

# SOW News

## In This Issue

Pneumonia Vaccination Resources . . .	2
ADHS Influenza Prevention Toolkit . . .	2
CDC Influenza Prevention Materials . . .	2
2006–2007 Influenza Surveillance Information . . . . .	2
HSAG Hosts HoW Meeting . . . . .	2
Consumers, Caregivers Taking Steps to Safer Surgery . . . . .	3
Secondhand Smoke Hurts the Heart and the Mind . . . . .	4
Maryland Facility Begins Discharge by Appointment . . . . .	4
<i>Safe Practices for Better Healthcare:</i> NQF to Release New Consensus Guidelines . . . . .	5
HSAG Acute Care Team Contact Info . .	5

## Transformational Change: Pneumonia Vaccinations

Since the beginning of the Centers for Medicare & Medicaid Service's (CMS') 8th Scope of Work, hospitals have been encouraged to make transformational changes. Participants at the October Hospital Workgroup Meeting (HoW) heard yet again the need for change during Dr. Dale Bratzler's presentation on "Achieving Transformational Change." But what exactly is transformational change, and how does one go about achieving this change? CMS does not provide us with a definition, but they do promote the need for hospital administrators and leadership to accelerate the change process. Webster's defines "transform" as meaning "to change the condition, character, or function of."

The Institute of Medicine (IoM) released *Performance Measurement: Accelerating Improvement* this summer. The IoM cites that the quality chasm identified in the late 1990s remains wide, with slow progress and fragmented improvements. The IoM continues by stating that there are obstacles to improvement and that one thing contributing to the lack of improvement is the deficiency of a goal-oriented, efficient system. Yet, goals for hospital improvement are defined by JCAHO and CMS in the form of quality measures for the care of patients with heart attack (AMI), heart failure (HF), pneumonia (PN), and undergoing surgery (SCIP).

Is the care provided to patients in Arizona contributing to the lack of progress? YES, it is. Care providers continue to resist guidelines developed by their own organizations. Organizations are hesitant to promote standing orders that would assure that the right care is delivered to the right patient every time. Clinicians continue to remain unaware of guidelines that impact the care they provide. Patients, although more knowledgeable than ever before, remain silent about requesting evidence-based care that should be provided to them.

Administering vaccinations to pneumonia patients is one area in which Arizona does poorly. On the CMS *Hospital Compare* Web site (<http://www.hospitalcompare.hhs.gov/hospital/home2.asp>) patients, stakeholders, and others can see that Arizona hospitals only provided pneumococcal vaccinations to 57 percent of the eligible patients in

(Continued on page 2)

2005. In comparison, the top 10 percent of hospitals in the country vaccinated their patients 89 percent of the time. Providing pneumococcal vaccinations is not a new quality measure nor is it a newly published guideline. In some states, vaccinations are a standard of care and those not administering the vaccine are subject to the risks and liabilities of providing substandard care.

Arizona hospitals are able to provide immunizations to patients requiring tetanus immunization with little fanfare. Why is it difficult to apply those same principles to assure that pneumonia patients receive the right care? It is difficult for all of the reasons listed above.

During his presentation to HoW, Dr. Bratzler noted that the National Quality Forum has recommended that all inpatients receive pneumococcal and influenza vaccination regardless of their admitting diagnosis. In a perverse way it may be simpler to assure that all patients receive vaccinations rather than just those admitted with pneumonia.

Preprinted orders, standing orders, guidelines, and other interventions are readily available for hospitals to implement. As a state, we need to achieve transformational change in the vaccination of pneumonia patients. We need to accelerate our progress, improve our results, and—most importantly—protect our patients.

We need to persuade providers to support vaccination guidelines, to advocate for guideline approval, and to support the implementation of interventions to assure that the right patients receive the right care. Hospital administrators must push for the adoption of guidelines and ask why the care is not being provided. Clinicians must understand the clinical measure, provide the care, and strive to assure that the right care is provided. Infor-

### PN Vaccination Resources

Tools to help providers increase their rates of influenza immunization are available at <http://www.ama-assn.org/ama/pub/category/16952.html>.

Tools to improve influenza immunization rates in health care workers are available at <http://www.ama-assn.org/ama/pub/category/16633.html>.

The August/September issue of *Summit Newsletter* is now available at [http://www.ama-assn.org/ama1/pub/upload/mm/36/summitnewsletter3\\_06.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/36/summitnewsletter3_06.pdf).

mation and literature about pneumococcal and influenza vaccinations needs to be readily available for patients.

Dr. Bratzler asked if a “C+” was good enough. At 57 percent, Arizona hospitals are not even achieving a C+ when it comes to vaccinating patients. We can do better, we can achieve transformational change, and we can make a difference.

### ADHS Influenza Prevention Toolkit

The Arizona Department of Health Services (ADHS) has developed a series of four easy-to-use Influenza Prevention Toolkits. Individual toolkits have been developed for (1) schools, child care, and parents; (2) health care, hospitals, long-term care, and assisted living agencies; (3) workplaces; and (4) local health departments.

The Flu Education Toolkits each have a selection of posters, flyers, brochures, and tips to help you create your own customized influenza prevention campaign for your workplace, school, child care facility, medical practice, or hospital. You can view and download the ADHS Toolkits at [http://www.azdhs.gov/flu/flu\\_toolkit.htm](http://www.azdhs.gov/flu/flu_toolkit.htm). Spanish versions are available for most of the materials.

### CDC Influenza Prevention Materials

The Centers for Disease Control and Prevention (CDC) has also developed a gallery of downloadable and easy-to-print education materials—including flyers and posters—for use in health care settings and in public settings such as schools, community centers, and workplaces. The materials—available in English and Spanish—are creative and easy to read and understand. Visit the CDC flu gallery at <http://www.cdc.gov/flu/professionals/patiented.htm>.

### 2006–2007 Influenza Surveillance Information

The ADHS and the CDC have both kicked off their influenza surveillance seasons. Both the CDC (<http://www.cdc.gov/flu/>) and ADHS (<http://www.azdhs.gov/flu/>) will be updating surveillance information weekly throughout this year’s flu season.

### HSAG Hosts HoW Meeting

Health Services Advisory Group (HSAG) hosted an Arizona Hospital Workgroup (HoW) meeting on

*(Continued on page 3)*

October 12 for over 60 participants representing 28 different organizations. The event was held to recommend interventions and processes that can be used to achieve transformational change, examine the impact of leadership on quality activities, understand beneficiary appeal rights, and review current Centers for Medicare & Medicaid (CMS) requirements for HDC and RHQDAPU.

Dr. Dale Bratzler, DO, MPH, Medical Director of the CMS Infectious Diseases Quality Improvement Organization Support Center at the Oklahoma Foundation for Medical Quality, provided a keynote presentation on achieving transformational change. Dr. Bratzler provided information and comments about implementing interventions designed to ensure that the right care is provided to the right patient every time. A question-and-answer period followed the presentation, which is available by visiting <https://ifmcevents.webex.com/ifmcevents/mywebex/default.php?Rnd9069=0.576333>.

Meeting participants also heard about CMS-proposed new rules for HINNS and NODMARS.

Materials distributed at HoW can be found at: [http://acute.hsag.com/how\\_october\\_meeting.asp](http://acute.hsag.com/how_october_meeting.asp). The next HoW Meeting is scheduled for January 11, 2007. For additional information about HoW, contact Suzanne Anders.

### Consumers, Caregivers Taking Steps to Safer Surgery

Leading consumer advocacy groups have joined with the Surgical Care Improvement Project (SCIP) to improve patient safety during surgery and increase communication between patients and their caregivers.

Of the 40 million inpatient and outpatient surgeries patients undergo each year, tens of thousands end up with associated postoperative complications. SCIP is working to prevent complications in four areas that comprise 40 percent of the most common complications after major inpatient surgery: infection, blood clots, and adverse cardiac and respiratory events.

SCIP is one of the first national quality improvement initiatives to unite hospital, physician, and nursing organizations; the federal government; the organization that accredits hospitals; private sector experts;

and now consumer advocacy groups in far-reaching surgical quality improvement. The goal is to use evidence-based measures to reduce preventable surgical complications by 25 percent nationwide by 2010.

The consumer groups, AARP, and the National Partnership for Women and Families collaborated with SCIP to develop a patient tip sheet that provides consumers with important information on ways to avoid surgical complications.

The tip sheet was introduced at a Washington, D.C., press conference on October 23, 2006. Featured speakers included: Mike Leavitt, Secretary of the U.S. Department of Health and Human Services; Ilene Corina, co-founder of PULSE, a grass-roots patient safety advocacy organization; and other SCIP members.

Consumers and patients need information that will help them become active partners in their care," said John Rother, AARP's Group Executive for Policy and Strategy. "SCIP supports improvement not only for hospitals and doctors, but for patients as well by giving them practical and actionable guidance that will contribute to the likelihood of better surgical outcomes."

"Our goal is to spread this evidence-based knowledge to the public as well as health care providers, so that every surgical patient receives the appropriate care every time. In doing this, we will save many thousands of lives," said Debra Ness, President, National Partnership for Women & Families.

"SCIP is a national quality initiative that aligns with one of the five key strategies of the CMS Quality Roadmap: CMS must work collaboratively with other health care partners in improving health care quality," said Barry Straube, MD, Chief Medical Officer and Director of the Office of Clinical Standards and Quality at HHS' Centers for Medicare & Medicaid Services. "SCIP will allow consumers to be better informed and enable health providers to make the necessary systematic improvements that CMS and its partners feel will improve patient outcomes, while reducing avoidable complications and costs."

The tip sheet, *Steps to Safer Surgery*, provides specific questions patients can ask their physicians and nurses

(Continued on page 4)

before surgery to ensure they are receiving care that will reduce their risk of having complications. The tip sheet and additional information about SCIP can be found at [http://www.ofmq.com/qiosc\\_scip.html](http://www.ofmq.com/qiosc_scip.html).

## **Secondhand Smoke Hurts the Heart and the Mind New Research on Environmental Tobacco Smoke (ETS)**

Two new studies have been published in the past year evaluating the effects on the rate of AMI (acute myocardial infarction) admissions to hospitals when smoke-free laws go into effect. These studies confirm earlier results from Helena, Montana, using large data sets by independent researchers. The drop in AMI rates in these communities ranged from 11 percent in Piedmont, Italy, to 27 percent in Pueblo, Colorado, to a 40 percent drop in AMI admissions in Helena, Montana.

Prenatal exposure to secondhand smoke, or ETS, has been proven to be a cause of ADHD (attention deficit hyperactivity disorder) in children, as well as other attention problems. Even low-level exposure of pregnant women to tobacco smoke is a significant contributor, according to a 2006 report published in *Environmental Health Perspectives*. Another 2006 study looked at the economic cost of children born with developmental delays due to prenatal exposure to ETS. This study looked at the cost per child exposed in utero to ETS and estimated over \$17,000 annual cost per case; this adds up to a total of millions of dollars in costs annually to Medicaid and other payers.

### **What can we do?**

It's important to keep our environment, for adults as well as children, free of secondhand smoke. Helping patients/clients who are dependent on tobacco has significant health benefits for smokers and for non-smokers; clinicians can learn how to deliver brief tobacco dependence treatment interventions.

Free continuing education programs, Brief Tobacco Intervention Skills certification, and Basic Skills Instructor workshops instructed by The University of Arizona HealthCare Partnership faculty are available at varied locations throughout Arizona.

The workshops offer CEU/CME and are funded by the Arizona Department of Health Services Office of Tobacco Education & Prevention.

For more information on continuing education and certification programs and a calendar of events, visit <http://www.healthcarepartnership.org> or contact the HealthCare Partnership by e-mail at [hcpinfo@u.arizona.edu](mailto:hcpinfo@u.arizona.edu) or by phone at 520.318.7253 x 126.

## **Maryland Facility Begins Discharge By Appointment**

This month, St. Joseph's Medical Center in Towson, Maryland, begins discharging patients by appointment in the latest phase of a three-year effort toward capacity maximization, says Jackie Connor, RN, MS, CCS, director of case management.

When Connor was hired in April 2005, she was asked to take over the part of the project that included improving the discharge process, "the back end of patient flow," she adds. "Other teams were working on the emergency department, the front end. We had an issue with 'boarders' in the ED and, as we started collecting data, what came to the surface was that if we could just fix transportation and discharge, 80 percent of the problem should be fixed."

Connor says her sense of the situation, however, was that a more comprehensive solution was needed. "We put together a multidisciplinary team last June, started working on the problem and, as we moved forward, put together subgroups as issues arose." When the discharge task force was established in June 2005, one of the main goals was to increase the percentage of patients discharged by noon, Connor adds. But even with that specific intent, several months of data collecting revealed little change. "What we found was that it was causing what we called 'bolus' discharges," she says. "It was a rapid, concentrated effort, a massive amount of patients, trying to get it all to happen before noon."

"Later in the day we would have 'bolus' admissions as the ED and the catheterization lab would empty out," Connor adds, "so there was not an even workload throughout the day."

*(Continued on page 5)*

That’s when the decision was made to move to discharge by appointment, she says. “What we’re attempting to do—and I haven’t seen this in any of the literature on the subject—is to try to schedule discharges for all patients, not just surgical patients.”

The idea has been piloted on the surgical unit with some success, and then with interventional cardiology patients, and is now being expanded to all patients, Connor notes. One group that will not be included is the maternal/child patient population, she adds, because there are no throughput issues there.

From: *Hospital Access Management*, [http://www.ahc-media.com/products\\_and\\_services/?prid=182](http://www.ahc-media.com/products_and_services/?prid=182)

**Safe Practices for Better Healthcare: NQF to Release New Consensus Guidelines**

In a November 1 announcement, members of a coalition of health care purchasers, quality groups, and federal agencies—in conjunction with the National Quality Forum—have agreed to support a single set of 30 “safe practices” for all hospitals to follow to help prevent patient deaths and injuries. Among other

practices, the guidelines recommend that hospitals promptly disclose medical errors to patients and their family members, implement evidence-based programs to prevent errors during nurse shift changes, and evaluate all support staff members for patient safety competency. The guidelines also include recommendations for implementation.

NQF developed the guidelines based on recommendations from CMS, the Leapfrog Group, the Joint Commission on Accreditation of Healthcare Organizations, the Institute for Healthcare Improvement, Kaiser Permanente, and others. In an interview with the *Wall Street Journal*, JCAHO President Dennis O’Leary said that hospitals might not have the ability to implement all 30 of the practices recommended in the guidelines at the same time. He said, “We want these changes to happen, but our concern is that if you ask hospitals to do too much at once, the risk is they won’t do anything well.” NQF will formally issue the voluntary guidelines, which will replace recommendations issued in 2003, after a public comment period ends on November 14.

The report will be available at <http://www.qualityforum.org/>.

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