Improve patient satisfaction scores to get the most out of your CMS reimbursement

Every healthcare provider will tell you that patients are customers, and customers can take their business elsewhere if they are unhappy about any aspect of their experience. To keep patients, and thus reimbursement, coming in the door, hospitals must focus on achieving strong patient satisfaction scores. Moreover, the Centers for Medicare & Medicaid Services’ (CMS) value-based purchasing program will incorporate Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) scores into its inpatient prospective payment system starting in 2013, so there is no better time to hop on the patient satisfaction wagon.

According to Peter Short, MD, senior vice president of medical affairs at Beverly (MA) Hospital, most patient satisfaction survey tools, including HCAHPS, are multidimensional. Thus, the medical staff, nurses, other care providers, food service, and housekeeping must tackle patient satisfaction scores from multiple angles.

According to www.hcahpsonline.org, the HCAHPS survey contains 18 patient perspectives on care that encompass eight key topics:

➤ Communication with doctors
➤ Communication with nurses
➤ Responsiveness of hospital staff
➤ Pain management
➤ Communication about medicines
➤ Discharge information
➤ Cleanliness of the hospital environment
➤ Quietness of the hospital environment

“When you talk about HCAHPS, you are talking about the whole patient experience. To demonstrate to patients that we have their best interests at heart, we have to be a team. It takes a team approach to improve HCAHPS,” says Short. Medical staff leaders can help heighten the team spirit by creating a patient-centered medical staff culture using the following hospitalwide tips.

“As physicians, we were in a little bit of denial, which is classic for physicians. We assumed the scores were wrong.”

—Gerda Maissel, MD

Implement multidisciplinary rounds

Jonathan Lovins, MD, SFHM, assistant clinical professor of medicine at Duke University Health System and hospitalist at Durham Regional Hospital (DRH) in Durham, NC, says that multidisciplinary rounds have helped improve the organization’s HCAHPS scores by 5% during the past three years because patients perceive a more coordinated approach to their care. “I think one of the things that disheartens patients the most is when they hear different stories from different providers,” says Lovins.
Every morning, nurse managers, case managers, nurses, physicians, and pharmacists meet for 10–20 minutes to discuss each patient. “As a hospitalist, I don’t feel like it saves me time, but at the very least, it seems to make patients more comfortable,” says Lovins.

Not only do multidisciplinary rounds help get all care providers on the same page, but they also help reduce mistakes that result from miscommunication (or noncommunication). In addition, they help all members of the healthcare team feel included in care decisions.

To implement multidisciplinary rounds, the medical staff appointed a physician to serve as the medical director for each of DRH’s two floors. Patients were then distributed geographically, meaning Dr. Jones’ patients are clustered on the first floor, while Dr. Smith’s patients are clustered on the second floor. “That was the hardest part. When we distribute the patients in the morning, we try to make sure that each physician gets patients only on that floor, which was hard because we have to sacrifice things like continuity of care to a degree,” explains Lovins.

For example, although hospitalists, who generally work seven days on and seven days off, were previously not assigned new patients on their last day of work, they sometimes now receive new patients so that patients are located on the correct floor for the hospitalist who starts work the next day.

According to Short, Beverly Hospital also performs multidisciplinary rounds. One of the major benefits, he explains, is that the same group of nurses works with the same handful of physicians, creating a team environment.

“We go in the patient’s room to see the patient. That way, if anyone has a question, they can get the same answer from the nurse or the doctor, and the patients know it is a team approach. Patient satisfaction is about communication to their family and the rest of the caregiver team,” says Short.

Use electronic discharge instructions and medication reconciliation

DRH recently switched to electronic discharge instructions and medication reconciliation, and it saw an increase in patient satisfaction. “We know patients are more satisfied with an electronic discharge document and electronic medication reconciliation because it is legible and clear,” says Lovins.

Rather than a physician writing out discharge instructions and a list of medications by hand and risking the patient or the pharmacist misunderstanding or misreading instructions, physicians now fill out an electronic form and print it for the patient.

The electronic discharge instructions and medication reconciliation documents also work to reduce errors by helping physicians make decisions. For example, if a physician selects an antacid drug, the computer program
Get an outside opinion

An outside opinion may be just what physicians need to improve their communication scores on the HCAHPS survey, says Gerda Maissel, MD, chief medical officer at Baystate Franklin Medical Center, a 90-bed community hospital in Greenfield, MA.

Physicians at Baystate Franklin consistently scored low on the HCAHPS survey. “As physicians, we were in a little bit of denial, which is classic for physicians. We assumed the scores were wrong,” says Maissel. But after tracking the scores over a period of months, it became clear that the problem didn’t rest with the data.

“We researched the literature and implemented best practices, and we saw a little bit of an improvement, but we were still baffled. We started color coding the data, and if you were below the line, you were red. We wanted to be green,” Maissel explains.

To address the problem, the medical staff brought in an individual with marketing experience and a kind, calming demeanor. She watched physicians interact with patients and gave them concrete, useful tips on how they could improve. Her demeanor was instrumental in relaying information to the physicians without sounding harsh or critical.

Although an evaluator does not need a background in marketing, Maissel notes that this evaluator’s experience helped her articulate to physicians what patients (i.e., consumers) want. It is important for the evaluator to be a nonphysician who can see the patient-physician interaction from the patient’s point of view. “I tried to evaluate physicians when I was in a different role, and I didn’t come close to what [our evaluator] came up with,” says Maissel.

As it turned out, the little things were what made all the difference. One physician wasn’t listening to patients long enough, and the evaluator suggested that the physician wait three to five seconds before responding to the patient to make sure the patient was done speaking. Another physician was overloading patients with information, making them feel overwhelmed. A third physician rushed when she explained things.

“It is not that anyone was being rude to patients or behaving outrageously where we had to discipline them, but there were subtleties that, when addressed, helped us cross the line from red to green,” explains Maissel.

Institute hourly nursing rounds

Medical staff leaders can encourage their respective nursing departments to institute hourly rounds. At DRH, hourly nursing rounds have improved patient satisfaction scores because they ensure patients don’t feel forgotten. DRH nurses check each patient for the four P’s:

➤ Pain
➤ Position
➤ Potty
➤ Partner (nurses work with nursing assistants)

“Potty is really important. By far the most common cause of falls is patients getting up to go to the bathroom. It has been shown many places that if you ask patients every hour if they need to potty, you can get your fall rate down to almost zero,” says Lovins.

Beverly Hospital’s nurses also round hourly. In addition, the hospital has a rule that a nurse should never ignore a call bell; even if the patient is not assigned to the nurse who notices the call bell, that nurse should still respond. The initiative forces nurses to think outside of their own workloads and focus on the needs of all patients on the unit.

Make each patient feel like the only patient

Physicians can have a profound effect on the patient experience by simply focusing on the patient in front of them and not succumbing to the buzz of distractions. When Short, a pediatrician, enters a patient’s room, the first thing he does is introduce himself. The second thing he does is say, “Let me wash my hands before I examine your child.” He then washes his hands in front of the parents. After examining the patient, he washes his hands...
again and makes a point of sitting down with the parents to talk. “Sitting down sends the message that you are not rushed, even if you are,” says Short.

“All of us need to understand that we are not just taking care of the medical problems of the person who is admitted; we are taking care of the person and the family. As long as you keep that in mind, you are going to have great patient satisfaction scores,” he says.

**Take time to talk to nurses**

When dealing with sicker patients, physicians should take the time to explain their thought processes to nurses. “I explain what I am doing and ask the nurse if he or she is comfortable with that. In the end, they are in the front lines. The benefit [physicians] get on the other end is if you communicate up front, you don’t get all these calls on the back end,” Short explains.

**Be a team player**

Caregivers often operate with blinders on. Nurses focus on their nursing responsibilities, and physicians focus on medical decision-making. In the process, they may both overlook the dirty towel on the floor or the empty juice cup on the bedside table.

“Patient satisfaction is everyone’s job in every area, which means if there is stuff on the floor, you don’t call housekeeping—you pick it up. If there is a spill on the floor, I clean it up because if I don’t, someone is going to slip,” says Short.

**Remind caregivers of their commitment**

At Beverly Hospital, each floor receives its own patient satisfaction scores. “Sometimes, just knowing your scores and having a little competition is healthy,” says Short. The hospital also reviews Press Ganey and HCAHPS scores weekly. If a physician, nurse, or other caregiver receives a compliment from a patient, the hospital recognizes that individual. If a physician goes the extra mile, Short writes him or her a personal thank-you note.

At DRH, physicians see a group patient satisfaction score, but they don’t see their colleagues’ individual scores. “We don’t compare with other departments, but the interesting thing is that our incentive is based on the hospital’s score and our individual scores, not the hospitalist group’s score,” explains Lovins.

**Consider giving patients health-related gifts at discharge**

Giving patients a gift at discharge, such as a pedometer, calorie counter, or pillbox, has two benefits: Patients may perceive their experience more positively, and the gift may help motivate them to follow their discharge plan, says Bradley Flansbaum, MD, a hospitalist engaged in a patient satisfaction improvement experiment at Lenox Hill Hospital in New York City.

Flansbaum notes that hospitals are constantly trying to improve the patient experience by offering Wi-Fi or installing bigger television sets. “If you are giving patients something that is useful for health, I would argue that you are doing more for the patient experience than putting a fountain in the lobby,” he says.

Patients should be given gifts that will help them stick with their discharge plans. For example, if a physician talks to a patient about cutting out soda to reduce insulin spikes, a calorie counter would help the patient keep track of his or her intake. If a physician prescribes more exercise, a pedometer will help the patient reach that goal. “As long as the item itself has a health-related meaning, I think it is legitimate,” says Flansbaum.

Hospitals may question whether the return in healthy habits is worth the investment in purchasing the gifts. “If one person changed their lifestyle for every 50 or 100 pedometers you give out, it may be worth it,” Flansbaum says.

With CMS incorporating HCAHPS and other patient satisfaction measures into the inpatient prospective payment system in the near future, hospitals must begin thinking creatively about ways to improve patient satisfaction. These tips can get you started without much monetary investment and serve as a jumping-off point for bigger initiatives.
Is money the primary force driving physicians into medical staff leadership positions?

Whenever medical staff leaders discuss medical staff engagement and alignment, talk of money isn’t far behind. Whereas 30 years ago, serving in a medical staff leadership role was par for the course, today physicians consider it going above and beyond the call of duty. Many hospitals offer medical staff members a stipend to entice them into leadership positions, but is money really the driving force?

According to Stephanie Russell, CPMSM, CPCS, an MSP at Swedish American Health System in Rockford, IL, and Ray Rabideau, MD, chief medical officer at Memorial Hospital in North Conway, NH, the answer is no.

For physicians at Swedish American, medical staff leaders are driven by the educational opportunities the organization provides, even though they were recently awarded an increase in pay. At Memorial, medical staff leaders are bound by their commitment to the small community hospital despite that they no longer receive compensation. Neither organization has experienced a decrease in medical staff leaders’ productivity or enthusiasm.

Memorial Hospital: Nixing the stipends

During the past several months, Memorial Hospital has eliminated stipends for medical staff members who participate in the medical executive committee (MEC) and the medical quality review committee. Currently, the medical staff president and the chief medical officer are the only leaders who receive a stipend, and the stipend is comparable to what leaders at other institutions within the state receive.

“We are in the process of reversing what we used to do in terms of remuneration. It has been difficult, but the participation process is something that hospitals need to find ways to continue to do with less financial investment,” says Rabideau.

At the same time that the medical staff is cutting leadership pay, the hospital is freezing merit increases for employees. According to Rabideau, the hospital is transparent regarding its financial performance, so the medical staff leaders who once got paid for their work understand the financial challenges ahead and took the news of their pay cut in stride.

Rabideau first announced the impending cuts over a year ago to give leaders time to prepare for the change. “I met with them one-on-one and I got their feedback. Every one of them was receptive to giving up their stipends and continuing to participate,” he says.

The organization is currently moving toward performance-based contracting. “Instead of being paid based on volume and productivity, we will be building measures of patient satisfaction, quality markers, core measures, and citizenship. The citizenship component will include participation in medical staff leadership, night call, and the hospitalist program,” Rabideau explains. Therefore, physicians will be paid a base salary, and those who score highly in the citizenship category by taking on a medical staff leadership role will earn more.

The organization has also created a committee comprising physicians, administration, and board of trustees members with the goal of finding better ways to align. “The first several meetings were about how we engage with each other and how to clean up history from past administrative issues,” Rabideau says.

Although medical staff leaders at Memorial Hospital are in a bit of a transition, having just lost their stipends and anticipating a new overall compensation structure, they have remained engaged.

“We have seen no increase in absenteeism and no decrease in interest. Now that [physicians] are becoming part of the hospital’s future, the ambition seems to be higher,” says Rabideau. “We need to recognize that we have to have more ownership, and that ownership can’t be something that is demanded of us. It is something we have to be invested in from the onset, and be agreeable to be responsible for the future.”
Swedish American: Giving leaders a raise

Swedish American pays its nine department chairs and officers—which includes the medical staff president, first and second vice presidents, and secretary/treasurer—an annual stipend. Fifty percent of pay for officers (except the secretary/treasurer) is from hospital funds, while the other 50% is from medical staff funds.

“We recently increased what we pay them because of the time that they spend doing medical staff work,” says Russell. “We felt that the more regulations that get put on the credentialing and medical staff processes, the more gets put on the chairs, so we felt like it was time to pay them more.”

Department chairs are paid on a sliding scale based on the number of department members. “We created a sliding scale because we felt that it was unfair for a department chair with 10 members to receive the same compensation as a department chair with 300 members,” Russell explains.

But leaders aren’t simply handed a check at the end of the year. Department chairs must attend 10 of the 12 MEC meetings held each year; if they don’t show up, they don’t receive their stipend. Instead, they receive $150 for each meeting they did attend (up from $100 per meeting last year).

According to Russell, although the stipend for medical staff leaders has increased, it still isn’t as attractive as the $10,000 dedicated to medical staff leadership education and training annually. When leaders attend an educational event, the organization provides them with $100 per day for taking time out of their practices. The annual $10,000 comes from medical staff dues, and physicians don’t making the annual contribution to support another physician in a leadership position. “When they are educated about how important their jobs are, we see a change in their behavior,” notes Russell.

The outcome

Memorial Hospital and Swedish American Health System couldn’t have taken more different approaches to medical staff leadership compensation. Yet both organizations experienced the same outcome: engaged leaders who have a vested interest in the organization.

Therefore, perhaps medical staffs need to think more creatively about ways to recognize and compensate physician leaders without putting so much emphasis on money. Granted, de-emphasizing dollars may be more challenging in some organizations than in others—some medical staff cultures demand that leaders be paid. Even so, consider alternatives to monetary compensation, such as hanging photographs of medical staff leaders in the hospital’s foyer, noting leaders’ achievements in the medical staff newsletter, or hosting an annual outing or event exclusively for medical staff leaders. The possibilities are endless.
Better Times Hospital is in crisis. The medical staff is deeply rooted in a departmental structure that relies heavily on committees, and few physicians want to serve on them. Joe, the medical staff president, has just finished reading *Leading Change* by John Kotter and has decided to follow the book’s suggestion of assembling a guiding coalition. The coalition must be able to create an environment in which it is safe to talk about several controversial issues, including whether the current medical staff structure is sustainable moving forward. The guiding coalition also needs to be large enough to include a variety of viewpoints, yet small enough to implement ideas efficiently.

Ideally, the members of the coalition will have influence over other medical staff members even if they do not currently occupy a formal position. As such, some of Joe’s choices for membership are obvious. Bill, a former medical staff president, is a true senior statesman and universally respected by just about everyone. Sally, a younger physician, is a champion of change. Charlie, a potential rising star, is the medical director of the hospitalist program and has advocated for a simplified medical staff structure since attending a seminar on the subject a couple of years ago. Joe also includes a board member with an extensive background in organizational dynamics and a hospital executive with experience in strategic planning.

Less clear is whether Joe should include Earl, who has served as the loyal opposition for all the years that he has chaired the medical staff bylaws committee. Changes from The Joint Commission, the state, and the Centers for Medicare & Medicaid Services have all been met with loud tirades. In the end, Joe chooses to include Earl because, despite his vocal outbursts, at heart he really does care.

Joe also questions whether to include Ellen, who joined the medical staff three years ago. She has not been consistently involved, but when she is, she offers great insights and positive contributions. Joe decides to engage her because she represents a generation that has to live with a potential new medical staff model for many more years.

The group has an organizational meeting, and Joe explains the ground rules, the most important of which is that dialogue must occur freely and without judgment or repercussions to create the trust necessary to work as a team.

Joe then tasks the group with holding an off-site retreat with guest speakers with expertise in medical staff models. The morning session will be open to medical staff leadership, hospital management, and the board so that everyone hears the same information about trends and successful models at other organizations. The afternoon session will be limited to the guiding coalition and will consist of a facilitated exercise to generate a vision and action plan for the hospital.

Joe exhorts the guiding coalition to set aside preconceived notions, to imagine a desired future state, and to begin with the end in mind. Part of the Better Times culture involves getting mired in hopeless details too early, which hinders forward movement. Joe tells everyone that if this endeavor is to be successful, leaders must change the medical staff culture.

With that firm foundation, the planning retreat is scheduled. Next month we go off-site with the coalition members. Until then, be the best that you can be.
Create expectations for medical staff members that go beyond conditions of appointment

If you took on a new job, you’d expect your employer to tell you what your duties entailed, what time to show up, and how “good performance” is defined within your role. For physicians, that doesn’t always happen. They often arrive on their first day at a hospital with no rules or expectations to guide them.

St. Mary’s Hospital in Richmond, VA, part of the Bon Secours Richmond Health System, created a list of physician expectations with the help of The Greeley Company, a division of HCPro, Inc., in Danvers, MA.

These expectations go beyond simple conditions of appointment. According to Jean Kearns, director of the medical staff services department at St. Mary’s, the list of medical staff expectations serves several purposes. First, it weeds out physician applicants who would not fit into the organization’s culture. “If you are not able to meet these expectations, maybe this is not where you want to be,” says Kearns.

Second, Kearns uses the document at reappointment to remind physicians of the behaviors expected of them.

Third, the document can be used as a behavior modification tool. “If someone doesn’t want to use [electronic medical records] or there are behavior issues, we can point to this document,” says Kearns.

See the list of medical staff expectations below to get your medical staff started on the road to exemplary compliance.

St. Mary’s Hospital expectations of physicians

This document describes the expectations that physicians have of each other as members of our medical staff based on the Accreditation Council for Graduate Medical Education/Joint Commission physician general competencies framework. The expectations described below reflect current medical staff bylaws, policies and procedures, and organizational policies.

**Patient care**: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff and/or national standards of care as defined by comparative outcome data, medical literature, and results of peer review activities
2. Plan and provide appropriate patient management based on patient information, patient preferences, current indications, available scientific evidence, and sound clinical judgment
3. Ensure that each patient is evaluated by a physician as defined in the bylaws, rules, and regulations, and document findings in the medical record at that time
4. Demonstrate caring and respectful behaviors when interacting with staff, patients, and their families
5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards
6. Counsel and educate patients and their families
7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention
8. If applicable, supervise residents, students, and allied health professionals to ensure patients receive the highest quality of care

**Medical knowledge**: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment
2. Maintain ongoing medical education and board certification as appropriate for each specialty
3. Demonstrate appropriate technical skills and medical knowledge using medical simulation technology where appropriate

**Practice-based learning and improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self-improvement of patient care
2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care
3. Use hospital information technology to manage information and access online medical information
4. Facilitate the learning of students, trainees, and other healthcare professionals

**Interpersonal and communication skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams as evidenced by the following:

1. Communicate effectively with physicians, other caregivers, patients, and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies
2. Request inpatient consultations by providing adequate communication with the consultant, including a clear reason for consultation and direct physician-to-physician contact for urgent or emergent requests
3. Maintain medical records consistent with the medical staff bylaws, rules, regulations, and policies
4. Work effectively with others as a member or leader of a healthcare team or other professional group
5. Maintain high patient satisfaction with physician care

**Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

1. Act in a professional, respectful manner at all times and adhere to the medical staff code of conduct
2. Respond promptly to requests for patient care needs
3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers
4. Participate in emergency call as defined in the bylaws, rules, and regulations
5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes
6. Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff
7. Make positive contributions to the medical staff by participating actively in medical staff functions, serving when requested, and by responding in a timely manner when input is requested

**Systems-based practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals, and improve quality
2. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care
3. Ensure timely and continuous care of patients by clear identification of covering physicians and by availability through appropriate and timely electronic communication systems
4. Provide quality patient care that is cost-effective by cooperating with efforts to appropriately manage the use of valuable patient care resources
5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate
6. Advocate for quality patient care and assist patients in dealing with system complexities

Applicant’s signature  Date

_________________  ___________________
Hospital incident reporting systems not up to snuff; events fall through the cracks

According to a recent Office of Inspector General (OIG) report, Hospital Incident Reporting Systems Do Not Capture Most Patient Harm (http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf), hospital reporting systems aren’t doing their job. The OIG surveyed 189 hospitals regarding their use of incident reporting systems and learned that hospital staff did not report 86% of events, partly because staff often misinterpret what constitutes patient harm.

Mary J. Voutt-Goos, RN, MSN, CCRN, director of patient safety initiatives at Henry Ford Health System in Detroit, and Ken Rohde, senior consultant at The Greeley Company, a division of HCPro, Inc., in Danvers, MA, agree that this news isn’t surprising in the least. Reporting has become complicated and burdensome, and several roadblocks prevent frontline caregivers from reporting often and accurately.

Although the OIG report isn’t earth-shattering, it serves as a sober reminder that there is no such thing as a day off when it comes to patient safety.

Why incident reporting systems fail

The first step to improving incident reporting systems is understanding why they don’t work as well as they should. Voutt-Goos says that several challenges get in the way of accurate reporting:

➢ Most reporting systems are complex and time-consuming, and clinicians don’t feel they have the time to use them.

➢ Often, when an individual completes an incident report, he or she does not receive feedback regarding what action the hospital took as a result of the report.

➢ Healthcare institutions often have long histories of punitive cultures. “Although most organizations are moving toward a just culture, it is going to take a long time for staff to feel safe,” says Voutt-Goos.

➢ Frontline caregivers don’t recognize many safety hazards because they are so used to working in systems where work-arounds are normal.

➢ Human factors, such as fatigue, are often absent from the analysis of an incident report. “Nurses working more than 12.5 hours straight have a higher risk for making mistakes. But those hazards aren’t recognized,” Voutt-Goos says.

➢ Leaders often have more positive perceptions of safety climate than frontline staff. “Leaders who have a less positive view of their safety culture tend to be from more highly engaged organizations and have a better chance of improving safety culture because they are aware of the barriers and recognize how hard it is,” says Voutt-Goos.

Medical staffs can make a difference

We have the evidence that incident reporting systems aren’t working as well as they should, but what can medical staffs do about it? Instead of waiting around for incident reporting technology to improve, Rohde and Voutt-Goos suggest the following:

➢ Lower the reporting threshold. Hospitals can encourage reporting by lowering the threshold of what gets reported. Regulators demand that organizations report never events and near misses, but smaller events should be reported as well to give the hospital a full picture of the types of events that occur. “Don’t let frontline staff worry if it is harm or not—just tell us. We will figure out if there was harm later on,” says Rohde.

➢ Encourage a just culture. “We are not going to get anywhere if staff thinks that they will be fired or blamed for reporting an event,” says Voutt-Goos. “When I talk to residents, fear of being wrong is the No. 1 reason they don’t speak up and share information.” Medical staff leaders and members should model behavior for residents by making it safe to speak up and report all incidents,
regardless of their severity. “If a staff physician or leader is not doing the behaviors, people down the chain aren’t going to do them either,” said Voutt-Goos Leaders should also avoid blaming specific individuals when something happens and instead ask, “How did the system fail?”

➤ **Lessen the burden of reporting.** A clinician should not have to click through 10 screens to file an incident report. “We often ask for too much information about the event. If we look at the Common Formats, the AHRQ data framework for categorizing events, it is huge, and the burden is tremendous,” says Rohde. Instead, hospitals can ask for less information up front and follow up with the individual who reported the event later.

➤ **Focus on the system, not just the process.** Voutt-Goos says one of the major roadblocks to making the best use of incident reporting data is that organizations turn immediately to the process in which the incident occurred but fail to fix the underlying system. For example, if a nurse gives a patient the wrong dose of medication, the hospital might focus on the process of dispensing medication but not consider that the nurse might have been overworked (meaning staffing and scheduling issues need to be addressed) or that the nurse may have experienced interruptions during the medication process (meaning the environment should be the focus of attention).

➤ **Change how the organization thinks about reporting.** According to Rohde, many organizations consider the number of incident reports an indicator of quality, but that isn’t necessarily the case. “If we had 14 falls, and the next month we have 17 falls, we jump to the conclusion that we are doing worse, and that is in direct conflict with us trying to encourage reporting,” says Rohde.

For the staff to not associate the number of incidents reported with the hospital’s quality, the reporting system needs to take the severity of events into consideration as well as the raw number of incidents. Perhaps this month, seven of the 17 falls resulted in injury, whereas in the month before, 12 of the 14 falls did. Therefore, the fact that three more falls were reported this month compared to last month is actually an improvement.

“We want an increase in the volume of reports, but we want the severity to go down,” says Rohde. “We hear about more falls, but they are more assists to the floor rather than broken hips.”

➤ **Triage incidents.** Not every incident deserves the same amount of attention. Rohde suggests a three-tiered approach to incident triage:

- Root cause analysis: This type of analysis is done infrequently, only when an incident causes significant harm and helps organizations understand why an incident happened.
- Apparent cause analysis: This type of analysis is done more frequently and is used for incidents that result in less harm.
- Common cause analysis: This type of analysis incorporates root cause and apparent cause data to find common threads that may be contributing to incidents.

➤ **Get the medical staff involved.** “Medical staff members must be active reporters and willing to point out breakdowns in the process in a way that is productive and nonpunitive,” says Rohde. The medical staff is an active participant in root cause and apparent cause analysis and is key to implementing changes that stem from incident reporting. Physicians are key players in the hospital culture, so they must help establish a nonpunitive, open reporting environment.

➤ **Communicate results.** Henry Ford conducted multidisciplinary focus groups, and the staff agreed that incident reporting systems felt like black holes—caregivers would report incidents but never hear another word about them, says Voutt-Goos. Often, leaders are aware of performance improvement initiatives associated with incidents but fail to communicate them to staff.

Although better incident reporting technology would increase accuracy, the frontline caregivers hold the responsibility of reporting incidents. The above cultural changes will not only help physicians and nurses feel more comfortable reporting, but they will also help hospitals improve their performance and create a safer environment for patients.
The quest for value in healthcare

by Buster Mobley, MD, executive vice president of medical affairs at St. Dominic Hospital in Jackson, MS

Back in 2007, the Institute for Healthcare Improvement created the Triple Aim, which challenges organizations to provide better patient care, achieve population health, and lower costs. Since then, several areas have been identified as barriers to achieving the Triple Aim. First on that list is accountability. Hospitals, physicians, vendors of healthcare products, and even patients are all accountable in their own way.

Let’s look at accountability in terms of utilization. All hospitals are challenged to cut costs, yet they are dependent on the physicians’ utilization of services, the vendors’ cost and control of products, and the patients’ insatiable appetite to use services regardless of their cost. Our population has been conditioned to seek care when they are sick, rather than engage in preventive care to keep them well. There is a disconnect relative to the cost of care because the insured population depends on the care being paid for, and the indigent population depends on the care being available at no cost.

As providers of care, hospitals and physicians are using diagnostics and treatments to cover the worst-case scenarios. The desire to find alternative, less costly care has evaporated because when physicians and hospitals provide less care, they also get paid less. Vendors often put pressure on providers to make the latest and greatest products available to patients, yet providers have no adequate comparative effectiveness data to help them select new products.

Another barrier to meeting the Triple Aim is the external pressure of reporting and accountability. If a handful of organizations are not compliant in their billing practices, all hospitals become subject to the audit processes designed to recapture lost dollars, and the financial burden of those audits is driving many hospitals to their knees.

The Triple Aim is bold. There is no process by which healthcare providers can hold patients accountable, such as by making them responsible for the costs associated with an unhealthy lifestyle. Proposed universal healthcare will not solve the patient accountability issue; it will only serve to drive the cost obligation to the existing overburdened healthcare system and providers.

So how can we address the quest for value and avoid the demise that many organizations have met over the past several years? First, hospitals and physicians must have a common objective and be collaborative in their approaches. We must address utilization by reducing variation, restructuring costs, and reducing unnecessary care. Everyone—both patients and providers—must be held accountable.

Second, hospitals must be vigilant with record-keeping. Proper documentation is critical as we move to ICD-10 within the next couple of years. The correct patient status is essential to adequate reimbursement and must match what the provider is charging, or else all parties will be denied reimbursement. The timeliness of recordkeeping is essential as well. Physicians no longer have weeks or months to complete medical records; they must be completed at the time of care.

Third, as foreign as electronic systems are to some physicians, there is no choice but to adopt them. We must be compliant with regulations, and our systems must work for us—we should not be working for our systems!