Maryland Association for Healthcare Quality

January – February – March 2010, Issue 35

In This Issue

PRESIDENT'S MESSAGE

Dear MAHQ Members,

It is truly a privilege and an honor to serve as association President in 2010. I can't tell you how impressed I am with the members of the MAHQ Board! They are a dynamic group of healthcare professionals who are eager to help you develop your career path. I would like to thank all of the Board members who have completed their service this past year and I look forward to serving with our current and new Board members in 2010. I would like to personally thank Ms. Cheri Wilson, Past-President 2009, for helping to increase the MAHQ's visibility this year and for her mentorship. Thanks Cheri!

A new decade is here and the MAHQ Board is planning lots of activities to carry on its mission to advance the practice of quality improvement in healthcare across the continuum of care and support our members' professional development

On **March 19th** the MAHQ is co-sponsoring keynote address speaker Sue Sheridan with the Maryland Patient Safety Center at the annual Maryland Patient Safety Conference. Ms. Sheridan shares her family's experience with medical system failures and promotes the formation of partnerships between family members and the healthcare team. The conference is held each year at the Baltimore Convention Center and the fee this year is $30.00. Please stop by the MAHQ table to say hello if you are planning to attend. You can register for his event online at www.mhei.org and click on Programs.

On **April 30th and May 1st,** a few of our Board members will be attending the 2nd Annual NAHQ State Leaders Summit. Attendees will benefit from a program aimed at developing leadership skills and an opportunity to learn what other state leaders are doing to build their associations.

Wednesday **May 19th** is the **date to save** for the MAHQ Spring Educational Conference. The conference will be held from 1pm to 8pm at Anne Arundel Hospital Center's beautiful new Health Sciences Institute in Annapolis. The MAHQ Board members are busy planning topics and speakers for the event. Our goal is to help you grow as a healthcare professional so if you have a topic you would like to learn more about, please contact me or one of our Board members – we'd love to hear from you.

From **October 18th through the 21st**, the MAHQ will be a conference series partner with

DiversityRx at the 7th annual National Conference on Quality Health Care for Culturally Diverse Populations. The Conference will take place at the Renaissance Baltimore Harbor place this year providing another convenient venue for our MAHQ members to develop as quality healthcare professionals. Conference attendees will learn about the implications of healthcare reform on culturally diverse populations; how to implement new Joint Commission standards on culturally and linguistically appropriate services; and how to respond to health IT and demographic data collection recommendations from the Institute of Medicine and federal health agencies. Information about registration will be provided as the event draws closer.

Finally, in the fall of 2010, we will be offering our annual fall educational conference. Again, if there are topics you would like to learn about, we need to hear from you. Please consider attending a future Board meeting as we are open to your ideas and suggestions for educational offerings. The Board meetings are held on the 4th Thursday of each month from 6pm-8pm at Rams Head Tavern in Savage, Maryland.

Sincerely,

Robin Craycraft, RN, MSN, CPHQ

In the Spotlight

Our MAHQ President 2010

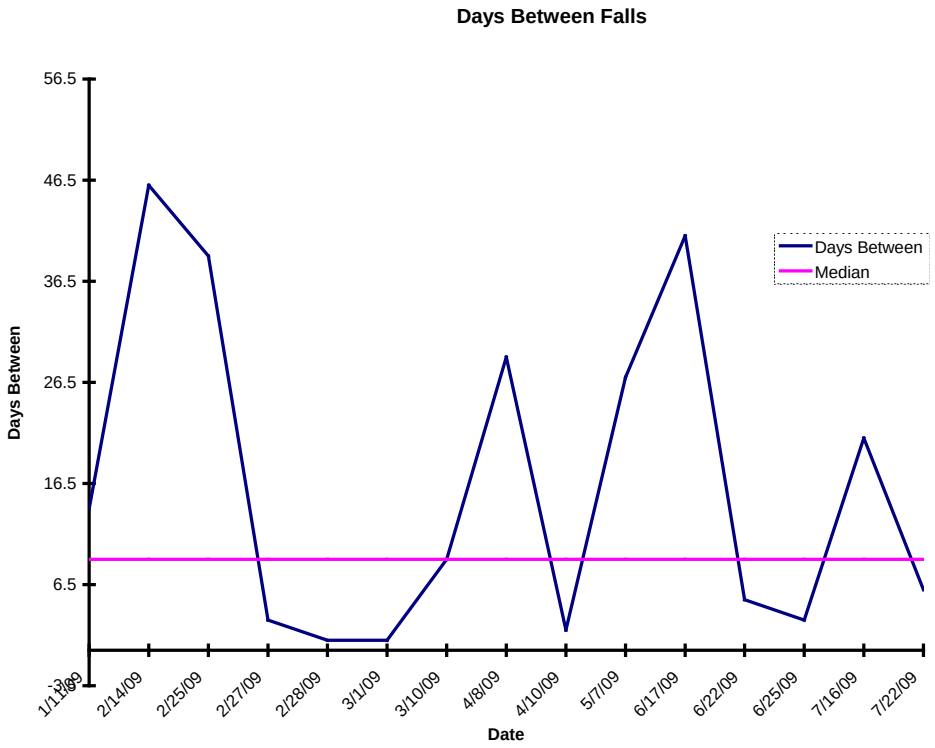
Ms. Craycraft is a Registered Nurse with a BSN from Towson University in 1985 and a Master in Nursing Leadership and Management from Walden University in 2008. She has served her entire nursing career at Good Samaritan Hospital in Baltimore and has held positions as a Rehabilitation Staff Nurse, Rehabilitation Care Coordinator, Rehabilitation Educator, Rehabilitation Quality and Accreditation Specialist, and Quality Review Coordinator for the hospital. Since 2005, Ms. Craycraft has been the Performance Improvement Manager at Good Samaritan Hospital. She earned her CPHQ in 2002 and has 15 years experience in healthcare quality. Ms. Craycraft joined the NAHQ in 2002 and the MAHQ in 2003. She served as an MAHQ Board Member at Large from 2006 through 2007 and President Elect in 2009.

Measuring Rare Events or Adverse Events

By Laura Schwartze, BSN, MS, CPHQ

Tracking rare events or adverse events happen so rarely that standard control charts are not effective. This is mainly because majority of the points may be “0”. A useful method for tracking these events is to calculate the days between each event. A point for each event is plotted on the run chart. ***Of course the goal of Rare Events tracking is to lengthen the time between these events.***

Example Run Chart



How to Construct a Run Chart

1. Construct a chart with the vertical line (or y axis) representing your variable and the horizontal line (or x axis) representing the time sequence.
2. Plot each data point in time sequence and draw a line connecting the points.
3. Find the Median of the data. To find the Median, rewrite the data points in value order and count off the data points to find the middle number. If you have an odd number of data points you will find a single number. However, if you have an even number of data points you will have two numbers in the middle. Simply add them together and find the average.

*To plot a "Days Between Run Chart", the y axis would be the number of days between each Fall and the x axis would be the date of each fall.

Identifying Process Change

- Visually an upward trend would indicate an improvement:
- 3 – 5 points above the median = possible improvement
- 5 -6 points above the median = probable improvement
- 8 or more points above the median = near certain improvement

Risk with Telephone Communication

How to Improve Patient Safety and Reduce Risk with Telephone Communication

Anne Huben-Kearney, RN, CPHQ, CPHRM Vice President, ProMutual Group

Submitted by MAHQ Past President Josephine Howard, RN, BSN, MS, CPHQ

Objectives of Ms. Huben-Kearney's presentation included:

1. Explain the importance of telephone communication in relationship to patient safety
2. Describe the value of a telephone triage system and use of telephone protocols.
3. Incorporate sample telephone documentation tools into practice
4. Discuss how to increase patient safety and reduce the potential of a medical malpractice claim related to the telephone.

Patient often rate communication as the most important measure of quality of care. Up to one fourth of medical care communication is done by phone. This includes prescription refills, appointment, relaying test results and information on diagnosis and treatment. Verbal communication involves 35% for facial expressions and 23% for body language. This means 58% of communication is lost on the phone.

Desired outcomes of telephone communication include

1. Safe patient care
2. Decreased liability due to patient mismanagement
3. Patient satisfaction
4. Staff satisfaction (and retention)
5. Efficient and cost effective care

There were 786 telephone related malpractice claims reported on 2007. The most frequent types of practices involved; internal medicine, obstetrics and pediatrics.
The most common allegation with medical malpractice cases involving telephone calls included; failed diagnosis, 68%, most common injury, death 44% and most common setting general medicine ambulatory practice.

The leading errors with telephone communication

1. Documentation (88%)
2. Faulty triage (84%)
3. Incomplete history taking (44%)
4. Multiple calls for same problems (44%)
5. Lack of policies and protocols for managing telephone calls (38%) - dropped messages and delayed response.
6. On-Call coverage issues 28 (%)

Ms. Huben-Kearney noted how telephone triage focuses on assessment, prioritization and referral to appropriate level of care. It is an interactive process and identifies the nature and urgency of client health care needs. Between 25% and 41% of medical malpractice claims originate in a doctor's office. With 70% of suits filed, there is a distinct problem with physician and patient relationship.

Biggest risk issues with telephone triage are underestimating; if patient is on the phone is it that serious, problem with "frequent flyers", uncooperative patients and knowledge deficit (staff and patient).

Recommendations include

1. Need to clearly define who gets what call when
2. Immediately put through to the physician/PA/APRN things such as chest pain, difficulty breathing

3. Return within a specific time frame regarding discussion regarding lab/diagnostic test results.
4. Calls to be handled by clerical staff regularly scheduled appointments.

The use of telephone triage form with telephone protocols is essential. Telephone protocols should include

1. Clinical rules for handling calls and giving advice
2. Guide the nurse in decision making
3. Provide structure yet be flexible
4. Never supersede nursing judgment
5. Standardize approach to problem.

Ms. Huben-Kearney stressed the importance of addressing factors that impair decision-making: this included being rushed, fatigued, hungry, work space constraints, and having to multitask (not is the dedicated triage nurse).

Appropriate training is vital and should include

1. Listening techniques
    a. Clarify info
    b. Remain neutral
    c. Summarize
2. Identification of ***Red*** flags
    a. Co-morbidities
    b. Debilitated or challenged patients
    c. Frequent flyers
    d. Repeat callers
    e. Poor historians
    f. Concerned family
    g. Extremes of age
    h. Gut instincts (yours or theirs)
    i. Language barriers
    j. Symptoms inconsistent with diagnosis
3. Documentation
    a. Document while taking the call.
    b. Document all calls
    c. Document that would “paint a picture” regarding what was aid and plan for follow-up.
    d. Be specific and objective.
    e. Use of a telephone call template to be sure all required info is collected.
    f. Advice given and/or alternate solution.
    g. Note disposition – referral to ED, appointment made etc.
    h. Always remind patient and document for patient to call back if symptoms worsen or do not resolve.
    i. File/save promptly (permanent part of the medical record).
4. Patient Satisfaction
    a. Includes the amount of time patients are on hold or busy signal.
    b. Inform patients of time frame to expect call back.
    c. Remember to end all calls by encouraging patients to call back is condition changes or if they do not receive a response within predetermined time frame.

Most importantly it is better to err on the side of having the patient visit the office for treatment. Even a policy for an office visit if two calls from the same patient occur within 24 hours is beneficial. Try to avoid antibiotic treatment over the phone.

In summary, Ms Huben-Kearney relayed how essential telephone communication is to health care and is used as a measure of quality of care. Adequate telephone triage and training in the proper use of protocols can help improve patient safety, increase patient satisfaction and reduce potential telephone related medical malpractice claims.

From NAHQ e-news

Joint Commission Q&A

Question: The Centers for Medicare & Medicaid Services (CMS) recently approved the continuation of deeming authority for The Joint Commission's hospital accreditation program through July 15, 2014. What does this mean for my hospital?

Joint Commission: The CMS designation means that hospitals accredited by the Joint Commission may choose to be deemed as meeting the Medicare conditions of participation. CMS found that the Joint Commission's standards for hospitals meet or exceed those established for the Medicare and Medicaid programs. Since the enactment of the Social Security Amendments of 1965, the Joint Commission's hospital accreditation program has had a unique statutory deeming authority. A change in the Medicare law in 2008 required that the Joint Commission apply to CMS to continue its hospital-deeming authority. CMS's notice of the 4-year continuation of the Joint Commission's deeming authority, through July 15, 2014, was announced on November 27.

Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement. Hospitals seeking Medicare approval may choose to be surveyed either by an accrediting body, such as the Joint Commission, or by state surveyors on behalf of CMS.

If you are an accredited hospital choosing to be deemed, your organization may be subject to a random validation survey or a complaint investigation conducted by CMS. In addition, the Joint Commission and other accrediting bodies with hospital-deeming authority are obligated to provide CMS with a listing of, and related documentation for, organizations receiving an adverse accreditation decision. Accrediting bodies must also provide CMS with accreditation decision reports for hospitals involved in CMS validation surveys and any other survey report requested by CMS.

In addition to hospitals, the Joint Commission has federal deeming authority for ambulatory surgery centers, critical access hospitals, durable medical equipment suppliers, home health, hospice, and laboratories.

For information about deemed status, call the Joint Commission's Washington, DC, office at 202/783-6655. For information on state initiatives, call the Joint Commission's Division of Business Development, Government, and External Relations at 630/792-5269.

NQF
NATIONAL QUALITY FORUM

NQF Endorses Updated Safe Practices Using the Latest Evidence

To guide healthcare systems in providing safe care, the National Quality Forum (NQF) has endorsed an updated list of Safe Practices for Better Healthcare. The 34 practices address issues like healthcare associated infections, pediatric imaging, and workforce development, and have been updated with the latest evidence.

Preventable errors cost the United States an estimated 98,000 lives annually and $17–$29 billion per year in healthcare expenses, disability, and lost worker productivity and income. These practices are a guide to healthcare systems in providing care that is free from error and harm.

Throughout the updated practices, language was added to emphasize the importance of involving patients and their families in making care safer. This update aligns with the National Priorities Partnership (NPP) priorities to increase patient and family engagement in healthcare and to improve the safety and reliability of the healthcare system.

Safe practices are part of NQF's safety portfolio which includes safety measures, educational Webinars on implementing safe practices, and Serious Reportable Events—a list of 28 serious medical errors that should never happen. NQF is also in the process of endorsing additional patient safety measures and a framework for reporting safety events.

2009 Conference Symposia Download Available

Download a free copy of the conference symposia presentation "Multidrug-Resistant Hospital-Acquired Infections: Reducing Risk Through Quality Improvement," from the 2009 NAHQ Educational Conference. Earn 1 CE credit when you complete the short quiz after viewing the file.

Second Annual State Leaders Summit Announced

NAHQ will once again invite state leaders from NAHQ-affiliated states for 2 days of training and networking at the State Leaders Summit. Hosted April 30– May 1, in Rosemont, IL, the program aims to develop effective leadership skills and address challenges state associations face today. 2009 attendees addressed strategic planning, membership building, financial management, and more. State leaders are encouraged to attend. Watch for registration information and make plans to join us. Questions? Contact Lori Barker, NAHQ staff, at lbarker@nahq.org or 847/375-6305.

Are you Social Networking?

Sherry Mazer, FACHE CPHQ, NAHQ's Special Interest Group Team Leader

Social networking is a term few of us used up until recently. Today, Facebook, LinkedIn, Twitter, and other social networking Web sites are household words. I even saw the job title "Director of Social Networking," which, let's admit it, sounds a lot more fun than "Director of Quality." Many organizations, including NAHQ, host groups on these sites. Anyone can join, both members and nonmembers, to take full advantage of the postings.

Social networking sites enable you to develop your own network of friends and colleagues and to read and comment on their postings. Posted pictures can help you keep in touch with friends and family easily. It allows you share updates on vacations, birthdays, and holidays all at once. It also lets professional societies like NAHQ discuss important topics such as healthcare reform and provide job postings to a wider audience at no cost. Consider these statistics:

- More than 150 million people around the world, even Antarctica, are now actively using Facebook and almost half of them are using Facebook every day.
- If Facebook was a country, it would be the eighth most populated in the world, just ahead of Japan, Russia, and Nigeria.
- Facebook is used in more than 35 different languages and 170 countries and territories.

Some words of advice: Your picture, biographical information, and postings are open to the public. You need to remember the adage, if you can't do, say, or show it in front of Mom, don't post it online. Also, many companies don't allow you to access them from home.

For many, however, the positives outweigh the negatives. If you haven't signed up yet, go to www.LinkedIn.com or www.Facebook.com to create an account. With an active account, sign up to be part of the NAHQ group on LinkedIn or a fan of NAHQ on Facebook. From there, your friends at NAHQ and others will invite you to be part of their networks. Log on to cyberspace and check out your old and new friends. I have a feeling that this social networking is going to catch on!

Sherry Mazer is regulatory officer, Temple University Health System in Philadelphia, PA. You can contact Sherry at 215/707-6763 or sherry.mazer@tuhs.temple.edu.

The following news article was submitted by Constance Yancy, facilitator of the managed care SIG.

IOM Releases Report on Increasing Value of Health Care

The Institute of Medicine's Roundtable on Evidence-Based Medicine, representing multiple stakeholders in the healthcare sector, has devoted substantial attention over the past year to exploring the issue of value in healthcare. Over the past couple years, a series of meetings was convened to consider the challenges and opportunities related to increasing the value returned from healthcare delivered by both improving outcomes and lowering costs.

The Healthcare Imperative: Lowering Costs and Improving Outcomes consisted of a

three-part workshop series exploring the drivers of spending, promising methods of cost control, and opportunities for and barriers to implementing policies. The goal of the workshop series has been to identify ways to reduce healthcare spending within the next decade without compromising health status, quality of care, or valued innovation. The meeting objectives included characterizing and discussing the major causes of excess healthcare spending, waste, and efficiency in the United States while improving health outcomes and exploring policy options relevant to those strategies.

Three workshops were organized. The first workshop, *Understanding the Targets*, focused on identifying the major drivers in the growth of healthcare spending. Five major driver categories were identified: unnecessary services, inefficiently delivered services, excess administrative costs, excessive pricing, and missed prevention opportunities.

The second workshop, *Strategies that Work*, focused on identifying various strategies and their potential to lower healthcare spending in addition to improving outcomes, including knowledge enhancement-based strategies, care culture and system redesign-based strategies, transparency of cost and performance, payment and payer-based strategies, community-based and transitional care strategies, and entrepreneurial strategies and potential changes in the state of play.

The third workshop, *The Policy*, focused on exploring policy options to speed the adoption of previously discussed strategies to control the drivers of healthcare spending.

Prepublication copies of the report The Healthcare Imperative: Lowering Costs and Improving Outcomes Workshop Summary are currently available online. The full report will be published in 2010.

DID YOU KNOW……

……We encourage you to submit an article, which may be about an interesting session or seminar that you have attended, your recent experience with JCAHO, project results, study or research results, or anything that would be of interest to quality professionals. If you submit an article that is published in the newsletter, you will receive a complimentary conference registration to be used during the upcoming year (excluding the CPHQ review course). Please email you submission to the Newsletter Committee Chair Laura Schwartze at laura.schwartze@hughes.net

BOARD MEETINGS OPEN TO MEMBERS

Board of Director's meetings is held monthly, ten months of the year. Meetings are usually held on the fourth Thursday evening of the month in rotating locations, for the convenience of the Board members. Some meetings are now conducted via teleconference. We welcome the attendance and input of the general membership, at all meetings. Contact any Board Member by email for information and directions. Verify the location and time on the morning of the meeting.

MARYLAND ASSOCIATION FOR HEALTHCARE QUALITY BOARD OF DIRECTORS 2010

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