an incredibly safe facility," he says. ■

5 Key Areas CMS Looks at in ASC Surveys
(continued from page 1)

1. Governing body responsibility. CMS has mandated that the governing body retains the ultimate responsibility for the overall operations of the ASC. It's important that the governing body understand exactly what this means and provide sufficient evidence this is happening within the facility. The surveyor will generally use two methods to ensure the ASC is following these standards: auditing board meeting minutes and looking at facility policies. The regulation particularly stresses the responsibility of the governing body for the following:

- Accountability for the quality assessment and performance improvement program
- The quality of the ASC's healthcare services
- The safety of the ASC's environment
- Development and maintenance of the disaster preparedness plan

2. Ongoing quality assessment and performance improvement. Quality assessment and performance improvement must be proven to be ongoing and data driven. CMS does not mandate how the QAPI program is established; it gives the ASC the flexibility to design its own program. In order to satisfy the regulatory conditions, the program must be proven to be ongoing, in that it is continuing and not a "one-time" effort. The surveyor will look to see whether the QAPI program collects quality data at regular intervals to be analyzed and updated frequently, as well as whether necessary corrective action(s) is (are) taken and proven to be effective.

The program must also be data-driven, in that it must identify in a methodical manner what and how data will be collected. Standard 416.43(c) states that the PI program activities must focus on high-risk, high-volume, and problem-prone areas.

3. Environment. Providing a safe, functional and sanitary environment is another issue that CMS is focusing on. In order to ensure that the ASC is compliant, the surveyor will look at infection prevention and control, fire safety, emergency equipment and emergency personnel. There have been many surveyors trained specifically in life safety, and they use their training to ensure that the facility is compliant in providing a safe physical environment.

4. Infection control. Infection control has become even more crucial to the ASC industry since the implementation of the standards in the 2009 Conditions for Coverage. Within the topic of infection control, CMS will be inspecting to ensure the ASC has an infection control program that minimizes infections and communicable diseases and maintains a sanitary environment. CMS will also be checking to ensure that there a designated qualified professional with infection control training leading the facility's infection control program.

5. Safe surgical checklist. In January of this year, CMS mandated that ASCs create and implement the use of a Safe Surgical Checklist. CMS has not been authoritarian in how this is accomplished and currently uses the World Health Organization checklist as an example.

The issues mentioned in this article will not change any time in the near future, but CMS' focus on these five areas will increase, which started with the advent of required quality reporting in October 2012. ■


Carla Daley Shehata

CMS' Systems Improvement Agreement: A Last Chance Alternative to Medicare Termination?

By Victoria May Fennel, MSN, RN-BC, CPHQ, Director of Accreditation and Clinical Compliance for Compass Clinical Consulting

In the past, when CMS conducted a survey and unfavorable findings led to a determination of immediate jeopardy, healthcare organizations had very little choice (prepare an acceptable corrective action plan or risk Medicare decertification) and very little time (23 days) to correct the deficiencies. For some healthcare organizations, failure to provide an acceptable corrective action plan following multiple citations of immediate jeopardy or repeated surveys with immediate jeopardy findings resulted in Medicare terminating the hospital's contract.

An alternative to Medicare termination

The loss of Medicare payment would force most hospitals to close. Compass Clinical Consulting has termed this the "hospital near-death experience." Because this course of action has devastating effects for the community as well as the hospital's employees and medical staff, CMS proposed an alternative course of action — a systems improvement agreement.

What is an SIA?

An SIA is a time-limited contractual arrangement between a Medicare-accredited healthcare organization and CMS. SIAs have been used in nursing homes and organ transplant centers in the past and recently have been implemented in hospitals.

Why enter into an SIA?

Entering into an SIA provides more time for a healthcare organization to fix its deficiencies than is typically allotted from a validation or for-cause survey. In some cases, the timeframe has been extended to as long as 19 months. Of course, CMS may rescind the pending termination sooner, especially when the hospital is found to be substantially in compliance with all of the CMS Conditions of Participation.

The SIA process

The SIA reads much like a legal document and stipulates the terms under which the healthcare organization agrees to:

- Obtain independent consultative review (at its expense);
- Submit the names of the proposed consultant companies and/or individuals (including their curriculum vitae);
- Acquire expertise in the development and implementation of an effective quality assessment and performance improvement program;
- Engage the services of an independent, full-time, on-site compliance officer for the duration of the agreement; and
- Other terms specified by CMS including resurvey by CMS within six to 12 months.

In return, CMS agrees to suspend the execution of the scheduled termination order pending the healthcare organization's fulfillment of the agreement. The SIA specifies the qualifications and responsibilities of the independent consultant/group and stipulates the content and frequency of the reports that are to be submitted to CMS. Consultants' reports are released to the healthcare organization only after they are approved by CMS.

At its discretion, CMS may elect to discuss the findings from the reports with the independent consultant/group by phone or in person at the healthcare organization's expense. The agreement itself is a public document — some examples of SIAs executed in the past couple of years are available on the Internet. Reports from the independent consultant/ group, though, are subject to federal and state privacy protections.

The systems improvement agreement is not easy, but it provides time for hospital leaders to plan and fix serious problems without a 23-day CMS decertification hanging over their heads.

The purpose: Positive organizational change and compliance

The purpose of the SIA is to effect large-scale organizational change to attain compliance with all of the CMS CoPs or Emergency Medical Treatment and Labor Act standards, as applicable to the situation. Additionally, by entering into an SIA, the healthcare organization agrees to retain responsibility for compliance with the CMS requirements and to waive all rights to administratively or judicially challenge the findings described in the Statement of Deficiencies (Form CMS 2567).

Conditions that could lead to immediate jeopardy

To understand when CMS might offer this last chance to avoid Medicare decertification and withdrawal of funding, it is important to recognize the conditions that place a healthcare organization in immediate jeopardy. Immediate jeopardy is defined as "a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death" (42 CFR 489.3, 2010).

There are several issues of non-compliance which may trigger immediate jeopardy: (a) "failure to protect from abuse," (b) "failure to prevent neglect," (c) "failure to protect from psychological harm," (d) "failure to protect from undue adverse medication consequences and/or failure to provide medications as ordered," (e) "failure to follow nationally accepted standards of practice for infection prevention," (f) "failure to correctly identify patients," (g) "failure to safely administer blood or blood products," (h) "failure to provide safety from fire, smoke and environmental hazards," and (i) "failure to comply with EMTALA requirements," according to the CMS State Operations Manual, Appendix Q - Immediate Jeopardy, 2004.

At a workshop in Arkansas earlier this year, CMS indicated there were 6,089 instances of immediate jeopardy logged in its intake department in 2010. Hospitals comprised 8 percent (480) of the total complaints; long-term care facilities represented 44 percent; and the remaining 48 percent were others. Hospitals that receive an immediate jeopardy citation are ineligible for participating in the CMS value-based purchasing program.

SIA considerations

The time and expense of entering into an SIA and effecting wide-scale organizational changes must be taken into consideration. However, should a healthcare organization opt not to accept or amend the terms of agreement, the alternatives are to voluntarily withdraw from participating in the Medicare program or have CMS terminate the organization's participation.

Either way, the result would be devastating, creating a large crater, a healthcare void, in the community.

What success looks like

Once the healthcare organization is resurveyed and demonstrates substantial compliance with all of the CoPs, the pending termination is stopped, which releases the organization from the state agency's jurisdiction. CMS then restores the deemed status of the healthcare organization and dismisses the SIA.

The SIA might be a last chance — but also a great chance — to create positive organizational change and make a real difference in improving patient care. ■

5 Points to Achieve 95% Hand Hygiene Compliance

By Rachel Fields

In 2010, MetroHealth in Cleveland started noticing an upswing in infections with resistant bacteria — a problem plaguing many hospitals across the country. In response, chief medical officer Al Connors, MD, piloted a program to decrease infection rates in the hospital, starting with a push for greater hand hygiene compliance. When the hospital first started tracking hand-washing rates, they were at about 65 percent compliance — higher than the national average, but, in Dr. Connors' words, "not as good as it could be."

Here, he discusses several tactics the hospital used to increase hand hygiene compliance to an average of 95 percent at MetroHealth.

1. Require all employees to undergo training. Dr. Connors borrowed a video on hand-washing from the CDC and required all employees at MetroHealth to watch it. The video was only 20 minutes and made the case for why all employees needed to wash their hands. "Of all our employees, only about 150 people didn't attend the training, and those people got a little note in their employee file that they missed the hand-washing video," Dr. Connors says.

He says the video helped get everyone at the health system on the same page on hand-washing; while everyone seemed to think it was a good idea, few people understood how serious the problem was. "When you asked people how often they washed their hands, they'd say, 'I think about 100 percent,'" he says. "It turned out to bea around 65 percent, and people just didn't know that."

2. Hire people to track compliance. MetroHealth educated its employees in Novembeer 2010 and installed four handwashing monitors at the health system in December. The monitors were all high school graduates — smart people, but not highly-trained specialists — who worked approximately 20 hours a week and cost the hospital less than $100,000 a year total. They wore white coats and carried clipboards and went around to every unit to report whether employees were following the policy. The theme of the campaign was "wash in, wash out"; every time an employee entered or left a room, they were expected to wash their hands.

Once the hospital had achieved a steady success rate for about a year, they decreased the number of monitors to two, in order to save money. In addition, they distributed a report every eight weeks rather than every four weeks to cut costs.

3. Increase your goal as you improve. After the monitors had been with the hospital for a month, MetroHealth analyzed four weeks of data and found that their compliance rate had increased from 65 to 83 percent. "It was pretty good and people were feeling pretty happy about themselves, but I wanted to set our goal higher," Dr. Connors says. The health system's original goal was to improve from 65 percent. Once they had reached 83 percent, Dr. Connors decided to set a new goal of 90 percent compliance.

"We're aiming for optimally protecting our patients, and nine times out of 10 sounds much better than seven times out of ten," he says. He spoke to the hospital's inpatient units and explained that five of the hospital's units were already above 90 percent. "I said to the others, 'Let's get out there — if they can do it, you can do it. They're not any smarter or better than you are.'"

4. Publicize information on progress. Dr. Connors says MetroHealth put information on hand hygiene compliance on the internal website for the hospital so that every employee could see it. "It didn't identify individuals, but rather said how each unit was doing," he says. When the next report came out, there were 12 units above 90 percent and 21 units below 90 percent.

Dr. Connors sent out an email to all units, letting them know of the progress. Five weeks later, all but one unit was over 90 percent and many were over 95 percent. Every week, the hospital posted the updated results so that every floor could tell how they were doing. Dr. Connors says the program simply came down to diligence from the program monitors, himself and the staff — everyone had to keep the results in mind at all times. Dr. Connors sent out regular emails to remind staff that he was "still watching," he says, to make sure no one became complacent and stopped following the guidelines.

5. Speak to outlier employees individually. Occasionally, your surgical facility may run into a particular nurse or physician who has issues with remembering to wash their hands. For the most part, Dr. Connors says the non-compliance is accidental — they think they've been washing their hands, but they aren't up to the level expected by the facility. He says he asked the handwashing monitors to report any employees who protested when told to wash their hands. For every physician mentioned, he called the provider individually and asked them about the instance. "I'd tell them that they needed to be a role model," he says. "If someone sees a doctor come into the room without washing their hands, they're confused about what to do." He says the physicians frequently had an excuse for non-compliance — for example, they were just going into the room to tell the patient one thing and left again quickly — but he made sure to restate the policy of "wash in, wash out."

Since implementing the program, MetroHealth has maintained a hand hygiene compliance rate of between 95 and 97 percent for over a year. For any unit that falls below the 95 percent threshold (as reported every eight weeks), Dr. Connors sends an email reminding them to stay on top of hand-washing. He says the best thing about the program was that it was cheap and easy to implement; any surgical facility in the country could do it with little cost and effort. ■

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