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Quality Insider

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THE MEDICARE QIO FOR LOUISIANA

Minden Medical Center's Baby Place 2nd in nation to earn TJC Gold Seal

By: **Lynne Rhodes, RN, MSN**
Director of Quality/Risk, Minden Medical Center

In May of 2011, Minden Medical Center's Baby Place earned the Gold Seal of Approval for healthcare quality from The Joint Commission. The Medical Center received Specialty Certification for Normal Deliveries. Minden Medical Center's program is the first and only one of its kind in Louisiana, and second in the nation to achieve this certification. This certification follows a previous Gold Seal of Approval received by Minden Medical Center for its Total Joint Replacement Programs (Hip and Knee) in July of 2010.

This certification means Minden Medical Center is following nationally recognized standards of care for normal deliveries. Team members who developed and submitted the program to TJC included Dr. Robert Russell, OB; Dr. Amanda Williams, OB; Dr. Stephen Coleman, OB; Dr. Melinda Willis, Pediatrician; Dr. Michael Ulich, Pediatrician; Dr. Elizabeth Phillips, Pediatrician; Adriane Delaney, RN, L&D Nurse Manager; Dana Haynes, RN, Nursery Nurse Manager; Donna Carter, RN, MSN, CNO; and Lynne Rhodes, RN, MSN, Director of Quality/Risk.




Baby Place team members (left to right): Elizabeth Glass, Deanne Pace, Holly Archer, Adriane Delaney (L&D Nurse Manager) and Donna Carter, CNO

The Joint Commission Gold Seal of Approval validates that the Baby Place at Minden Medical Center consistently demonstrates commitment to a higher standard of service. To earn this distinction, a disease management program undergoes an extensive, unannounced on-site evaluation by a Joint Commission reviewer every two years. The program is evaluated against Joint Commission standards

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Save the date! Thursday, May 3, 2012



2012  LOUISIANA
**MEDICARE QUALITY
SUMMIT & AWARDS**



Please mark your calendar for Thursday, May 3, 2012 and join us at the Crowne Plaza in Baton Rouge for the Louisiana Medicare Quality Summit & Awards. And don't forget to check our Summit fan page on Facebook to get Summit 2012 updates and see highlights from last year's event. Online registration will be available at <http://louisianaqio.eqhs.org> beginning April 1, 2012.



Exhibitor Forum and Speaker Support is provided by the Louisiana Rural Health Association. For information regarding the Summit exhibitor forum, please contact Stacy Fontenot, Executive Director LRHA, (985) 369-3813.

TeamSTEPPS®: A team approach to improving resident patient safety

By: Deborah Serio, MBA, BSN, RN,
CWCN, CPE
Quality Improvement Specialist

The value of teamwork in caring for residents in a nursing home can't be emphasized enough. It takes a variety of talents and skills to ensure the residents' needs are being met. Effective teamwork also serves as a safety net in healthcare delivery protecting against such issues as falls, pressure ulcer development and restraint use.

- As a staff member, what is it like to work on a healthcare team?
- Who is in charge?
- What are the team goals for your residents?
- How does the team handle workload increases if a resident becomes ill?
- What if a doctor's order needs to be verified?

High performing teams address these issues and more. They are adaptable, accurate, productive, efficient and safe. This is the thought process behind TeamSTEPPS®, a program that provides tools and strategies for improving communication and teamwork, reducing the chance of error, improving resident outcomes, as well as resident and staff satisfaction.



TeamSTEPPS® stands for **Team Strategies and Tools to Enhance Performance and Patient Safety**. It is an evidence-based program developed by the Agency for Healthcare Research and Quality (AHRQ) in collaboration with the Department of Defense (DoD). The program evolved from research in such high-risk fields as aviation, where errors in performance may lead to serious consequences. It is backed by many years of research on teams and team performance.

TeamSTEPPS® was developed in response to the Institute of Medicine's 1999 publication of *To Err is Human*, which concluded that medical errors cause up to 98,000 deaths annually. The program has proven results and



The TeamSTEPPS® logo

has been used in hospitals across the nation. Nursing homes will soon have the opportunity to use this program. A nursing home version is anticipated to be released in 2012.

TeamSTEPPS® focuses on four teachable-learnable skills: **Leadership**, **Situation Monitoring** (knowing what is going on around you), **Mutual Support** (being aware of team members' needs) and **Communication**.

There is a dynamic relationship between these skills and outcomes. Outcomes include team members interpreting goals in the same way, mutual trust and an understanding of team roles and responsibilities.

Working on such a team is a very positive experience, where team members trust the intentions of their teammates. These team members are more efficient, are able to adapt to changes and know how to back each other up. They have a plan, know who is supposed to do what and how they are supposed to do it. In addition, the team members will more readily identify and correct errors. These skills and competencies produce teams that are adaptable, accurate, productive, efficient and safe.

Leadership involves the ability to coordinate the activities of team members by ensuring team actions are understood, changes in information are shared and that team members have the necessary resources. Team leaders can use such tools as the "Brief," which is a short session prior to

starting a project, to discuss team formation, assign essential roles and establish expectations. Other tools include the "Huddle," when there is a need to adjust the plan, and the "Debrief," a review of team performance and effectiveness after an event to improve the process in the future.

Situation Monitoring is the process of continually scanning and assessing what's going on around you to maintain situational awareness. Using this skill allows team members to be "on the same page." For example, if a resident is at high risk for falls and the CNAs, nurses, and housekeeping are continually aware of the resident, they can be proactive rather than reactive to a fall. The "Cross Monitoring" tool ensures mistakes or oversights are caught quickly and easily. The "I'M SAFE Checklist" tool enables a member to ensure he/she is fit and ready to fulfill their duties.

In long term care, situations can change quickly. **Mutual Support** allows team members to anticipate and support each other through accurate knowledge of their responsibilities and workload. It fosters an environment where assistance is actively sought and offered to protect team members from work overload situations. It also includes "Advocacy and Assertion" skills which can be used when team members' viewpoints don't coincide with the decision



maker. The "Two-Challenge Rule" allows members to deal with conflict and "stop the line" if they sense a safety breach. The program offers additional tools to manage conflict and ensures team members are speaking the "same language."

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Medicare expands savings initiative

Excerpt from an article published December 28, 2011

By **Marsha Shuler**, Capitol news bureau
The Advocate, Baton Rouge

A program designed to help some senior citizens avoid quick return trips to the hospital is expanding from the Baton Rouge area to Lafayette, Hammond, Covington and the Northshore.

The federally funded program is aimed at reducing Medicare costs by stopping revolving door hospital admissions. The idea is to curb health care spending and keep chronically ill patients healthier.

At the heart of the program is a “health coach” who works with patients so they have the information essential to their well-being when they are discharged from the

hospital — information that would prevent a quick return because of a relapse.

“We are looking at the patient as the solution, rather than the problem,” said Laurie Robinson, a registered nurse and director of care coordination services for eQHealth Solutions.

Robinson spearheaded eQHealth’s Baton Rouge-area pilot project (2008-2011), which was a three-year program funded through a \$2.1 million grant from the Centers for Medicare and Medicaid Services. The community was one of 14 around the U.S. receiving program funding.

The program targeted patients who had suffered heart attacks and those diagnosed with congestive heart failure, pneumonia and pulmonary disease. The aim was to reduce the number of patients returning to

the hospital within 30 days of discharge by helping them identify early signs of problems and keep up with medicines they were prescribed, the frequency and stop dates.

Prior to the three-year Baton Rouge area project, the 30-day readmission rate per 1,000 Medicare patients stood at 18.8 percent. The project reduced the rate to 13.6 percent for those patients who received coaching from eQHealth.

Five local hospitals participated in the Baton Rouge area project: Our Lady of the Lake Regional Medical Center, Baton Rouge General, Ochsner, Lane Regional Medical Center in Zachary and St. Elizabeth’s in Gonzales. Two hundred patients participated in the program over the time period.

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2011 Round Up: Our 10 Picks for Readmissions, Care Coordination Resources

Reprinted from “Smarter Health Care” the eQHealth Blog
Visit www.eqhssmarterhealthcare.org to read more and to subscribe

December 19, 2011

Hospitals have until October 2012 before the penalties for high readmissions take effect but the clock has already started ticking. CMS began monitoring readmission rates earlier this year and hospitals are preparing for the rollout.

It’s an opportune time to review some of this year’s best discussions on reducing readmissions and care coordination. Below is a list of resources we’ve found that will help your understanding of today’s conversations:

1. [Atul Gwande for The New Yorker](#) on one example of how medical costs, such as unnecessary re-hospitalizations, can be lowered by zeroing in on health care “hot spots” and focusing on coordinating care at the community level.
2. [Becker’s Hospital Review](#) – Ten proven strategies for reducing readmissions.
3. [Kaiser Health News](#) – Stats from the national VA health system illustrate that even with focused reduction efforts,



combating patient ‘rebound’ is going to be difficult.

4. [American Medical News](#) – How three hospitals reduced their readmission rates: Successful interventions from Atlanta, San Francisco, and Kirkland, Washington hospitals.

5. [Fierce Healthcare](#) reports on a recently released NEJM study that highlights a lesser known factor in predicting high readmissions – high hospitalizations.
6. [The Health Care Blog](#) – Lack of coordinated care is at the crux of preventable readmissions and controlling health costs.
7. [Disease Management Care Blog](#) – Without reliable scientific models for predicting readmissions, will hospitals be unfairly penalized?
8. [Commonwealth Fund](#) – Report on lessons learned from four top-performing U.S. hospitals with exceptionally low readmission rates and the key factors that contributed to their success.
9. [Kaiser Health News](#) – Conflicting incentives for hospitals to reduce readmissions.
10. [Urban Institute report](#) on the savings opportunities in improved care coordination for chronic and long-term care.

Congratulations!

Congratulations to Lisa Solomon, eQHealth Quality Improvement Specialist who works with providers on the Physician Quality Reporting System (PQRS) project. She



was recently notified that she passed the Clinical/Practitioner Consultant examination administered by Health Information Technology Professional (HIT Pro™).

HIT Pro™ administers competency exams to Health IT professionals in order to confirm that their experience and skills are at a level that meets the nation's need for health information technology experts.

About the Clinical/Practitioner

Consultant role

This role melds the background and experience of a licensed clinical or public health professional with that of an HIT consultant. Clinicians who pass this exam have demonstrated their ability to:

- Suggest solutions for health IT implementation problems in clinical and public health settings.
- Address workflow and data collection issues from a clinical perspective, including quality measurement and improvement.
- Assist in selection of vendors and software.
- Advocate for users' needs, acting as a liaison between users, IT staff and vendors.

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The fourth skill, **Communication**, is the process by which information is clearly and accurately exchanged among team members.

To ensure critical information is covered in reporting, TeamSTEPPS® uses the SBAR (Situation, Background, Assessment, and Recommendation) tool. Other communication tools, such as the "Call-Out" and "Check-Back" techniques, ensure accuracy and safety. Nursing homes encounter

transfers from hospitals on a regular basis, and the "I Pass the Baton" tool can help nurses and admission coordinators ensure they receive vital information during a care transition.

The TeamSTEPPS® program is a powerful solution to improving teamwork and patient safety within an organization. It offers tools and strategies to handle such barriers as lack of information sharing, lack of coordination and follow up, conflict, fatigue, workload and lack of role clarity in a team. This

evidence-based system offers the tools and strategies to deal with these barriers. Nursing homes should embrace this opportunity to enhance team performance.

If you would like more information on this program and how eQHealth Solutions QIS can help you launch it in your nursing home, contact Kim Byers at 225-248-7006 or kbyers@eqhs.org. TeamSTEPPS® program information can be found at: <http://teamstepps.ahrq.gov>.

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through an assessment of a program's processes, the program's design for evaluating and improving care within the host organization, and via interviews with patients and staff. The program must adhere to nationally accepted standards of care and practice guidelines designed to improve quality of patient care. The practice guidelines chosen by The Baby Place physicians and nurses were:

- ◆ ACOG Practice Bulletin #107, August 2009: Induction of Labor. Clinical management Guidelines for Obstetrician-Gynecologists from the American College of Obstetricians and Gynecologists.
- ◆ Guideline for the Use of Antenatal Corticosteroids for Fetal Maturation, Journal of Perinatal Medicine, 36(2008), Recommendations and guidelines for perinatal practice.
- ◆ Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother:



"Going Home Protocol," Academy of Breastfeeding Medical Clinical Protocol Committee, ABM Clinical Protocol #2 (2007 revision).

The Joint Commission launched its Disease-Specific Care Certification program in 2002. It is the first program of its kind in the country to certify disease management programs. A list of programs certified by the Joint Commission is available at www.jointcommission.org. Founded in 1951, The Joint Commission seeks to continu-

ously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission evaluates and accredits more than 17,000 health care organizations and programs in the United States, including more than 9,500 hospitals and home care organizations, and more than 6,300 other health care organizations that provide long term care, behavioral health care, laboratory and ambulatory care services. In addition, The Joint Commission also provides certification of more than 1,000 disease-specific care programs, primary stroke centers, and health care staffing services. An independent, not-for-profit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. Learn more about The Joint Commission at www.jointcommission.org.

LSMS/LSU Joint-Study Details Lack of EMR Adoption By La. Physicians

BATON ROUGE - One of the most significant challenges facing physicians today is the adoption, or lack thereof, of Electronic Medical Record, or EMR, technology.

Despite potential incentives and penalties as dictated by the American Recovery and Reinvestment Act, or ARRA, which are dependent on a physician's willingness to use EMR technology, the medical community is still hesitant to adopt EMRs, according to a newly published study by Drs. Andrew Schwarz, Ph.D., and Colleen Schwarz, Ph.D. Both are professors at Louisiana State University's E. J. Ourso College of Business and the Center for Computation and Technology.

The report, a joint study between the Louisiana State Medical Society and LSU, is titled "Findings on the Non-Adoption of EMR Technology Among Physicians in Louisiana."

"There are a unique set of factors that explain why someone chooses to not adopt a technology that do not explain why they do," said Andrew Schwarz.

"In our review of the current discourse over EMR, we saw an alarming trend – an attempt to blame the doctors. In our research, we call this 'pro-innovation bias' – blaming the individual not adopting the technology instead of taking a critical view of the technology itself. We wanted to uncover what was really going on with EMR from the perspective of the doctor, with our approach being physician-centric.

Why are business professors interested in the medical community?

"We were often asked why two business professors would be interested in understanding the issues confronting the medical community," Schwarz added. "We are interested because this represents an interesting business case. In the case of the medical community, we have a marketplace where the consumers of the EMR technology (i.e. the physicians) have little to no control over their pricing structure and



are being forced to adopt a technology from vendors operating in a free market."

Phase One

In phase one of the study, the researchers conducted 15 face-to-face interviews with physicians across the state who had not adopted an EMR. They also interviewed four other physicians who were either users of EMRs or experts on the matter. From those interviews, they came up with 31 factors that were cited as reasons for the non-adoption of EMR technology.

Phase Two

Those led to phase two of the study, which was the development and distribution of a web-based survey that went to 3,324 members of the Louisiana State Medical Society. Twenty-one members opted out of the survey, leaving a sample population of 3,303 physicians. Eight



hundred and sixty-six doctors began the survey, a 26.2% response rate, with 594 finishing for a 68.5% completion rate.

Those 594 physicians were made up of practicing physicians, retired physicians and medical students/residents from across the state and representing a variety of specialties. Seventy-eight percent of the subjects were male and 22 percent were female. Racial diversity was also achieved with 78 percent of the respondents being white, 2.5 percent were African-American, 2.5 percent were Asian, 2 percent were Hispanic and the remainder indicated "other."

Adopters vs. Non-Adopters

The respondents could be broken down into two main groups - adopters and non-adopters. Respondents were almost split evenly, with 50.4 percent being adopters and 49.6 percent being non-adopters.

Non-adopters of EMR technology had six over-arching concerns with EMRs:

- Negative views of EMR technology
- A lack of impact on their performance as a physician
- Negative views of the EMR marketplace
- Initial and long-term implementation concerns, i.e. cost and re-training
- Institutional distrust, including distrust of the federal and state government and insurance companies
 - Security and legal concerns

Interestingly, adopters and non-adopters did agree on one section of the survey: institutional distrust.

Adopters and non-adopters were differentiated based on several factors, including their views of EMR technology, views of EMR impacts, views of EMR vendors, initial and long-term

implementation cost concerns, institutional distrust, security and legal concerns and incentives and penalties. Those same factors were used to analyze and compare physicians' views on EMR technology by six regions, which span Louisiana. Each region, it should be noted, had its own views on EMRs, leaving the researchers to conclude that overcoming physician resistance toward adoption will require a differentiated, regional strategy

Interestingly, adopters and non-adopters

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did agree on one section of the survey: institutional distrust.

Specifically, physicians have a high level of distrust toward the two entities involved in encouraging the adoption of EMR - HMOs and the government. Indeed, physicians do not trust how HMOs will penalize them for non-adoption of EMRs, how the HMOs will use the data, how the HMOs will use the EMR to monitor work practices, and they do not trust the motivations of the HMOs for encouraging adoption. The same can be said regarding their reasons for not trusting the federal government

Physicians do not trust the government's motivations for requiring adoption of EMRs, how it will use the data, how it will use the EMRs to monitor work practices, and that the government will not alter the definition of "meaningful use of EMRs."

"It is clear to us that there is no national strategy for deploying EMR solutions," said Schwarz. "This is a case of believing in the power of technology to solve problems that there is no way that it reasonably can. There is no demonstrable link between EMR deployments, mean-

"...the non-adopter physicians expressed significant skepticism over the ability of the EMRs to improve the quality of their work or their decisions."

Colleen Schwarz, Ph.D

ingful use, and quality of care outcomes. Rather than taking our time and setting a national strategy, stimulus money and incentive pressure is being put on physicians to adopt questionable technology that is not proven to result in the outcomes that we hope to achieve."

Time, said Colleen Schwarz, is another important factor in all of this.

"Physicians already feel stretched for time and they do not have the extra time necessary to devote to learning how to use the new system," she said. "In addition, the non-

adopter physicians expressed significant skepticism over the ability of the EMRs to improve the quality of their work or their decisions. Therefore, the physicians are reluctant to spend their extra time or money to invest in a technology when they are skeptical of its ability to improve the quality of their work or their communication with their patients."

To view the entire report, visit: www.lsms.org/EMRstudy.

About LSMS

The Louisiana State Medical Society is a voluntary association of physicians begun in 1878 providing leadership for the advancement of the health of the people of Louisiana and serving as the premier advocate for patients and physicians.

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Now, Robinson said, CMS has given eQHealth the go-ahead to move into other parts of the state and the nonprofit organization has received another three year CMS grant to do so.

Robinson said she has been conducting training sessions around the state at the request of the Louisiana Hospital Association on the "transition coach" model that eQHealth used in Baton Rouge.

"We know it works," Robinson said.

Robinson said the Lafayette, Hammond, Covington and Northshore areas were chosen for the expansion because of the concentration of Medicare patients age 65 and above, the number of hospital discharges among the population and readmissions, as well as interest in implementing the "health coach" system.

A different twist on the new federal grant initiative is that the CMS is challenging eQHealth to bring patients to the table with hospital officials to get the patient perspective on the hospital discharge system, Robinson said.

For more information about this program and additional funding available through the **Community-based Care Transitions Program** (Affordable Care Act - Section 3026 funding), please visit <http://louisianaqio.eqhs.org/caretransitions.htm> or email Donna Rodrigue at drodrigue@eqhs.org



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