Sample protocol for evaluating patients preoperatively

Hospitalists at the Cleveland Clinic's IMPACT Center preoperatively evaluate noncardiac surgery patients to assess their risks and optimize their health before surgery. See a sample protocol on p. 5.

Recruiting tip for May: Orientation for hospitalists

Don't leave your new hires out in the cold when it comes to hospital systems and policies. Cejka Search provides tips for properly orienting them on p. 7.

How to translate LOS savings into added bed capacity

You've demonstrated to administration that your hospitalists reduce LOS and improve overall patient care. Take the next step and calculate how much added bed capacity they create for the hospital. See p. 9.

In the news

Nine cases of tubing misconnections have been reported to the JCAHO, eight of which resulted in the patient's death. Read about the JCAHO's latest Sentinel Event Alert on p. 11.

Facilities’ response to adverse events should give hospitalists key role

Just as hospitalists are key players in the care of hospitalized patients, they also should be at the forefront of a facility's response to an adverse event or medical error. As many clinicians know, an effective response to an adverse event or medical error not only could prevent a costly and traumatic malpractice suit, but it could also prevent future patient harm and improve care by identifying breakdowns in the system and opportunities for quality improvement.

“IT'S IMPORTANT FOR HOSPITALISTS TO NOT ONLY PLAY A COLLABORATIVE AND PROACTIVE ROLE WITH VARIOUS SERVICES TO IMPROVE QUALITY AND REDUCE RISK, BUT WE ALSO HAVE TO BE LEADERS IN COMMUNICATING WITH PATIENTS AND FAMILIES IN AN OPEN AND HONEST WAY,” SAYS SYLVIA C.W. MCKEAN, MD, FACP, MEDICAL DIRECTOR OF THE HOSPITALIST SERVICE AT BRIGHAM AND WOMEN'S HOSPITAL IN BOSTON.

“WHEN THINGS GO WRONG—AND THERE ARE MANY WAYS THAT THINGS CAN GO WRONG—HOSPITALISTS NEED TO BE LEADERS IN COMMUNICATING THE ERROR,” SHE SAYS. BEYOND SURGICAL ERRORS, A PATIENT COULD FALL OUT OF A CHAIR DURING TRANSPORT, A
Preop assessments

clear patients for surgery, but also to optimize the health of patients who have medical conditions, Jaffer says. Before the IMPACT Center was founded in 1997, the Cleveland Clinic was forced to cancel surgeries regularly because patients were not cleared or in optimal health, Jaffer says. “Patients were unhappy, surgeons and anesthesiologists were unhappy, and there was lost revenue [because] the operating room was not utilized.”

In the past, surgeons admitted patients a day or two before their surgeries to perform diagnostic testing and assessment in the hospital. Today, primary care physicians (PCP) are more likely to perform preoperative assessments, but for many reasons, the quality of the assessments can be hit-or-miss, according to Jaffer. PCPs may not have the time, skills, or interest to perform the thorough assessments that are necessary.

**Tip:** The coordination of an outpatient infrastructure is one of the keys to establishing a successful perioperative program. It is important to consider which mechanism(s) your facility will use to schedule appointments, examine patients, and communicate with them and their PCPs on an outpatient basis. (For more information about setting up an outpatient infrastructure for your program, see “Hospitalist program needs outpatient orientation to make preoperative clinic a success” on p. 3.)

The current need for good preoperative assessments of surgery patients is so great that it’s almost difficult to imagine that a hospital medicine service could fail in launching such a program, Jaffer says. Last year, the IMPACT Center (coupled with a satellite center for eye surgery) billed $5 million for the Cleveland Clinic—double the $2.5 million it billed in 2003.

“The biggest problem our program faces is meeting the surgical demand.”

—Amir Jaffer, MD

**Tip:** Preop assessments at the IMPACT Center are billed to payers for patients with medical conditions. For about 5% of patients who are healthy and do not have medical conditions, the IMPACT Center bills the surgical service for history and physical.

**The 10 S’s**

To guide hospital medicine programs in developing their own preoperative assessment clinics or services, Jaffer developed what he calls the 10 S model. The following are 10 considerations for administrators and hospitalists who want to establish a preoperative assessment program at their own institutions:

1. **Strategy.** The first consideration is identifying your institution’s “type” and deciding which population you want to target for preoperative care, says Jaffer. Identify surgeons who want your services and will champion your cause. At the Cleveland Clinic, anesthesiologists were the leaders requesting the services of the IMPACT Center. They wanted to focus on anesthesia issues and did not feel equipped to handle patients’ complex medical conditions before surgery. The IMPACT Center now screens patients for many types of surgery, including:

   - neurosurgery
   - orthopedics
   - colorectal surgery
   - vascular surgery

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At the Cleveland Clinic and other programs, orthopedic surgeons have been at the leading edge of requesting preoperative services from hospitalists.

2. Space. Secondly, you will need office space for evaluating patients. Jaffer recommends negotiating for free space from the hospital when possible.

Another inexpensive alternative is to set up shop at a preadmission testing clinic that is already oriented toward providing preoperative services.

3. Staffing model. The IMPACT Center has a staff of four administrative personnel, two nurses, and five hospitalists. Jaffer says that if he wanted to run a leaner operation, he could probably get by with two administrative staff members. He estimates that one hospitalist is needed to see about 14 patients per day and .5 nurses is needed for each hospitalist. Some programs make use of physician extenders (e.g., physician assistants) and residents in their preoperative clinics. In terms of scheduling, Cleveland Clinic hospitalists work at the IMPACT

Hospitalist program needs outpatient orientation to make preoperative clinic a success

One challenge for a hospital medicine program in setting up a preoperative clinic is putting in place an outpatient infrastructure for scheduling appointments, examining patients, and communicating with them on an outpatient basis, says Jeffrey Dichter, MD, FACP, founder of the hospitalist program at Ball Memorial Hospital in Muncie, IN. A hospital medicine program typically does not have that outpatient infrastructure, he says.

Scheduling is a particularly key function for a preoperative clinic. The preoperative clinic at the 350-bed Ball Memorial assesses about 250 patients per year, says Dichter.

The program got its start when orthopedic surgeons began requesting that hospitalists perform preoperative assessments of their patients who were scheduled for joint-replacement surgery.

Currently, the clinic schedules two to three assessments per week but could handle up to three patients daily Monday through Friday, according to Dichter. The hospitalists see patients at the specialty practice’s offices.

Whenever possible, the practice tries to assign a patient in the preoperative clinic to the same hospitalist that will care for him or her postsurgery to establish familiarity, Dichter adds. The hospitalists at Ball Memorial also strive to fulfill their commitment to begin a patient’s preop assessment within 15 minutes of a patient’s arrival.

To ensure success, a preoperative clinic must also be diligent in following up on tests ordered during the preoperative assessment. This step is critical enough to warrant establishing a standardized procedure, Dichter says. “This is not an insignificant amount of work or devotion of resources.”

Dichter recommends dedicating one staff member to the outpatient portion of the practice. He or she doesn’t have to be a full-time employee, but should be one who is accountable. Dictations, which should be done in a timely manner and sent to the anesthesiologist when complete, are another consideration.

There are also special communication challenges in operating a preoperative assessment clinic, Dichter says. Primary care physicians and referring physicians must be informed regularly of their patients’ preoperative assessments.

Specialty consultants should be told why they are being asked to assess a preop clinic patient. Lastly, patients must be educated about why it is necessary to undergo a preop assessment, Dichter says.
Center for two weeks at a time. During the course of a year, the 24 hospitalists at the Cleveland Clinic will work at the preop clinic for a total of about eight to 12 weeks. Jaffer says the rotations in the preop clinic give hospitalists time to decompress and may help prevent burnout.

4. **Salary.** Once you determine the number of staff needed, you can then project the budget for salaries, which, of course, are influenced by the geographic area in which you are providing services, Jaffer says.

5. **Structure.** The IMPACT Center offers preoperative assessments every day from 8 a.m. to 3:30 p.m., with an hour off for lunch. Patient appointments last for half an hour. For new programs, Jaffer recommends that hospitalists designate certain hours during the week when they will conduct preoperative assessments. It is important to accommodate surgeons, especially at the beginning, he stresses. If you turn down too many requests for preoperative assessments on patients because of an overbooked schedule or a lack of staff, surgeons may stop requesting your services, Jaffer adds.

6. **Skill set.** Before undertaking a perioperative program, ensure that hospitalists are comfortable with their perioperative medicine skills. Hospitalists just out of residency programs “are not always up to speed in the nuances of perioperative medicine,” Jaffer says. Others may shy away from providing outpatient services because they’re more comfortable with the inpatient setting.

7. **Screening tools.** According to Jaffer, it would be a waste of time for a hospitalist to conduct a preoperative assessment on a healthy 30-year-old who is scheduled for toe surgery. As a result, it is important to screen all patients. The anesthesia department at the Cleveland Clinic has developed an online perioperative health questionnaire called the HealthQuest that rates patients’ risk profiles on a scale of one to four based on medical history. Patients with scores of three or four are usually referred to the Cleveland Clinic. Some vendors market screening programs based on this module, but a hospital medicine program could develop its own questionnaire for screening purposes.

8. **Standardization.** An important role for hospitalists is to help standardize their facility’s perioperative care by ensuring that all practitioners involved in a patient’s care are on the same page regarding cardiopulmonary risk assessment, perioperative beta blockers, anticoagulation therapy, diabetes management, etc. Jaffer says hospitalists’ involvement in preoperative assessments of patients provides a perfect opportunity for them to communicate with surgeons and anesthesiologists about the standardization of care before, during, and after surgery.

9. **Services.** About one in five patients who undergoes preoperative assessment is recommended as a candidate for postoperative services with a hospitalist, Jaffer says.

As a result, the IMPACT Center hospitalist who rotates on the inpatient medical consult service and is aided by the internal medicine residents provides postoperative follow-ups. Patients are recommended for postoperative follow-up if they are at high risk for cardiac or pulmonary complications, delirium, or confusion; require perioperative anticoagulation management; or have other medical issues. In addition to preop services for elective surgery, a hospital medicine program can offer preop services for more emergent procedures (e.g., hip fractures, etc.) for which patients may come through the emergency department, Jaffer says.

10. **Systems issues.** Part of a preoperative program launch plan entails outlining for administrators the benefits of providing such assessments to the system as a whole. According to Jaffer, preoperative assessments by hospitalists can result in

- reduced lengths of stay
- fewer routine lab tests
- fewer surgery cancellations on the day of surgery
- shorter times from hospital admission to surgery
- improved outcomes

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Sample protocol for evaluating patients preoperatively

In preoperatively evaluating patients, hospitalists at the Cleveland Clinic’s IMPACT Center use the following guidelines:

1. General
   ✓ A standardized typewritten unified preoperative assessment form that is available in the electronic record of the patient and printed the day before surgery so it is available as a hardcopy for the anesthesiologists and the surgeons. The form highlights detailed history of present illness; past medical and surgical history; review of systems; medications; allergies; physical exam; impression of the patient’s risk for the planned surgery; and succinct, legible, and evidence-based recommendations.
   ✓ Subacute bacterial endocarditis prophylaxis when indicated.
   ✓ Laboratory evaluation for all patients older than 50 using institutional guidelines.
   ✓ Electrocardiogram in all patients with known cardiac disease, new chest pain, shortness of breath, or significant coronary artery disease risk factors.
   ✓ Discontinue (D/C) herbal medications about two weeks before surgery.
   ✓ D/C nonsteroidal anti-inflammatory drugs for five to seven days before surgery.
   ✓ D/C acetylsalicylic acid and aspirin for 10 days before surgery if deemed safe.
   ✓ D/C Clopidogrel for five days before surgery if deemed safe.
   ✓ Hold ACE inhibitors and diuretics the morning of surgery.

2. Cardiac
   ✓ Functional class assessment (grades 1 to IV)
   ✓ Noninvasive cardiac testing according to American College of Cardiology/American Heart Association guidelines in patients
   ✓ Pacemaker checks on all patients with permanent pacemakers or automatic implantable cardioverter defibrillators
   ✓ Echocardiograms for suspected aortic stenosis

3. Pulmonary
   ✓ Screening peak flow evaluation at the discretion of the physician for patients who show chronic lung disease, wheezing, or crackles upon lung examination; previous irradiation; or resection to the chest or signs of active respiratory tract infection
   ✓ Spirometry (forced expiratory volume [FEV], forced vital capacity, and flow-volume loops) if indicated in patients with FEV less than 1L or known severe restrictive lung disease
   ✓ Reassessment of patients suboptimally prepared for surgery at initial visit with reversible conditions (e.g., active wheezing, acute or chronic dyspnea)

4. Neurologic
   ✓ Carotid ultrasound for patients with new (or previously uncharacterized) carotid bruits with referral in selected case for a consultation on endarterectomy for those with stenosis greater than 80%
   ✓ Consult for a history of malignant hyperthermia

5. Hematologic
   ✓ Stop warfarin five days before elective surgery and recheck on the international normalized ratio on the morning of surgery
   ✓ Use bridging anticoagulation with heparin products in patients with a high risk of thromboembolism
   ✓ Perform coagulation tests in patients with a known hemorrhagic diathesis, known family history, or long-term warfarin therapy

6. Endocrine
   ✓ Prophylactic use of perioperative intravenous glucocorticoids in patients at risk for adrenal suppression (prolonged corticosteroid treatment within the past year or known adrenal insufficiency)
   ✓ Screening blood glucose (and glycosylated hemoglobin in selected cases) in all diabetics with preoperative optimization of glycemia as appropriate
   ✓ Thyroid function tests in patients suspected of clinical hypo- or hyperthyroidism preoperatively

Musculoskeletal
 ✓ Cervical radiographs (with flexion views) in selected patients with rheumatoid arthritis (e.g., prolonged or deforming disease and anticipated general anesthesia)
Consensus  < p. 1

resident could forget to order a drug, or an attending physician could fail to follow through on a recommendation, says McKean.

Evidence-based guidance
To provide evidence-based guidance to hospitals about how they can best respond to patients and their families in situations in which an adverse event has occurred, a group of risk managers and clinicians from several Harvard teaching hospitals met to develop a consensus statement. The Massachusetts Coalition for the Prevention of Medical Errors (www.macoalition.org) released the statement When Things Go Wrong, Responding to Adverse Events, A Consensus Statement of the Harvard Hospitals in March. It aims to provide hospitals with general principles for developing their own institutional policies.

McKean says that a generation ago, the physician was “a king who was expected to take care of everything.” Today, myriad practitioners are involved in the care of a patient, and the patient—not the physician—has taken center stage. Further, physicians were not expected to apologize to patients for mistakes or adverse outcomes a generation ago, but today it is becoming more common. The consensus statement emphasizes the importance of a prompt apology to the patient for the harm that has been done, even when it is unclear what happened.

Among the key principles developed by the Harvard hospitals on responding to adverse events are
- a timely response to the patient and family
- support for the caregiver
- financial compensation for the patient

Prompt apology and response
When a provider unintentionally harms a patient, the same clinician who was involved in the injury usually continues to care for the patient, the report states. “As a result, patients may be frightened and have conflicting feelings about their caregivers, even when they are sympathetic and supportive,” the statement notes.

According to the statement, a skillful response to an adverse outcome will reduce the patient’s emotional trauma, whereas an inadequate or insensitive one will likely cause further emotional trauma. In fact, in a survey of 149 patients at an academic outpatient clinic that asked patients to respond to three medical error scenarios (minor, moderate, and severe), 98% said they wanted some acknowledgement of errors, even if the error was minor.

When informing a patient and his or her family of an error or adverse event, the coalition advises that a hospital’s care team take the following four steps:

1. Promptly tell the patient what happened.
   Leave details about how and why for later, the statement advises. Limit discussions to known facts and avoid speculation. Inform the patient about the incident as soon as it is recognized and he or she is ready physically and psychologically to receive the information (typically within 24 hours). The initial explanation should focus on what happened and how it will affect the patient, including immediate effects and the prognosis. The caregiver should acknowledge the event, express regret, and explain what happened. If speculative information is shared and then is later contradicted, it may hurt the provider’s credibility. Although the tendency is for caregivers and patients to want to avoid each other at first, it is important to communicate early and to continue to do so.

2. Take responsibility. Attending physicians should take responsibility for adverse events even when they did not make the mistake that caused the injury, the statement says. Taking responsibility does not mean assuming all of the blame, as multiple factors likely contributed to the event. “However, as the leader of the team, the physician is an

“When things go wrong—and there are many ways that things can go wrong—hospitalists need to be leaders in communicating the error,”

—Sylvia C.W. McKean, MD, FACP
integral part of the clinical system that delivers care to the patient in question. [He or she] is understandably the person who the patient and family assume is responsible for the care,” the statement says. The hospital and its leaders should also accept responsibility and communicate this responsibility to the patient and family.

3. **Apologize.** If a hospitalist is the attending physician, he or she should apologize even when someone else made the error. In these cases, a hospitalist could jointly make the apology with the practitioner (e.g., resident, nurse, radiologist, etc.) who made the error. “Although errors by individuals usually result from systems failures [which need to be identified and addressed], few patients understand that,” the statement says. “They hold the individual responsible.”

4. **Explain what will be done to prevent any future events.** Caregivers often underestimate the importance of explaining to patients what steps will be taken to prevent future adverse events, according to the statement. However, hearing such an explanation gives positive meaning to a patient’s experience. McKean says that making improvements in the system and patient safety following an error or adverse event is a natural role for hospitalists.

“[Hospitalists'] roles are so central to improving the hospital setting that not only should they take part in the communication of an apology but also in determining how this error will lead to further quality improvement initiatives,” McKean says. She advises using such cases as examples when teaching nurses and residents as well as ensuring that hospitalists are involved in a root-cause analysis of the event.

**Financial compensation**
In considering how to compensate patients for adverse events, waiving fees and providing reimbursement for extra expenses could help patients feel that they are being treated fairly by the hospital and providers, the statement says. The payment of even small sums for miscellaneous expenses (e.g., family housing, travel, child care, disability aids, housekeeping ser-

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**Recruiting tip of the month**

**Orientation for hospitalists new to your program**

Great news: You have successfully hired a hospitalist. Now it’s time to ensure that the newest addition to your staff understands how things get done at your organization.

Whether the hospitalist has years of experience or is transitioning from a residency program, it’s up to the hospitalist program to provide specific instruction on the organization’s systems, processes, and policies. Failure to adequately orient your new hospitalist to the program could lead to feelings of stress and alienation, reduced productivity, and avoidable mistakes.

Elements of a strong and effective orientation program include

- implementing of a formalized training program to help the new hospitalist learn the ropes of your organization and make him or her feel more at ease in the new position.
- introducing the new hospitalist to staff and arranging meetings between the hospitalist and the individuals with whom he or she will work closely.
- creating a welcoming environment by inviting the new hospitalist to social events. It is important to include the new hospitalist’s significant other/family in the orientation, especially in cases in which the physician/family has relocated to the community.

Editor’s note: This tip was submitted by **Paul Smallwood**, vice president of physician search with St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.
VICES, AND TRANSPORTATION TO APPOINTMENTS) COULD HAVE A POWERFUL, POSITIVE EFFECT ON THE PATIENT’S RESPONSE TO THE SITUATION, ACCORDING TO THE STATEMENT.

MCKEAN RAISES THE QUESTION ABOUT WHETHER A PATIENT WHO HAS SUFFERED HARM SHOULD HAVE TO PAY HIS OR HER HOSPITAL BILL. UNDER THE CURRENT SYSTEM FOR FINANCING HEALTHCARE, PATIENTS HAVE LITTLE RECOURSE BUT TO FILE A LAWSUIT IF THEY FEEL THAT THEY DESERVE FINANCIAL COMPENSATION. SHE SEES A DISCREPANCY BETWEEN PATIENTS WHO SUE AND PATIENTS WHO SHOULD BE COMPENSATED. FURTHER, IT OFTEN TAKES FIVE TO TEN YEARS FOR PATIENTS AND FAMILIES TO RECEIVE COMPENSATION THROUGH A SUCCESSFUL LAWSUIT, ACCORDING TO MCKEAN, WHEREAS—IF WARRANTED—A HOSPITAL COULD PROVIDE COMPENSATION IMMEDIATELY.

THE STATEMENT DESCRIBES THE “3RS” PROGRAM (RECOGNIZE, RESPOND, RESOLVE) AS ONE MODEL FOR REIMBURSING PATIENTS AND FAMILIES FOR AN ADVERSE EVENT. RUN BY THE DENVER-BASED COPIC INSURANCE COMPANY (WWW.CALLCOMIC.COM), THE PROGRAM PROVIDES COMPENSATION TO PATIENTS AND FAMILIES WITHOUT ATTORNEY INVOLVEMENT. PHYSICIANS AND HOSPITALS ENROLLED IN THE PROGRAM TRIGGER THE PROCESS BY REPORTING AN ADVERSE OCCURRENCE. THAT OCCURRENCE IS THEN REVIEWED BY 3RS PROGRAM ADMINISTRATORS, WHO MEET TO REACH A JOINT DECISION WITH THE PHYSICIAN(S) INVOLVED REGARDING WHETHER TO CONTACT PATIENTS ABOUT COMPENSATION. THE 3RS PROGRAM IS NOT USED WHEN

- THE PATIENT INVOLVED IN THE EVENT DIES
- THE PHYSICIAN/HOSPITAL INVOLVED RECEIVES A DEMAND LETTER
- THE PATIENT’S OUT-OF-POCKET MEDICAL EXPENSES EXCEED $25,000
- A PATIENT OR OTHER INDIVIDUAL FILES A COMPLAINT ABOUT THE EVENT WITH THE BOARD OF MEDICAL EXAMINERS

SINCE THE PROGRAM BEGAN IN 2000, THERE HAVE BEEN 2,174 QUALIFYING INCIDENTS AND 512 PAYMENTS, AVERAGING $5,680 PER PAID INCIDENT, ACCORDING TO THE STATEMENT.

SUPPORTING AND TRAINING CLINICIANS

MANY HOSPITALISTS HAVE NOT BEEN ADEQUATELY TRAINED IN DELIVERING BAD NEWS, COUNSELING PATIENTS, AND APOLOGIZING TO THEM, THE STATEMENT SAYS. AS A RESULT, AND ALSO BECAUSE OF THEIR OWN FEELINGS OF SHAME AND GUILT, THEY MAY FAIL TO COMMUNICATE COMPASSIONATELY AND EFFECTIVELY.

TO COMBAT THESE BARRIERS, THE COALITION ADVISES THAT HOSPITALS “PROVIDE FOR ‘JUST-IN-TIME’ CONSULTATION AND GUIDANCE TO CLINICAL STAFF AT THE TIME OF AN ADVERSE EVENT . . . BECAUSE BUSY CLINICIANS ARE UNLIKELY TO ATTEND COURSES ANNUALLY OR MAINTAIN THEIR [COMMUNICATION] SKILLS, JUST-IN-TIME REFRESHER MODULES SHOULD BE DEVELOPED FOR CAREGIVERS TO BE GIVEN WHEN NEEDED AT THE TIME OF A CRISIS.”

FINALLY, TOO LITTLE ATTENTION HAS BEEN PAID TO SUPPORTING THE CAREGIVER IN THE TIME OF SUCH CRISSES, THE STATEMENT SAYS. HOSPITALS SHOULD NOT ONLY SUPPORT THE CAREGIVER WITH COMMUNICATION TRAINING AND EXPERT COACHING BY EXPERIENCED PROFESSIONALS DURING THE TIME OF THE INCIDENT, BUT THEY SHOULD ALSO PROVIDE COUNSELING SO CLINICIANS DO NOT BECOME THE “SECOND VICTIMS” OF THE INCIDENT.

AT BRIGHAM AND WOMEN’S HOSPITAL, MCKEAN SAYS RISK MANAGERS PROVIDE THE SUPPORT CAREGIVERS NEED. IN FACT, RISK MANAGERS FREQUENTLY ARE PRESENT WHEN PRACTITIONERS COMMUNICATE WITH PATIENTS. THEIR INVOLVEMENT NOT ONLY EnsURES SUPPORT FOR THE CAREGIVER, BUT MAY ALSO REASSURE THE PATIENT THAT STAFF OTHER THAN THE PHYSICIAN KNOW ABOUT THE INCIDENT AND IT “WON’T BE COVERED UP,” MCKEAN SAYS.

EDITOR’S NOTE: GO TO WWW.IHI.ORG/BR/BRONLYRES/A4CE6C77-F65C-4F34-B323-20AA4E41DC79/0/RESPONDINGADVERSEEVENTSPDF. TO ACCESS WHEN THINGS GO WRONG, RESPONDING TO ADVERSE EVENTS, A CONSSENSUS STATEMENT OF THE HARVARD HOSPITALS.
The next step in assessing your program’s value: How to translate LOS savings into added bed capacity

With hospital medicine now in its second decade, it’s clear that a hospitalist program has the potential to reduce patients’ average length of stay (LOS), improve the overall quality of care provided, and foster the use of evidence-based medicine, says Ron Greeno, MD, chief medical officer of Cogent Healthcare (www.cogenthealthcare.com), which manages and develops hospitalist programs nationwide.

However, few hospitalist program directors take the next step and calculate how much added bed capacity a hospitalist program can create for a hospital. At a time when many hospitals are forced to close their emergency departments (ED) or turn away patients because they do not have enough beds, it’s a step worth taking, says Greeno. In his view, a hospital being forced to close its ED due to a lack of beds is tantamount to a grocery store closing because it doesn’t have enough groceries. “No other business would tolerate this,” he says.

Because of the sheer number of patients that hospitalists manage, even small savings in LOS can reap big dividends, according to Greeno. If new construction is required, each new hospital bed could cost as much as $800,000–$1 million, he says. For a fraction of the cost, a hospital can create significantly more bed capacity with a successful hospital medicine program, says Greeno.

**Return on investment**

“A hospitalist program can create real value in so many different areas for hospitals that if administrators see it as a cost drain, or if they [underfund] the program, they miss the point,” Greeno says. “But you have to build the program right to create value.”

“When you calculate added capacity, the numbers are staggering,” he adds.

In one hospital at which Cogent manages the hospital medicine program, Greeno says the average LOS for its hospitalists is 3.7 days, compared to 5.5 days for other physicians. The 160-bed hospital admitted 3,168 patients in 2005 and ran at full capacity most of the time, he says. If that facility reduced LOS on all admissions by 1.8 days, it could create about 5,700 “open bed days,” or roughly 1,500 additional admissions for the hospital, he says.

With the revenue for each admission averaging $7,500, a hospitalist program that effectively reduced LOS could potentially generate additional revenue of $7.7 million, Greeno says. Even a one-day reduction in LOS from five days to four could automatically expand a hospital’s bed capacity by 20%, Greeno says.

“It doesn’t matter what numbers you plug in. The point is [that] you can create a surprising amount of capacity,” he adds.

“Some of the best hospitals in the country understand that their hospital medicine program is going to be the centerpiece of their ability to compete from both a financial and regulatory standpoint, so they build their best program they can,” Greeno says.

**Build in processes to support goal**

When developing a hospital medicine program, Greeno advises taking a broad perspective on the potential return on investment (ROI) to the hospital. He finds that many programs narrowly focus on how hospitalists reduce costs on an individual-case basis. To meet the hospital’s unique goals, processes must be put in place that will make it possible for the hospitalist program to achieve that goal.

For example, Greeno notes that Cogent worked with one hospital in a city with a large population of uninsured patients and Medicare recipients. That facility wanted to decrease its hospital readmissions, which could translate into significant cost savings for the hospital.

“If you want to decrease readmissions, you have to hard-wire processes to meet that goal,” says > p. 10
Greeno. “It costs money to build these processes, but it also creates value multiple times over.”

In addition to consistently using evidence-based medicine, Greeno says, the hospitalist program with a large uninsured patient population also established the following standardized discharge process to meet its goals:

- A staff member contacts the patient postdischarge to ensure that he or she is following through on the physician’s orders and is doing well after leaving the hospital
- The hospitalist dictates the patient’s discharge summary by phone and a data entry clerk types the recorded dictation into a database
- The discharge summary is faxed to the patient’s primary care physician within 12 hours of dictation
- The call center reviews the discharge summary with the patient within 48 hours of discharge

Greeno notes that by walking the patient through his or her discharge plan, the hospitalist program can address questions such as, “Did the oxygen arrive? Did the home-care worker arrive? Is pain under control?” In 18%–20% of cases, some element of the patient’s care has not been resolved and the call center can help to close that loop, Greeno says. He adds that the call center also plays a role in improving the program by conducting a patient satisfaction survey about the care that patients received from their hospitalist.

By decreasing readmissions across the board and ensuring that all admissions were appropriate for both insured and uninsured patients, the hospital was able to reduce costs while improving patient care, Greeno says.

He notes that when developing a hospital medicine program, administrators should also consider the potential for reduced malpractice liability and increased job satisfaction among nurses as other payoffs. Yet another often-overlooked benefit of a hospital medicine program is that hospitalists’ services can be marketed to the medical community as a service line much like a new gamma knife or joint replacement.

“Some of the best hospitals in the country understand that their hospital medicine program is going to be the centerpiece of their ability to compete from both a financial and regulatory standpoint, so they build the best program they can.” —Ron Greeno, MD

Heart failure simulator on tour

Hospitalists can join other clinicians in experiencing how it feels to be a heart failure patient during the yearlong national tour of “Heart FX Pod,” a heart failure patient educational simulator developed by AstraZeneca. In April, the Heart FX Pod is scheduled to be at 10 hospitals in Maryland, Virginia, Washington, DC, California, and Texas.

Heart FX Pod is a multisensory, interactive, patient-perspective simulation of the effect of heart failure on walking. By stepping inside one of six private booths in the simulator, a healthcare provider will gradually feel the debilitating effects of heart failure. To see the Pod’s schedule, go to www.heartfxpod.com/reserve/monthview.php.
The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on April 3 released a new Sentinel Event Alert about tubing misconnections. Inexperienced staff and connector devices that are compatible across multiple lines and catheters are the most common causes of tubing misconnections, according to the alert.

“The most important thing for hospitals is to review this alert [and] discuss it at their safety committee and with nursing staff and central supply staff,” says Kurt A. Patton, MS, RPh, former JCAHO executive director of accreditation services. “[Hospitals] need to evaluate what they purchase, what they use, and what their risks might be. The only way they can fail is to not distribute and not discuss this information.” Patton is now principal of Patton Healthcare Consulting, LLC.

According to the alert, nine cases (involving seven adults and two infants) of tube misconnections have been reported to the JCAHO’s Sentinel Event Database, eight of which resulted in the patient’s death. The other case led to significant patient injury.

The majority of the nine cases involved luer connectors, which act as a universal connector for tubing, according to the alert. The connectors enable users to connect two different tubes, which can lead to error. Other causes included using tubes for inappropriate procedures and keeping dissimilar tubing next to each other on or near the patient. The JCAHO has called on manufacturers to redesign tubing and connectors to reduce interoperability between disparate lines and thereby create a mechanical inability to connect incorrect lines.

Hospitals should take extra care to ensure that new tubes, catheters, and connector devices do not correspond with those already in use at their facility, says Patricia Gilroy, MSN, MBA, clinical patient safety coordinator at Alfred I. DuPont Hospital for Children in Wilmington, DE.

“We conduct tests and assess risks on the devices before we purchase new tubing . . . We want to make sure it can’t be connected to our current pumps and connectors,” Gilroy says.

Proper training in IV pump use and labeling lines is a great way to prevent errors, says David Benjamin, PhD, fellow at both the American College of Clinical Pharmacology and American Society for Healthcare Risk Management. Benjamin spoke about the subject while commenting in the April Briefings.
on Patient Safety, an HCPro, Inc., publication, about a United States Pharmacopoeia study. “Hospitals have to make sure they train people and make sure they are familiar with the specific pumps they use,” says Benjamin. That’s true of any type of equipment the hospital uses, he adds.

Unfortunately, it can be easy to confuse different lines running through the same pump, said Benjamin. “When you see a patient receiving multiple infusions, it’s really easy to confuse the lines. It can look like a plate of spaghetti.”

Gilroy says tracing the lines before making a connection can help to avoid mistakes. The JCAHO’s alert recommends tracing back from the patient to the origin of the tubing, a method that Gilroy endorses.

Beyond tracing back lines, staff should properly label each line to further reduce confusion.

Janet Hosta, RN, MSN, professional development director at Youville Hospital & Rehabilitation Center in Cambridge, MA, recommends using opaque tags whenever a patient is hooked up to more than one line or device. “Tracing just isn’t enough sometimes,” she says.

The JCAHO also recommends using colored lines to help avoid confusion, but warns against relying solely on color to differentiate the tubes. Recheck these lines as well. The JCAHO recommends the check be done as part of a patient handoff, which is one of the 2006 National Patient Safety Goal requirements.

Hosta says the checks should occur more often than that. “Recheck connections every time they are disconnected or reconnected, not just at arrival or during the handoff process,” she says.

Gilroy says hospitals must teach patients and family members that connecting lines is more complicated than it seems and that they should not try and fix a disconnected line themselves.

Editor’s note: To read the entire Sentinel Event Alert, go to www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_36.htm.