Frequent Practice and Real-Time Feedback Are Keys to Improved Resuscitation

“Conflicts of Interest” Are Becoming Hot Topics in Healthcare

HEALTHCARE COMPLIANCE

DOING

The Right Thing

- Avoid conflicts of interest
- Improve resuscitation rates
- Improve cyber security
- Always explain things to patients in a way they can understand
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IMPROVING REGULATORY COMPLIANCE: A KEY PRIORITY FOR 2015

In this issue of the PX Advisor, our theme is regulatory compliance. As you well know, healthcare is a heavily regulated industry; we are under the oversight of myriad state and federal agencies ranging from OSHA to CMS—in addition to private organizations such as JCAHO and NCQA. We also closely follow the directives of specialty organizations, such as the American Heart Association and the Centers for Disease Control, and the recommendations of leading trade associations, such as the American Hospital Association, the American Medical Association, and the American Health Care Association.
In this environment, healthcare organizations today are facing numerous compliance challenges. Many in the industry are feeling overwhelmed by the increasing number of regulatory mandates stemming from recently enacted legislation such as the HITECH Act, the Accountable Care Act, and the HIPAA Omnibus Rule. There is also heightened government interest in regulatory and transparency issues, with the Office of Inspector General (OIG) showing new vigilance for acts of fraud or misconduct. At the same time, CMS is increasingly requiring greater transparency in numerous areas such as patient experience, readmission rates, clinical quality metrics, and physician payments from manufacturers and group purchasing organizations.

A 2015 study by PriceWaterhouseCoopers indicates that healthcare CEOs are worried about the risk of over-regulation with some 71% of CEOs saying they are nervous about recent changes in regulation. Another recent survey by the Information Security Media Group indicates that healthcare leaders mentioned “improving regulatory compliance” as their top priority for the year. It is clear that this is a topic of significant concern to healthcare executives.

In our PX Advisor for this quarter, we take a look at a number of these challenges. We consider new recommendations from the American Heart Association for continuous resuscitation training, new trends in managing corporate conflicts of interest, the growing number of organizations operating under Corporate Integrity Agreements (CIAs) with the OIG, increasing threats to cyber security, and challenges faced by the industry in reducing unnecessary hospital admissions.

We hope this issue will inform you of some of the important developments regarding regulatory compliance and that you will gain some insight from others that will help you to mitigate risks in your own organization.
ONLINE MEDICAL TECHNOLOGY

An Interview with HCA’s Lee Ann Hanna

Currently the Director of Education at Tri-Star Centennial Medical Center (HCA), Nashville, TN, Ms. Hanna has over thirty years experience in healthcare settings; sixteen years experience in neonatal, pediatric; and adult critical care; and eighteen years’ experience in knowledge management and quality improvement. She is a Certified Professional in Healthcare Quality and is a National Association for Healthcare Quality (NAHQ) Fellow. Lee Ann regularly presents at nursing and quality education conferences on the local, state, regional, and national levels.

We recently spent some time speaking with Lee Ann Hanna about her insights and experience around healthcare education and compliance.
**HealthStream**: You have a tremendous amount of experience on both the provider and management side of healthcare education. What, in your opinion, is the biggest change in Pharmaceutical/Medical Device (PMD) training over the last five years?

**Lee Ann Hanna**: Devices and drugs have been around for a long time; we implement new and/or we convert to the next. Similar to my answer the first time we talked almost three years ago, the biggest challenge continues to be that these changes are coming even more quickly. Implementations may come rapidly; sometimes this is based on outcomes data, regulatory directives, availability of products, and/or contract negotiations. Organizations are continuously moving to highest quality and best price. Neither a good or bad thing, it’s a reality of our economic environment.

While that is the biggest change, there are other changes that affect PMD training. PMD companies face the same challenges as healthcare organizations. Their environment is moving at a rapid pace, and competition and resources are just as challenging for them. These companies must also work in a cost-effective and efficient manner, especially when it comes to training. Some PMD companies consider training to be a value-added service. Other PMD companies will not sell a product unless staff members are educated and competent to use their products. The latter understand that proper use of their devices and drugs will lead to improved outcomes and higher quality. If you take care of quality, everything else falls into place.

Overall though, I feel like we are learning to work better; the people who work within HealthStream, our facilities, and even our administrators are learning to work better with manufacturers to provide the training that we need for staff and our patients.

**HealthStream**: In our recent survey of nurses, 77% said that medical product training had an above average effect on the ability to do their job. The same percentage said that it has an above average effect on their confidence. Do these numbers align with your experience?

**Lee Ann Hanna**: Yes it does, but I wish the numbers were higher. As an industry, we should approach device training as an area where we can focus our efforts for improvement. Honestly, there is nothing more frustrating than to be asked to use a device or administer a drug without training. According to the rules and regulations of registered nurses in our state, nurses should not perform nursing techniques or procedures without proper education and practice.

If we have a product that we use incorrectly, it could affect everyone negatively, not just the patient and the hospital, but also that employee and ultimately the manufacturer. If we use the product correctly, effectively, and efficiently, we maintain the high quality and outcomes which benefit both the patients and the organization. This would also serve as a great marketing tool from the manufacturer’s perspective.

**HealthStream**: You have mentioned before that the training support that you receive varies from manufacturer to manufacturer. What would you say is the best balance of training options that healthcare organizations and manufacturers should work together to provide in order to successfully support the front line staff?

**Lee Ann Hanna**: Yes, the training options absolutely vary between manufacturers. During the past year I have worked with PMD companies that have provided no training, as well as with PMD companies that have provided online training, classroom training, and go-live support.

Support to be provided by PMD companies during training and go-live is often negotiated during the contracting process. I advocate clinical education’s participation during negotiation procedures between PMD companies and healthcare organizations. Organizations that do not negotiate these costs and services up front may incur higher training costs and patient safety risks downstream.

So back to the question. Yes, some companies still use brochures, posters, and CDs. Although the effort is appreciated, these are not effective or efficient training methods, especially for our organization. First, it is difficult to reach all applicable staff members. Our organization is spread out over 50+ acres, and we have an off-site department. We have 1400+ clinical staff members who work all combinations and types of schedules common to hospitals. Second, it is difficult to track and report this type of training. Imagine having to manually record the participation of 1400+ staff member’s review of a brochure, poster, or CD.

Several manufacturers have started to move toward posting training videos on internet sites, such as...
HealthStream: How important is the timing of education and training, especially as it relates to compliance?

Lee Ann Hanna: Very important! Training needs to be timed correctly. If the training is rolled out too soon after implementation, or during implementation, staff members may not have enough time to complete their training and reflect on the changes. Critical thinking is born out of reflection. If the training is rolled out too long before implementation, staff members may forget, become de-skilled, and retraining costs may be incurred.

Even with little to no lead time on a product upgrade or recall, we are able to quickly put together the applicable information, including post-assessment if needed, and distribute it to the appropriate student groups. This is especially important since our employees are spread over a large area which would make it difficult to get the information to everyone in a timely manner.

Sometimes we are surprised with a product update or recall. It happens. It isn’t always easy, but with the ability to quickly distribute the education to the appropriate people, it makes the process a lot more effective and removes some of the stress that comes with the timing issue.

HealthStream: What systems or procedures do you have in place to ensure clinical competency with online training?

Lee Ann Hanna: We use a variety of methods that measure knowledge, skill, behavior changes, and outcomes. The most common methods we use to evaluate if learning happened are post-tests and simulation. A well-crafted test question will measure knowledge and skill. We rarely use yes-no or true-false questions. We prefer to use case scenarios that require critical thinking. Simulation may be performed in a virtual or a class room setting. At our facility, class room simulation is at the low and moderate fidelity levels. HealthStream has a number of options that allow well-crafted post-test questions and virtual simulations.

The most common methods we use to evaluate if learning was transferred to the workplace are bedside and medical record audits and analysis of outcomes data. Validation of behavioral changes must be demonstrated at the bedside. For example, our organization is serious about our programs that strive for zero hospital acquired...
infections. We audit many aspects of care such as frequency of dressing and tubing changes, correctness of device and dressing use, etc. The staff members who do the work perform the audits. Deficiencies are corrected immediately. The evaluation of behavior becomes, in and of itself, another learning opportunity.

We understand that, depending on level of complexity, there may be a learning curve during which time staff members may need to be remediated. Learning curve aside, what I have observed is use of online PMD company-sponsored training programs brings accountability and responsibility for learning to a new level.

I have to tell you, combining the competency and learning platforms with our product training is wonderful because it makes us totally compliant with all the waived and moderate complexity testing laboratory directives. Our lab loves it because they can easily run reports. This used to be a very labor intensive task for them because the tracking and aggregating were all manual. The integration has saved them time, but also makes it much easier to tell who is compliant and allows them to move to remediation much quicker.

HealthStream: Do you feel like compliance tracking has changed for you over the past several years? In other words, when you think about compliance do you feel differently knowing that you have data at your fingertips?

Lee Ann Hanna: Oh definitely. It is a wonderful thing when I can just pull a report from my learning system or competency management system. I frequently get compliance questions from human resources and other departments, asking if and when an employee completed a specific course. Sometimes I even get calls suggesting that an employee does not have the specific type of training needed to do something. Many times it turns out that it has been a while since the employee took the course and has forgotten, and I am able to quickly confirm that information and help move the process forward more efficiently.

On a more global scale, we have several surveys each year for specialty certifications that move much more smoothly since I am able to easily run reports on everything from completions to competencies.

HealthStream: Are there any areas where improvement can be made?

Lee Ann Hanna: In my opinion, the common element missing from companies introducing new or revised products is this: the follow-up conversation is unstructured. If these companies were asking the same evaluation questions [post-training and implementation] of multiple organizations, they could pick up strengths and weaknesses of their products and training programs. They could apply this information to improve their products and training programs. Use of the device or drug and associated outcomes could be improved.

Wouldn’t it be great with the technological advances and improvements that we have now that we close the circle, so to speak, by distributing the initial education and training, then follow-up 6-9 months later and use that feedback in the PMD marketing and our continued education program. I don’t think we are there yet, but I do feel like the LMS integration is a huge step in that direction.

Top 5 Benefits of Online Product Training
1. Provides flexibility to staff in both course creation and completion.
2. Increases accountability and responsibility.
3. Allows you to distribute consistent, structured material without depending on specific trainers.
4. Allows you to assign to specific audiences and track compliance.
5. Provides opportunities for refresher training, and allows students to retake until they master the content.

Learn more about HealthStream’s solution for online medical technology training at www.healthstream.com/onesource.

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.
The days when social media was viewed solely as a fun communications platform for younger generations are definitely over. Today, with 1.28 billion Facebook users and another billion on Twitter, social media has become a key way people connect and socialize with one another in work and in everyday life. In healthcare settings, the impetus to use social media is no different than in any other industry. When used correctly, it is an excellent tool that can increase awareness of hospital services, create a two-way dialogue with patients, families, and the community, and improve the patient experience. It is also a powerful communication tool that fosters easy collaboration between physicians and clinicians, is used in training, and helps organizations promote cultural standards, team building, and employee satisfaction and recruitment.
At the same time, we are all aware of stories about the misuse of social media in the workplace. Ensuring responsible use of social media in healthcare settings, such as hospitals and other patient care environments, can be tricky, according to David Rosenthal, Vice President of Business Development for compliance solutions at HCCS—a HealthStream Company, which offers online compliance training and tracking solutions to healthcare facilities. “In healthcare, it’s easy to quickly cross the line from improper use to illegal actions,” says Rosenthal. When a physician described her experience in the ER in a blog posting, including detail about the patient’s injuries, a third party was able to identify the patient by name. She thought she had left out enough identifiable information. That physician was found guilty of unprofessional conduct and was fined by the state medical board.

In another real-life case, a physician was punished for taking a ‘surgery selfie’ and posting it on social media. Other common situations involve nurses who share photos of interesting patient X-rays on their Facebook pages, which can lead to termination for HIPAA violations.

When a healthcare worker releases patient information that violates federal regulations it can result in serious penalties and reputational issues. Moreover, the views of a physician, nurse, or other staff member represent the organization for which they work and potentially affect patients. Postings on social media can impact a patient or client’s desire to use or work with that facility. Does this mean your organization should implement a strict policy that drastically limits or prohibits physicians and staff from using social media? No. This is not realistic in today’s world. Also, federal labor laws prohibit such a move, and it would compromise employee loyalty and satisfaction. In fact, the National Labor Relations Board rulings state that all employees have specific workplace speech and assembly protection. It is critical, however, to design social media and security policies that address potential liabilities in today’s click-and-post culture.

**SOCIAL MEDIA RISKS INCLUDE:**

- Release of private company information
- Release of PHI
- Improper photos of staff and patients
- Release of private employee information
- Online bullying
- Hurt feelings/morale
- Offensive on religious, gender, sexual orientation, or other grounds
- Portray facility in unfavorable terms
- Improper access to network/computer virus

When a physician described her experience in the ER in a blog posting, including detail about the patient’s injuries, a third party was able to identify the patient by name. She thought she had left out enough identifiable information. That physician was found guilty of unprofessional conduct and was fined by the state medical board.
3 Tips for Creating an Effective Social Media Strategy

Every healthcare organization should regularly review and update social media and security policies. “Social media is changing all the time, and organizations need to continually review policies to stay up to date,” says Rosenthal. Also, it is important to educate staff on acceptable use of social media and your policies. Be sure to enforce the policies. On top of that, keep the following in mind as you develop social media policies.

HELP STAFF REDEFINE THEIR SOCIAL MEDIA IDENTITIES

For most social media users there is no separation between personal use and business use. “They fail to grasp that their personal and professional social media personas are one and the same,” says Rosenthal. This leads to the belief that, for example, it’s okay to post pictures of and discuss a relative who is a patient on social media. “However, it is important to convey that there is no such thing as more than one identity,” states Rosenthal. Essentially, employees are representatives of that facility on and off the clock. This also holds true for physicians. “It doesn’t matter if they are at work with patients or not, the public persona must reflect positively on the facility,” says Rosenthal.

REDIRECT ONLINE BEHAVIORS

“It all comes down to training users not to use social media in the normal way they are used to doing,” says Rosenthal. According to him, organizations must educate staff on acceptable use of social media at work and at home. “Today, most people walk around with smartphones in their pockets. In fact, 50% of smartphone users connect hourly,” says Rosenthal, who adds that it is very typical for users of social media to record things that happen to them during the day, such as food they eat and the people they see on the street. “If you see someone dressed unusually you might take a picture of that and post it to your social network. However, if you start doing those things within a healthcare facility with patients and protected healthcare information, you quickly run into HIPAA and privacy violations,” says Rosenthal. To address these situations, make sure your policies extend to outside of work and include cell phone camera use. Also, social media policies should cover patients, family members, and guests.

ARE YOU COVERED?

- Does your policy extend to outside of work?
- Does your policy include social media postings about co-workers?
- Does your policy have information about supervisor behavior?
- Does your policy include cell phone camera use?
- Do you have policies that cover patients, family members, and guests?
Illegal actions aren’t the only area hospitals need to consider when it comes to social media policies. “There are plenty of common issues that come up, like employees who make comments about their job and coworkers, that can hurt morale and affect the institution,” says Rosenthal [See next page: Know Your Social Media Security Risks.] When an employee posts something as simple as, ‘I am bored,’ this can impact the organization’s reputation. Healthcare organizations should also have policies for addressing sticky situations such as friending patients and what to do if a group of workers bullies another worker on Facebook by unfriending them or posting malicious content about them.

**HIPAA PRIVACY RULE**

HIPAA protects all identifiable information held or transmitted by covered entities or business associates in any form.

**Protected Health Information (PHI) can include, but is not limited to:**

- Names
- Social security numbers
- Addresses
- Dates of birth
- Photos of faces, tattoos, or other unique characteristics
- Medical conditions

**SOCIAL MEDIA TRAINING**

A good training program will increase employee understanding, acceptance and compliance of social media policies. When offering training, it is important to address multiple learning styles. “Studies show that adults reach higher retention rates if they are able to see, hear, and interact with training materials,” says Rosenthal. Make learning engaging by using different media platforms, including video, live actors, and interactive exercises.

“The goal is not just to complete training but to change behaviors,” says Rosenthal, who adds, “Ultimately, if you haven’t provided guidance and education about what is acceptable and what isn’t when using social media, you open yourself up to significant liability and the potential impact of a negative public perception of your facility.” Enforcing social media policy now will prepare your staff for proper behavior as social media expands into areas such as mobile healthcare apps. Having solid social media policies and clearly educating staff are necessities in the always-connected world we live in today.
KNOW YOUR SOCIAL MEDIA SECURITY RISKS

Social media also involves the constantly changing security risks that hospitals need to be aware of, according to Tom Pendergast, Ph.D., Director of Awareness Solutions at MediaPro, an e-learning development company. The primary security risk is when an employee inappropriately releases any form of company information. “That could be releasing intellectual property, trade secrets, and patient information,” says Pendergast.

Workers in industries such as healthcare are at risk for targeted phishing attacks via social media. [NOTE: “Phishing” is defined as requesting confidential information over the Internet under false pretenses in order to fraudulently obtain credit card numbers, passwords, or other personal data.] “They might seek people on LinkedIn or Facebook who work at a specific hospital and send that person malware,” says Pendergast. This includes email messages and web links that can release viruses. “It’s important to teach employees to exercise a lot of skepticism and view with suspicion any unfamiliar attempt to direct you to a website or to solicit information from you,” offers Pendergast.

Other ways to mitigate risk include asking employees to create complex passwords and conducting phishing campaigns that send out a fake email to staff to determine who is more prone to fall victim to these attacks. In the end, shares Pendergast, “Because there are so many ways criminals use social engineering to gain access to an individual and an organization, we try to teach people to be more paranoid.”

“Phishing” is defined as requesting confidential information over the Internet under false pretenses in order to fraudulently obtain credit card numbers, passwords, or other personal data.

At the same time, inappropriate use of social media that damages an organization’s reputation is also a security issue. For example, per Pendergast, an employee may mention a new product release that the marketing department wasn’t ready to announce. “It isn’t a crime, but they’ve just compromised their company’s competitive advantage by doing that,” he notes. Additionally, there are certain social networks that create security hotspots, such as Facebook and LinkedIn. LinkedIn encourages employees to talk about what’s happening in their professional lives and thus can create a challenge for hospitals. According to Pendergast, “An employee might upset co-workers by posting a promotion they received when that promotion hasn’t been announced.”

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.
To Know About Hospital Readmissions

As required under the Affordable Care Act, CMS began imposing a penalty on hospitals with excessive Medicare readmissions in FY2013 (October 1, 2012) as part of the Hospital Readmissions Reduction Program (HRRP). CMS defines a “readmission” as someone who has been readmitted to the same or another acute care facility within 30 days of an initial hospital stay. For the first two years, the HRRP applied to Medicare patients with diagnoses of acute myocardial infarction (AMI), heart failure, or pneumonia, but the program was expanded in FY2015 to include elective hip or knee replacement and congestive obstructive pulmonary disease (COPD) patients. CMS will expand the program again in FY2017 with the addition of coronary artery bypass graft (CABG) patients. The program excludes patients who are transferred to another acute care facility within 30 days and patients who have planned readmissions for things such as chemotherapy or rehabilitation. The HRRP applies to all IPPS facilities but excludes psychiatric, rehabilitation, long-term care, children’s, cancer, and critical access hospitals as well as all hospitals located in Maryland. In the nearly three years the program has been in place, hospitals and regulators alike have learned a great deal about readmissions and the key factors driving them. We have even witnessed some unintended consequences from the HRRP. Following are some things you will want to know about this important topic.

Robin L. Rose  MBA
Vice President,
Healthcare Resource Group,
HealthStream
Readmissions are common and expensive.
In the U.S. today, one in five elderly patients is readmitted to the hospital within 30 days of discharge, costing Medicare some $15 billion per year (Kowalski, 2015). However, readmission rates vary greatly by hospital and by state, providing us with an indication that we might have the opportunity to reduce rates by improving hospital processes.

Certain types of patients are at high risk of hospital readmission.
There are a number of known factors, such as socio-demographic status and healthcare history, that place someone at high-risk for a readmission. As might be expected, frail, elderly, and lower income patients who lack support at home are at highest risk.

<table>
<thead>
<tr>
<th>Medicare Patient Characteristics Associated with Risk of Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socio-demographic</strong></td>
</tr>
<tr>
<td>• Gender (male)</td>
</tr>
<tr>
<td>• Poverty (Medicaid or uninsured)</td>
</tr>
<tr>
<td>• Age (Medicare)</td>
</tr>
<tr>
<td>• Lack of stable living situation and/or support at home</td>
</tr>
<tr>
<td>• Low English and/or health literacy</td>
</tr>
<tr>
<td><strong>Disease burden</strong></td>
</tr>
<tr>
<td>• Takes six or more medications</td>
</tr>
<tr>
<td>• CHF, diabetes, COPD</td>
</tr>
<tr>
<td>• Depression, psychoses</td>
</tr>
<tr>
<td>• Cancer, renal, or lung disease</td>
</tr>
<tr>
<td>• Alcohol or drug dependency</td>
</tr>
<tr>
<td><strong>Healthcare history</strong></td>
</tr>
<tr>
<td>• Index admission for heart failure, heart attack, pneumonia, or certain types of surgery</td>
</tr>
<tr>
<td>• Recent admission(s)</td>
</tr>
<tr>
<td>• Frequent ED visits</td>
</tr>
<tr>
<td><strong>Physical status</strong></td>
</tr>
<tr>
<td>• Disabled</td>
</tr>
<tr>
<td>• Frail</td>
</tr>
<tr>
<td>• Signs of poor nutrition</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>Discharged during a weekend or holiday</td>
</tr>
</tbody>
</table>


---

### Readmission Rates within 30 Days of Discharge

<table>
<thead>
<tr>
<th>Number of States</th>
<th>Range in Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>13.3 – 17.5%</td>
</tr>
<tr>
<td>14</td>
<td>17.6 – 19.1%</td>
</tr>
<tr>
<td>13</td>
<td>19.2% - 20.1%</td>
</tr>
<tr>
<td>10</td>
<td>20.2 – 23.2%</td>
</tr>
</tbody>
</table>

Source: Jencks, 2009
CMS is focused on high volume, high cost diagnoses.

The HRRP Program is focused on five diagnoses (orange in the table below) that are responsible for a high percentage of 30-day readmissions and a high percentage of total Medicare cost due to readmissions. Although these diagnoses are among the Top 10, they are not the Top 5 based on rank.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Hospital Discharges</th>
<th>Number of 30-Day Readmissions</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure</td>
<td>847,073</td>
<td>209,017</td>
<td>25%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>696,122</td>
<td>145,896</td>
<td>21%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>924,160</td>
<td>144,894</td>
<td>16%</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>883,245</td>
<td>131,125</td>
<td>15%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>606,186</td>
<td>126,443</td>
<td>21%</td>
</tr>
<tr>
<td>Device complication</td>
<td>596,062</td>
<td>121,036</td>
<td>20%</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>705,616</td>
<td>104,607</td>
<td>15%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>480,958</td>
<td>97,784</td>
<td>20%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>397,166</td>
<td>88,629</td>
<td>22%</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>520,901</td>
<td>85,932</td>
<td>16%</td>
</tr>
</tbody>
</table>

Source: AHRQ, Healthcare Cost and Utilization Project, April 2013.

While the conditions in the table above have a high number of 30-day readmissions, they do not necessarily represent the conditions with the highest readmission rate. Conditions that have the highest readmission rate are as follows.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Hospital Discharges</th>
<th>Number of 30-Day Readmissions</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickle cell anemia</td>
<td>87,326</td>
<td>27,837</td>
<td>32%</td>
</tr>
<tr>
<td>Gangrene</td>
<td>33,786</td>
<td>10,693</td>
<td>32%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>37,480</td>
<td>11,593</td>
<td>31%</td>
</tr>
<tr>
<td>Disease of white blood cells</td>
<td>54,861</td>
<td>16,771</td>
<td>31%</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>17,394</td>
<td>4,776</td>
<td>27%</td>
</tr>
<tr>
<td>Systemic lupus/connective tissue disorders</td>
<td>18,850</td>
<td>5,123</td>
<td>27%</td>
</tr>
<tr>
<td>Mycoses</td>
<td>23,026</td>
<td>6,222</td>
<td>27%</td>
</tr>
<tr>
<td>HIV infection</td>
<td>34,958</td>
<td>9,230</td>
<td>26%</td>
</tr>
<tr>
<td>Mental health/substance abuse</td>
<td>60,417</td>
<td>15,695</td>
<td>26%</td>
</tr>
<tr>
<td>Peritonitis/intestinal abscess</td>
<td>25,219</td>
<td>6,315</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: AHRQ, Healthcare Cost and Utilization Project, April 2013.
More than three-fourths of hospitals were penalized in FY2015.

Hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions—not just those which resulted in readmissions. CMS began imposing penalties in FY2013 when the maximum penalty was 1% of the hospital’s base inpatient claims. This amount increased to 2% in FY2014 and will remain at 3% for FY2015 and subsequent years.

Some 78% of acute care hospitals (2,610) were assessed a penalty for FY2015, up from 66% the year before, due in part to the fact that the number of diagnoses monitored by CMS increased from three to five. The penalties assessed by CMS for FY2015 totaled approximately $428 million.

Hospitals caring for the neediest patients are most likely to incur a penalty.

The American Hospital Association recently conducted an analysis looking at how HRRP penalties varied by hospitals’ Disproportionate Patient Percentage (DPP). They concluded that hospitals with a high percentage of needy patients were not only much more likely to be penalized but also more likely to pay a higher penalty. Many are worried that these penalties will have unintended consequences on our nation’s teaching and safety-net hospitals. According to Steven Lipstein, president and CEO of BJC HealthCare in St. Louis, “[Because penalties fall disproportionately on] teaching and safety-net hospitals that care for disadvantaged patients, the Hospital Readmissions Reduction Program diverts money away from these hospitals and has the unintended consequence of worsening disparities between rich and poor” (AHA, 2015).
Hospitals are only one piece of the readmissions puzzle.

Recent analyses of hospital readmission rates posted by CMS on its Hospital Compare website indicate that the variables that most directly impact hospital readmissions are actually things that are outside the control of an acute care hospital. A widely-quoted study on this topic concluded that some 58% of the variation in hospital readmission rates can be accounted for by the county in which the hospital is located (Herrin, 2014). In fact, county measures such as socioeconomic status (SES), availability of primary care physicians, and nursing home quality explain nearly half of this county-level variation. When hospital-level variables such as hospital ownership, teaching status, bed size, and safety-net status were added, very little additional variance was explained.

These findings cast some doubt on the design of the HRRP, and the study authors conclude, “That the majority of the unexplained variation in hospital readmission rates can be attributed to counties rather than hospitals suggests that narrowly targeting hospitals with reimbursement adjustments and other incentives can lead at best to marginal improvements in readmission rates; the more effective policies might be directed at the wider system of care, including primary care and nursing home quality” (Herrin, 2014).

Hospitals can make improvements to reduce readmission rates.

Studies have shown that there are a number of processes that occur during the inpatient stay and in the early stages of post-discharge care that do impact readmission rates. Most hospitals are focusing their improvement efforts in these areas. The following table identifies some of these common process breakdowns.

<table>
<thead>
<tr>
<th>Common Process Breakdowns Associated with Potentially Preventable Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Gaps During Stay</strong></td>
</tr>
<tr>
<td>• Patient safety (especially medication and infection-related)</td>
</tr>
<tr>
<td>• Medication reconciliation not completed or inaccurate at admission or discharge</td>
</tr>
<tr>
<td><strong>Patient Factors</strong></td>
</tr>
<tr>
<td>• Lack of understanding of post-discharge plan of care</td>
</tr>
<tr>
<td>• Lack of understanding of what to watch for (warning signs), how to respond</td>
</tr>
<tr>
<td>• Non-compliance with any or all elements of post-discharge self-management and care</td>
</tr>
<tr>
<td><strong>Lack of Timely Post-Discharge Care</strong></td>
</tr>
<tr>
<td>• No appointments available or no relationship with PCP</td>
</tr>
<tr>
<td>• Logistics, such as no transportation</td>
</tr>
<tr>
<td>• Primary care physician unaware of hospitalization</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td>• Delayed, lacking or inadequate communication with next provider of direct care</td>
</tr>
<tr>
<td>• Lacking or inadequate communication with home care provider (including family)</td>
</tr>
</tbody>
</table>


Skilled Nursing Facilities (SNFs) are next.

Research has shown that the density and quality of SNFs in a county has a significant impact on hospital readmission rates (Herrin, 2014). Roughly 40% of hospital inpatients are discharged to some type of post acute facility, with roughly half of these discharges going to a SNF (AHRQ, 2009). Recent analyses indicate that 23.5% of Medicare beneficiaries who are discharged from a hospital to a SNF are readmitted to the hospital within 30 days, at a cost to Medicare of $4.34 billion (Mor et al., 2010). Mor comments that, “These rehospitalizations have been shown to be frequent, costly, and often preventable,” (Mor et al., 2010).
To address the substantial impact that SNFs have on hospital readmissions, CMS is planning to roll out a readmissions reduction program targeting skilled nursing facilities. The Protecting Access to Medical Care Act of 2014 includes a value-based purchasing (VBP) program for SNFs. Beginning in October 2018, CMS plans to institute financial incentives that link Medicare payment rates to performance standards in order to hold SNFs accountable for their readmission rates. It is expected that the VBP program will provide a catalyst for SNFs to address long time staff turnover and development challenges and to seek better data sharing between hospitals, SNFs, and primary care providers.

End of Life Planning has a tremendous impact on readmissions.

Use of hospice and palliative care services during the last phase of life can greatly reduce the need for hospitalization during this time period. Research has shown that use of these end-of-life services can reduce hospitalizations in the subsequent 30 – 180 days by 40-50% and allow patients to spend on average 10 fewer days in the hospital during their last two years of life than those without such planning (Kowalski, 2015).

The challenge is that most patients who are discharged from the hospital fail to receive the education and planning necessary for end-of-life care. Studies have shown that there are low rates of referral for hospice and palliative care, although these services can lead to a substantially higher quality of life for the patients who receive this care. In 2012, an estimated 1.54 million patients received hospice services, up from 1.25 million in 2008 (NHPCO, 2013).

There are concerns about the design of the HRRP.

Now that we have some history with the HRRP, we can analyze and learn from the results. First and foremost, we are seeing a drop in hospital readmission rates. Medicare all-cause readmission rates had stubbornly held around the 19% mark from 2007 to 2011, before dipping to 18.5% in 2012 and then to 17.5% through the end of 2013 (McKinney, 2014). However, there may also be some unintended consequences or areas of concern associated with the program:

- As noted earlier, hospitals with a higher percentage of low income patients are paying the highest penalties—often millions of dollars. By paying these penalties, is there a negative impact on their ability to deliver quality patient care?
- CMS penalties are assessed on all Medicare admissions, not just those that result in unnecessary readmissions, so that there is an imbalance between the total penalty amounts and the actual cost to CMS for the readmissions. Is CMS taking financial advantage of hospitals in an effort to reduce their own costs?

- Some perceive the hospital readmission rate to be a proxy for hospital quality; however, is this valid given that only about 40% of readmissions may be preventable by measures that hospitals directly control?
- Hospital readmissions may account for a significant proportion of the hospital contribution margin. Will the HRRP be effective for hospitals where the penalty is less than the marginal profit from these readmissions or less than the incremental cost of reducing readmissions?
- Under a fee-for-quality model, hospitals are incentivized to reduce admissions. However, fewer admissions can cause the hospital readmission rate to be higher. Do these conflicting objectives cause a dilemma for hospital executives?
With so many priorities for 2015, how important is reducing readmissions? How much effort do you see focused in this area?

I think hospitals take this initiative very seriously. It is definitely on their radar screens because of the high financial penalties that are involved. We are aggressively looking at ALL 30-day readmissions, not just the five diagnoses targeted by CMS. We are routinely watching our rates as part of our on-going physician quality monitoring.

What is your opinion of the Hospital Readmission Reduction Program (HRRP)?

I’ve been in practice for more than 30 years, and this is actually something that is overdue. We shouldn’t be rewarded for poor quality or unsafe care. But there are a lot of gray areas in the program too. For example, we shouldn’t be penalized for unavoidable readmissions or when the readmission is unrelated to the initial inpatient visit.

What are the key steps hospitals should take to reduce readmissions?

What do you see working?

The key is to take multiple steps to prevent a readmission. We need to be focused on plans for discharge as soon as the patient is admitted. You can’t wait until the day before. You need to try to have everything in place before the patient leaves the hospital.

There also needs to be good communication all around. Physicians, nurses, case managers, social workers, therapists, family members, and the patient all need to work together during the patient stay to address all of the patient’s post-discharge needs. We also need to be in contact with the pharmacy department to make sure they can support any unusual medications that the patient might need upon discharge.

Finally, we try to ensure that there is prompt discharge follow-up with the primary care physician and other post-acute organizations that might be involved. We know there is a strong relationship with how soon the patient sees their primary care physician and readmission rates.

What impact is the HRRP having on hospitalists?

We have to be heavily involved in efforts to reduce readmissions. We can’t just sit back and let others work around us. Some 70% of our patients are followed by a hospitalist, with 15% - 20% of these being cardiology patients, so we are covering a lot of patients that may be at high risk of readmission.

It doesn’t look good on our records when one of our patients is readmitted. It’s embarrassing and inherently wrong to have patients be readmitted because they couldn’t get the necessary medicine or the appropriate follow-up care.
What Is a Corporate Integrity Agreement?

A CIA, according to the Department of Health and Human Services (HHS) Office of Inspector General (OIG), is a “document that outlines the obligations an entity agrees to as part of a civil settlement with the Federal government. A healthcare entity agrees to the CIA obligations in exchange for the OIG’s agreement that it won’t seek to exclude the entity from participation in Medicare, Medicaid, or other Federal health care programs.” CIAs have many common features, but each one contains facts specific to the individual case.

Even the most seasoned compliance officer cringes upon hearing or reading the words Corporate Integrity Agreement (CIA), because that officer knows that a CIA will be disruptive to the organization. A CIA requires significant attention, data collection, legal defense, negotiation, new systems, new policies, oversight, and enforcement, possibly for many years. Healthcare facilities of all types, including hospitals, pharmaceutical manufacturers, long-term care, physician groups, and more have all seen increases in CIAs. Yet, these organizations often struggle with what to do if a recipient of one.

MEETING THE TRAINING REQUIREMENTS OF CORPORATE INTEGRITY AGREEMENTS

Debbie Newsholme  CCEP, CHC
Director, Content Development
HCCS—a HealthStream Company
How Does an Organization Receive a Corporate Integrity Agreement?

CIAs can have numerous causes. For example, an entity or provider may have a pattern in its billing processes that raises a red flag with an auditor, either internal or external. Issues are also identified through data mining or data analytics. Auditors look for claims or other types of billing that fall outside the norm (i.e., “outliers”). An occasional anomaly could be explained as a simple error, but continued trends may signal fraudulent activity. If abnormalities are found in the billing or claims submission processes, investigations must be called in to detect the cause and fix the broken steps immediately. Other types of problems (e.g., Anti-Kickback or Stark violations) may be reported to the OIG or the Centers for Medicare and Medicaid Services (CMS) through the appropriate self-disclosure protocol if they are discovered internally. Reporting violations that are discovered internally can be an advantage in negotiating whether or not a CIA is appropriate. Whether a violation is discovered internally or externally, the result of an OIG investigation may be a CIA.

Healthcare organizations or providers can also end up with a CIA through Qui Tam, or whistleblower lawsuits. The whistleblower (who may be someone within the organization, a former employee, or a patient) files suit on behalf of the United States government under the False Claims Act. Under the False Claims Act, the attorney general or Department of Justice attorney investigates the allegations and determines whether the U.S. government will join the lawsuit. If fraud is uncovered, the OIG may enter into a CIA with the organization.

“Quality of Care” CIAs occur when a False Claims Act settlement resolves allegations of fraud that emanate from the quality of patient care. These CIAs usually require providers to engage an independent monitor, who evaluates the provider’s ability to discover, assess, and improve patient care.

Often, staff must complete initial CIA training within 90 to 120 days after the CIA is signed. This does not leave much time for organizations to select or produce training to meet the requirements.

Training – A CIA Mandatory Requirement

CIA settlement agreements include money that must be paid to the government, as well as training. The CIA contains a section that defines which group(s) within the organization must be trained and the types of training that must occur. Often, staff must complete initial CIA training within 90 to 120 days after the CIA is signed. This does not leave much time for organizations to select or produce training to meet the requirements.

The organization must identify the individuals, groups, or departments requiring training and the types and length of training required. “General” training typically requires two to three hours and applies to all members of the workforce, including board members and volunteers. “Specific” training may also be required for individuals within a business unit or function where the issues occurred. It may target individuals performing functions related to billing and coding, documentation of services, patient access to care or care-management activities, patient care, etc. The total time requirement for learners to spend in training is typically four to six hours annually.

Case Studies

The following case studies are two actual examples of healthcare organizations that used HCCS online courses to meet the training requirements of their CIAs. Should any violations of regulations be uncovered at your organization, the information here can be instructive in regard to the type of training that organizations should be proactively providing to their staff to meet compliance requirements, reduce liability, and mitigate damages.
CASE STUDY #1

Background:
This health system, composed of a general medical and surgical hospital, was faced with a CIA that was the result of an upcoding and Qui Tam lawsuit. It was accused of admitting patients who could have been treated in other settings.

Training involved as part of the CIA:
General Training for All Staff
(1 hour annually) included:
• CIA requirements overview
• Compliance program overview (code of conduct, policies, and procedures)

Specific Training for Admission and Claims Preparation Staff (1 hour annually) included:
• Federal healthcare program requirements concerning medical necessity of inpatient admission/length of stay
• Federal healthcare program requirements regarding the accurate coding and submission of claims
• Policies, procedures, and other requirements applicable to the documentation of medical records
• Personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate
• Applicable reimbursement statutes, regulations, and program requirements and directives
• The legal sanctions for violations of the Federal healthcare program requirements
• Examples of proper and improper claims submission practices

Board Member Training (1 hour annually) included:
• General training
• Board member responsibilities
• Corporate governance

HCCS training courses used to fulfill requirements for this CIA:
Professional Compliance, Corporate Compliance with Code of Conduct and CIA customizations, HIPAA Compliance, and False Claims Act and Employee Protections
CASE STUDY #2

Background:
This medical center was faced with a CIA involving a False Claims Act and Qui Tam lawsuit related to changing admission status of patients.

Training involved as part of the CIA:
General Training for All Staff (2 hours annually) included:
- CIA requirements overview
- Compliance program overview (code of conduct, policies, and procedures)

Specific Training for Claims Preparation Staff (3 hours annually) included:
- Billing and reimbursement training
- Federal healthcare program requirements regarding accurate coding and submission of claims
- Policies, procedures, and other Federal healthcare program requirements applicable to documentation of records
- Personal obligations to comply with all applicable Federal healthcare program requirements
- Applicable reimbursement statutes, regulations, and program requirements and directives
- Legal sanctions for violations of the Federal healthcare program requirements
- Proper and improper claims submission practices

Board Member Training (2 hours annually) included:
- General training
- Board member responsibilities
- Corporate governance

HCCS training courses used to fulfill requirements for this CIA:
Professional Compliance, Corporate Compliance with Code of Conduct and CIA customizations, Nursing Facility Compliance, and Documentation for Quality Care

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.

About Health Care Compliance Strategies (HCCS) – a HealthStream Company
The best protection against receiving a Corporate Integrity Agreement is to have an effective compliance program in place. Health Care Compliance Strategies (HCCS) has worked with many organizations, large and small, to provide training to support an effective compliance program and to help meet the training requirements of Corporate Integrity Agreements. This depth and breadth of experience makes HCCS uniquely qualified to act as a partner and consultant to any organization or provider facing a CIA. The overall goal of Health Care Compliance Strategies, through our courseware, is to change organizational behavior.

Learn more at hccs.com.
In our feature article this quarter, HealthStream takes a look at the practice of resuscitation. Many of us have perceptions from popular television shows that resuscitation is almost always effective; however, the truth is that we are really not as good at resuscitating as you might think. Currently, we are only able to revive about 19% of those with in-hospital cardiac arrest.

New research from the American Heart Association and others is showing that more frequent CPR training is needed in our healthcare organizations and that real-time feedback using voice-assisted manikins can greatly improve students’ skills at resuscitation. Even long-time CPR instructors have been shocked to discover that they do not pass tests incorporating the more sophisticated tools that can be leveraged to measure performance.

Marnie Kelly MBA
Vice President, Healthcare Workforce Solutions
HealthStream
Most hospitals in the U.S. use traditional classroom instruction to train employees in CPR, with only about 30% making the switch to the American Heart Association’s HeartCode® program that includes online instruction coupled with practice using Voice-Assisted Manikins. Those who have made the upgrade have seen improvements in CPR quality, code response rates, and employee confidence and competence. The American Heart Association’s Resuscitation Quality Improvement (RQI) program is the next generation of this training. By breaking the learning that is typically required every two years into short quarterly modules, learners are proving to have higher retention and patient survival rates.

Here we look at the latest available research on resuscitation and talk with Resuscitation Scientist, Associate Professor, and Emergency Medicine Specialist Dr. Michael Kurz about his experiences at the University of Alabama-Birmingham.

**Cardiac Arrest is a Leading Cause of Death**

Internationally, more than 135 million cardiovascular deaths occur each year, and this number is increasing. Across the globe, for every 100,000 people, cardiac arrests range from 20-140 people. Unfortunately, survival rates are low and range from 2 – 11% (Meaney, et al., 2013).

In the U.S., survival rates are slightly higher but still less than 15%. Cardiac arrest is a leading killer in the U.S. “claiming more lives than colorectal cancer, breast cancer, prostate cancer, influenza, pneumonia, auto accidents, HIV, firearms, and house fires combined” (Meaney et. al., p. 418).

Even in hospital settings, survival rates are surprisingly low and typically range from 15 – 20%. Interestingly, there is a difference in survival rate based on the time of day that the arrest occurs. For example, there is a 20% survival rate if the arrest occurs between 7 AM and 11 PM. However, the survival rate drops to 15% if the arrest occurs between 11 PM and 7 AM. Meany et al. also reported that there is a survival difference based on the interaction between location in the hospital and time of the arrest. There is only a 9% survival rate if the arrest occurs in an unmonitored setting at night. The rate increases to about 37% if the arrest occurs during the day in the operating room or a post-anesthesia unit. Clearly, there is an opportunity in the U.S. healthcare system to reduce variation and improve overall survival rates from cardiac arrest.

**High-Quality CPR is a Helpful Defense**

Prompt and effective CPR intervention has shown to be helpful in improving survival from cardiac arrest. The amount of time between the cardiac event and the performance of high-quality CPR is related to survival (Kardong-Edgren, Oermann, Odom-Maryon, and Ha, 2010). The depth and rate of compressions used during CPR has also been shown to impact the outcome of cardiac arrest. "When rescuers compress at a depth of <38 mm, survival-to-discharge rates after out-of-hospital arrest are reduced by 30%. Similarly, when rescuers compress too slowly, return of spontaneous circulation (ROSC) after in-hospital cardiac arrest falls from 72% to 42%.” In the 2010 Consensus Statement of the American Hospital Association, Dr. Peter A. Meaney, MD, MPH, of Children’s Hospital of Philadelphia, and colleagues conclude, “Poor-quality CPR should be considered a preventable harm” (Meaney et al., p. 418).

**High-Quality CPR is Challenging**

High-quality CPR is difficult. CPR quality is poor even among trained medical professionals. Smith, Gilcreast, and Pierce (2008) as reported by Kardong-Edgren, Oermann, and Odom-Maryon (2012) found that "only 63% of nurses (44% were working in critical care or emergency departments/operating rooms) could pass BLS at 3 months after course completion and only 58% at 12 months” (p. 9).

Kardong-Edgren et al. (2012) conducted a year-long study using 10 nursing schools and 606 nursing students. The goal of the study was to determine the number of nursing students that were unable to perform CPR compressions and ventilations correctly. “After CPR course completion, 57 (10%) of the 606 participants were unable to perform correctly either
of these two skills (compressions and ventilation). For participants who completed monthly practice, the number of participants unable to perform either of these two skills decreased from 25 (8%) to 3 (1%) compared with the no practice group, which decreased from 32 (11%) to 17 (6%)” (p. 13).

Why Is High-Quality CPR So Difficult to Master and Retain?

- Most CPR training programs are infrequent, which results in quick deterioration of skills that are taught (Meaney et al., 2013).
- Instructor-led CPR training may not be effective for learning basic CPR skills or retention of these skills (Kardong-Edgren et al., 2010).
- Students often fail to develop adequate skills during CPR training—especially in the areas of compression rate, compression depth, and ventilation rate. (Kardong-Edgren et al., 2012)
- Providers are unable to retain CPR skills without practice (Germann, Kardong-Edgren, and Odom-Maryon, 2011)

Some Solutions to the Problem

An AHA expert panel found that CQI (continuous quality improvement) programs have proven to be more effective in enhancing the quality of CPR when compared to training programs that are only taken once every two years. However, the CQI approach has not been used widely in healthcare organizations. Thus, the overall quality of CPR remains low although there are opportunities to improve through the use of CQI programs (Meaney et al., 2013). The panel recommended continuous training programs that are characterized by frequent and short training sessions. This continuous model enhances retention of skills learned. One of their final recommendations was to “implement strategies for continuous improvement in CPR quality and incorporate education, maintenance of competency, and review of arrest characteristics that include available CPR quality metrics” (Meaney et al., 426).

A study by Kardong-Edgren et al. (2010), conducted prior to the AHA panel’s summary, addressed several of their recommendations. The purpose of their study was to compare a computer-based CPR course that included VAM (voice assisted manikin) feedback (HeartCode® BLS) with an instructor-led course (IL) in terms of compression rate and depth, correct hand placement, ventilation frequency and volume on 604 nursing students across 10 nursing schools. While they found no difference between the two methodologies on compression rate, “students who had the HeartCode course and practiced CPR on VAMs had significantly more compressions with adequate depth (p < 0.0001) and ventilations with adequate volume (p < 0.0001) than did students trained by instructors (p. 1023).”

A few other studies found similar results.

- Niles, Sutton, Donoghue, and Kalsi (2009) found that refresher training with a portable manikin/defibrillator system resulted in significantly shorter times for proficiency in CPR.
- Mpotosa, De Weverb, and Cleymanse (2013) found that short self-learning CPR sessions with a training video and computerized voice feedback manikin training was very successful in learning effective CPR.
- Diez, Rodriguez-Diez, and Nagore (2013) in a study of 2nd year medical students found that VAM participants (as opposed to IL) performed more accurately in terms of hand position and produced better compression rates. Cost reduction and time saving for instructors was also mentioned.

In conclusion, the research is clearly indicating that more frequent and more automated training can improve resuscitation skills. These findings are corroborated by the following article from Resuscitation Scientist Dr. Michael Kurz.
1) Our failure rate is high

For many of us, our perceptions of resuscitation have been heavily influenced by what we have seen on TV. We have the notion that the patient almost always survives; however, the reality is very different. Survival rates from in-hospital cardiac arrests (IHCA) are actually quite low—averaging 19% for adults and 35% for children (Griffin, 2013).

We know that these survival rates could be much higher if healthcare professionals consistently provided life support according to the specifications of the American Heart Association (AHA). A survey recently conducted by Ipsos, a global survey-based research company, to assess adherence to the AHA guidelines. More than 1,000 self-reported “CPR experts” were surveyed, with the typical respondent having performed CPR for more than 13 years, been in their current position for about seven years, and performed CPR approximately 300 times in their career and 23 times in the past 12 months (O’Connor, 2010). The results showed that 75% of these individuals perceived their CPR skills to be quite high, and most said they were familiar with the AHA guidelines. Yet, only 26% reported that their performed rate, depth, and ratios were fully compliant with the AHA’s ECC and CPR guidelines. Although TV makes it look easy, it is really quite hard to do CPR well for two minutes.

Target CPR Performance Metrics

1. Chest Compression FRACTION (CCF) >80%
2. Compression RATE of 100 to 120/minute
3. Compression DEPTH (Adult) >50mm
4. Full Chest Recoil (with ZERO leaning)
5. Avoid EXCESSIVE VENTILATION
   a. Minimal chest rise
   b. RATE, 12 breaths/minute

Source: American Heart Association, 2013

2) Current training methods are less than optimal

Today, healthcare professionals are trained in CPR every two years. Most employees take AHA’s Basic Life Support (BLS) course for Healthcare Providers, while those working in more intense environments, such as the Emergency Department and ICU, take the more in-depth Advanced Cardiovascular Life Support (ACLS) course. While some healthcare organizations have

Michael Kurz considers himself to be a “Resuscitation Scientist.” He began his training at the University of Virginia in Charlottesville, where he obtained his M.D. degree and an M.S. in Health Evaluation Sciences. Dr. Kurz did his Emergency Medicine Residency at the University of Chicago and his Emergency Cardiac Care Fellowship at the Virginia Commonwealth University Medical Center. Along the way, he has served as a paramedic and flight physician. Dr. Kurz is now Associate Professor of Emergency Medicine at the University of Alabama-Birmingham (UAB), where he is also one of five attendings for post-resuscitation service and focuses on improving resuscitation outcomes both inside and outside the hospital.

Although he is not yet 40 years of age, Dr. Kurz has received numerous research awards. He has 25 articles published in peer-reviewed journals, with 6 more pending, and is a reviewer for a variety of academic publications including Circulation, Annals of Emergency Medicine, and Resuscitation. He is a volunteer for the American Heart Association (AHA) and an author of the 2015 AHA Guidelines for CPR and ECC which will be released in October. [He neither holds an official role with nor receives any financial support from the AHA.]
upgraded to the use of online courses with computer-enabled manikins that provide immediate feedback, a majority of employees are still training using classroom instruction and manikins that are not computer-enabled to provide feedback. Recent research has illuminated two basic problems with this historical approach.

First, live instructors in a classroom setting are not able to provide the full range of feedback necessary to ensure high-quality CPR. For example, a live teacher can coach on the RATE of compressions, necessary, but they can neither assess the true DEPTH of the compression nor the RECOIL time between compressions. Second, research is showing that CPR competence rapidly erodes and is not sustained throughout the two years in between certifications. The following graph shows a peak in competency at the time of the 2-year training, but steady erosion from that date until the next training course. Clearly, the current two-year course model does not lend itself to the necessary maintenance of competency.

3) There is a better way

Research is showing that targeted, frequent training sessions of only 6-8 minutes can dramatically improve CPR skills competency. A recent study examined the effects of quarterly, 6-minute training sessions on the CPR performance of nursing students. One group of nursing students practiced their CPR skills after 3, 6, 9, and 12 months, compared to a control group that had no practice sessions. The study found that the group who practiced either maintained or improved their skills over time while the control group showed significant deterioration of skills (Oermann et al., 2011).

In response to a preponderance of data corroborating these findings, the AHA 2010 Guidelines on CPR and ECC recommend the use of more frequent training for improved CPR proficiency.

Healthcare providers in the Resuscitation Quality Improvement (RQI) Program are required to participate in quarterly 6-8 minute CPR skill simulations using a new mobile RQI station. In addition, students are assigned brief online modules focusing on cognitive content that must be completed each year. The computerized manikin stations provide real-time audio-visual feedback during the skills assessment to ensure proficiency on all CPR metrics (including compression depth and recoil), allowing students to make real-time adjustments in their delivery of CPR. This approach also aligns with the optimal way adults learn with frequent, short, intense bursts of training.

4) Pilots show clinical and financial success

Pilots of the new RQI Program have been underway since 2012, with participation from sites like The Ohio State University and Kaiser Permanente San Diego. Pilots have shown an improved maintenance of competence among staff, and survey participants have indicated a high level of satisfaction with the new program.

The business case for RQI has also been confirmed. We are finding that the RQI Program can provide as much as a 6x ROI compared to traditional classroom instruction. It is cheaper, more effective, and safer than older methods. Proficiency and competency are improved even though RQI requires significantly less time per person for training.
5) Staff are stunned to learn that they may have not been delivering high quality CPR

The AHA, Laerdal Medical, and HealthStream have collaborated to bring a turnkey solution to RQI for healthcare organizations. The University of Alabama-Birmingham began using this program in early 2015. Initially, people were attracted to the new toy, and we found that early adoption was high. My staff liked the real time feedback. Many were stunned because they had passed their 2-year training but were unable to deliver high quality CPR for more than 30 seconds using the new mobile station. Staff also liked that they could receive training in only 6-8 minutes during their regular shift rather than having to attend time-consuming classes. Staff have been holding competitions to see who has the best metrics on the shift, and this has led to more confident, competent providers.

The biggest challenge is gathering the courage to accept disruptive innovation. It was a difficult decision to move away from our personnel-intensive classroom process until we saw our own pilot results. To me, the RQI Program just makes a lot of sense. I think it is going to be widely adopted in the healthcare industry over the next 2–3 years.

Effects of monthly practice on nursing students’ CPR psychomotor skill performance


In a study of 606 nursing students from the University of North Carolina at Chapel Hill and Washington State University, participants were given an initial HeartCode® BLS training course and then randomly assigned to one of two groups. The experimental group received 6-minute CPR training at 3, 6, 9, and 12 month intervals. The control group received no additional training. Overall, the CPR skills of the experimental group were significantly better than those of the control group.

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.
Around half of all Americans have a chronic health condition, and 25% have more than one chronic condition. Clearly, these patients need more medical attention than the typical person. However, sometimes patients may experience problems getting the care they need—obstacles of many kinds may prevent them from being successfully treated in today’s complicated healthcare environment.

A key concern is the transition of the patient from the hospital to the home or post-acute setting. In much of life, transitions are often trouble spots. When people or organizations make exchanges, it can be challenging. Unfortunately, it is no different for hospitals, patients, and caregivers. Transition issues may result in unnecessary suffering, error, poor follow-up, and ultimately another trip to the emergency room. All of this works to increase medical costs (Desjardins, 2015).

According to CMS, about 20% of Medicare discharges from the hospital are readmitted within 30 days at a cost of billions of dollars per year. Due to wide variability by state and even by hospital, we know that many of these readmissions could be avoided. As a result, many are calling for improvements in discharge and care transitions. Complicating the picture is this—care transitions are a point of vulnerability and danger. This is especially true for the elderly and those with difficult and complex conditions and situations (Rooney & Arbaje, 2013).

This article will focus on the issues that relate to transition of care, possible solutions to these issues, and a snapshot of how we are doing.

Dr. Randy Carden Ed.D
Senior Research Consultant,
HealthStream

Points of Vulnerability that Can Lead to Unnecessary Readmissions
Why Are There Issues with Transitions of Care? Where Are We Vulnerable?

What makes these transition points so difficult? Why are the “hand-offs” prone to issues? Several points of vulnerability are listed below.

Challenges with the Elderly

The elderly experience more difficult transitions than younger patients due to multiple health issues, possible cognitive slippage, dependency, and multiple medications. It is estimated that almost two-thirds of readmissions from nursing homes could be avoided (Vognar & Mujahid, 2015).

Brief Medical Encounters

Our current model tends to be typified by brief medical encounters where we focus on treating disease states rather than the person (Rooney & Arbaje, 2013).

Education

Patient education and specifically poor health and healthcare literacy are related to transition issues and increased probability of readmission (Rooney & Arbaje, 2013).

Failures in follow-up, support and coordination of care

Patients often have issues with remembering post-discharge instructions and following discharge plans (Rubin et al., 2014). This can have profound implications, because most of the time the patient bears much of the responsibility for his or her care.

Medication Errors

Medication errors were found to be present in about half of all discharged patients. These errors were more common in patients with poor health literacy and lower numeracy or the ability to use and understand numbers (Mixon et al., 2014).

Fragmentation of Care

Historically, hospitals and post-acute providers have not been well-connected. There has been a failure to account for challenges that may occur once patients are sent back into the community (Rooney & Arbaje, 2013).

Social Challenges

Lack of social support can be a major problem. Basic things like transportation, food preparation, following dietary restrictions, and taking medications properly often prove to be overwhelming.

The Joint Commission is advocating for better collaboration and coordination around transitions to reduce readmissions.

Possible Solutions to Transition of Care Issues and Problems

What is to be done to help remedy the situation? The following culture change ideas have been suggested as ways to improve the transition from hospital to other providers or the community.

Enhanced Communication

One of the most effective interventions would be more effective communication. A recent study by Record et al. (2015) supports the proposal for improved communication. They found that a post-discharge physician-initiated telephone call was related to higher scores on the 3-item Care Transitions Measure (CTM-3), which assesses patient perception related to readiness for the transition from hospital to home. Higher scores predict reduced likelihood of a visit to the emergency department within 30 days of discharge.

Patient as Consumer

A recommended culture change is the change in orientation from patient to consumer. Recent positions by the Joint Commission and CMS may help reinforce this change in our thinking. The Joint Commission is advocating for better collaboration and coordination around transitions to reduce readmissions. Furthermore, the relatively recent advent of the CAHPS surveys is playing an important role in establishing the patient as consumer. CAHPS surveys allow patients as consumers to evaluate care based on standardized items that are comparable nationally. These new initiatives associate reimbursement with outcomes and are receiving profound attention (Rooney & Arbaje, 2013).
New Transition of Care Models

Another aspect of culture change has been the development of new transition of care models. Several care transition models have been developed over the last 15 years. Although somewhat different in their approach, they do share some commonalities. They tend to focus on risk factors, patient education, effective discharge planning beginning at admission, and post-discharge follow-up. Social needs are given priority. Inter-disciplinary rounding, involvement of community partners in new protocol development, enhanced communication, and the development of effective information technology are commonly found in these models (Rooney & Arbaje, 2013).

Solving Sender/Receiver Issues

In a recent publication, the Joint Commission (2013) summarized the findings of their evaluation of several healthcare organizations, including hospitals, nursing homes, rehabilitation centers, home health, and behavioral health and ambulatory clinics. In all cases they found that these organizations were striving to address sender/receiver issues. There was also a consensus that the following factors contributed to effective transitions—strong leadership, positive relationships between sender and receiver, interdisciplinary involvement, effective communication, medication reconciliation, education, assigned accountability, and electronic health records (when not used as the sole mode of communication).

Collaboration

The Joint Commission found that the single most important “take away” from their analysis was the need for collaboration. They found that more collaboration was needed on a variety of fronts—between providers and patients, providers and families, providers and post acute services, etc.

Consideration of Personal and Social Factors

Personal beliefs, culture, and socioeconomic factors should be considered as ways to break through barriers to care. Failing to do so tends to place blame on the patient for issues that occur in not following the treatment plan (Rooney & Arbaje, 2013).

How are We Currently Doing with Transition of Care: A Snapshot

In 2013, CMS added three transition of care questions to the HCAHPS inpatient survey. They are

- “During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.”
- “When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.”
- “When I left the hospital, I clearly understood the purpose for taking each of my medications.”

The 2014 and 2015 data from HealthStream’s HCAHPS inpatient database was accessed in order to evaluate whether or not the scores have changed over that period. The results are shown below and indicate that scores on each item and the aggregate of the three items have increased over the last year. This increase is encouraging. Perhaps the efforts spoken of in this article are producing a positive effect.

<table>
<thead>
<tr>
<th>Question</th>
<th>2015 N</th>
<th>2015 Top Box</th>
<th>2015 Mean</th>
<th>2014 N</th>
<th>2014 Top Box</th>
<th>2014 Mean</th>
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<tr>
<td>Taking Preferences into Account</td>
<td>401,906</td>
<td>47.080%</td>
<td>3.402</td>
<td>195,798</td>
<td>43.580%</td>
<td>3.364</td>
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<td>Good Understanding of Responsibilities</td>
<td>409,440</td>
<td>56.774%</td>
<td>3.517</td>
<td>200,405</td>
<td>54.811%</td>
<td>3.497</td>
</tr>
<tr>
<td>Understood Purpose of Medications</td>
<td>331,395</td>
<td>61.111%</td>
<td>3.582</td>
<td>160,293</td>
<td>59.374%</td>
<td>3.564</td>
</tr>
</tbody>
</table>

Aggregate Transition of Care                   | 1,142,741| 54.622% | 3.495 | 556,496 | 52.174% | 3.469 |

2014 & 2015 Transition of Care HCAHPS Item Scores
Standard Expectations, Local Flexibility Key to Favorable Transition of Care Ratings at Catholic Health Initiatives

“While our patients give us favorable ratings in the transition of care aspects of care, we have the opportunity to reduce variation across our markets and further improve the patient experience by introducing standard practices such as risk stratification using the LACE tool, and applying RED interventions with our population at high risk for readmission,” says Susan Allmond, Director of Strategic Planning and Alignment, at Catholic Health Initiatives (CHI).

Consumers have choices of where they seek and who delivers their care. “Delivering quality care across the continuum is a key component in our care delivery philosophy. At CHI we focus on successful transitions for meeting the needs of local communities and populations we serve. We accomplish this collaboratively among providers, participants of our clinically integrated networks and the consumers we serve,” reports Dee Miller, CHI Director, Acute-Post Care Management.

CHI is partnering with post-acute providers in communities. According to Miller, “Designing a continuing care network with providers having aligned goals of quality and education has had a powerful impact for our consumers. First, getting alignment across the continuum, and second gaining consumer involvement when designing these relationships. We have involved established Patient and Family Councils for assistance in understanding the consumer point of view.”

“Designing a continuing care network with providers having aligned goals of quality and education has had a powerful impact for our consumers.”

CHI has found that standardizing their processes has changed the perspectives of all providers. Allmond notes, “This doesn’t mean delivering a cookie cutter program; it means standard expectations for the discharge process in all markets while allowing for local flexibility in how those standards are delivered.”

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.

References
This issue of the PX Advisor is focused on compliance.

In healthcare, we have come to associate the term with all of the rules and requirements around providing safe patient care and safe workplaces, avoiding conflicts of interest, and even following proper billing practices. But the dictionary defines compliance as the act of conforming, acquiescing, or yielding. In many ways complying with all of the rules around CAHPS programs feels a lot like throwing our hands up in surrender. CMS expects HealthStream and healthcare facilities to fully comply with all of the official protocols for each CAHPS survey. This is especially complicated because the rules are not consistent between programs. For example, for the ACO and PQRS CAHPS surveys we are not allowed to add any supplemental questions to the survey. In contrast, HCAHPS does not place any restriction on the number of additional questions that hospitals can add to the survey. Home Health CAHPS allows a proxy to be surveyed if the patient is unable to participate. However, for HCAHPS we are only allowed to interview the patient. In-Center Hemodialysis CAHPS requires that we make up to 10 telephone attempts to interview the patient, while HCAHPS only requires 5 attempts.
While I have the privilege and responsibility of serving as HealthStream’s CAHPS subject-matter expert, the fact is that CAHPS requires the attention of our entire company. Everyone at HealthStream from our Chief Executive Officer Bobby Frist to our CAHPS interviewers are focused on ensuring that we not only follow the rules, but that your results are accurate. One of CMS’s goals for all of the CAHPS surveys is to provide consumers with information that will help them decide where to get care. Coupled with CMS’s plans to link facilities’ actual performance on several additional CAHPS surveys to reimbursement, we have a compelling argument that accuracy and compliance with all of the protocols, no matter how complex, are vital to your success. That is why at HealthStream all of our PX teams are focused on CAHPS every day.

But you also have a role in ensuring accuracy and compliance with each CAHPS program’s unique requirements. For example, did you know that you are not allowed to show a copy of the HCAHPS survey to patients? Did you know that you cannot use HCAHPS-style questions when rounding on patients? Did you know you are not allowed to contact a patient who completed the Home Health CAHPS survey unless he or she gives permission? Did you know you are allowed to advertise your HCAHPS Star Ratings? These are just a few examples of the various requirements that facilities need to be aware of when they are participating in a CAHPS survey. In addition to this quarterly article, HealthStream has prepared Resource Guides and fact sheets to help you understand each survey’s unique requirements. And, any member of your HealthStream team is available to answer your questions.

In this quarter’s Re-CAHPS article, we have included an update on the new Outpatient & Ambulatory Surgery CAHPS and ED-CAHPS surveys, as well as a few additional updates. You will also be able to test your knowledge of CAHPS protocols. Are you a CAHPS master or novice, or somewhere in between?

CAHPS Compliance Check did you know…?
Whether you are involved in one or more CAHPS surveys, the amount of detail you need to know is astounding. Below are some facts that just may surprise you. Did you know…

| CAHPS for ACOs | CMS has added Stewardship of Patient Resources as one of the scored Survey Summary Measures to the CAHPS for ACOs Survey? ACOs will be scored on the question: Did you and anyone on your health care team talk about how much your prescription medicines cost? |
| CAHPS for PQRs | The anticipated data collection schedule for the 2015 survey is November 2015 to February 2016? Beneficiaries will be selected for the survey based on Medicare services received during the first three quarters of CY 2015. |
| CG-CAHPS | AHRQ has released significant changes to the 12-Month version of the CG-CAHPS Survey? Perhaps most noteworthy is the change in the survey reference period from “in the past 12 months” to “in the past 6 months.” This change aligns the voluntary surveys with the CMS-mandated CAHPS for ACOs and CAHPS for PQRS surveys. |
| HCAHPS | CMS does not prohibit hospitals from marketing their HCAHPS scores? However, CMS has said that hospitals should not market HCAHPS composites or calculations they have created themselves, or use the CMS name as an endorsement (e.g., “according to CMS,” “CMS rankings”). CMS says that “hospitals should follow ethical and professional judgment when using such information for marketing, advertising and public relations purposes.” |
**Home Health CAHPS**
Patients in Medicare managed care plans are eligible for HHCAHPS? CMS requires home health agencies to code the payer for each patient as either: 1) Medicare; 2) Medicaid; 3) Private Insurance; or 4) Other. Only patients flagged by the HHA as Medicare or Medicaid are eligible for the HHCAHPS survey. That means if you are coding patients in Medicare Advantage plans as ‘other’ or ‘private insurance’ they are being unnecessarily excluded from the HHCAHPS survey.

**Hospice CAHPS**
CMS says they will publicly report Hospice CAHPS Survey results when at least 12 months of data are available? However, the plans for public reporting have not been finalized. CMS states the earliest they would publicly report Hospice CAHPS and other hospice quality measures is FY 2017.

**ICH-CAHPS**
Starting in performance year 2018 the ICH-CAHPS survey moves from a reporting measure to a clinical measure? This means that eventually your facility’s performance on the ICH-CAHPS Survey will impact your ESRD QIP score and resulting payments from CMS.

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**CAHPS Across the PX Experience**

![CAHPS Across the PX Experience](image)

- **Hospital**
- **Ambulatory**
- **Post-Acute**
- **Medical Office**

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36 HealthStream PX Advisor
Outpatient & Ambulatory Surgery CAHPS (OAS-CAHPS)

Voluntary National Implementation begins in 2016
Last year, we would have predicted that ED-CAHPS would roll out before OAS-CAHPS, but CMS surprised us when they announced that facilities would be able to administer the survey on a voluntary basis starting in 2016. Similar to the roll-out of HCAHPS, this survey will start as a voluntary reporting program until CMS publishes the official mandate. Medicare-certified hospital-based outpatient surgery departments and ambulatory surgery centers will be able to participate. Adult patients undergoing both medically and non-medically necessary surgeries and procedures will be surveyed.

Because CMS is not yet requiring that facilities conduct the survey, you have a few options.

Option 1: Participate in the Voluntary National Implementation. With this option, HealthStream will field the full compliance survey using one of the approved methodologies and follow all of the official protocols. We will then submit your survey data to CMS for eventual public reporting. The advantage of this option is that you will be ready to go once the survey becomes required. You’ll understand the protocols and have worked with your staff to understand and respond to the survey data. The disadvantage is that this is a more costly option because you’ll be required to field the full survey using the official administration protocols.

Option 2: Field HealthStream’s OAS-CAHPS Interim Survey. We’ve taken the CMS survey and pared it down to include only the scored questions. Additionally, HealthStream has conducted our own pilot of the survey. That means you’ll have benchmarks for national comparisons. Other advantages of this option include that it is more cost effective, and it gives you the flexibility to add custom questions and even to use the eSurvey methodology before the survey becomes required.

HealthStream will support you regardless of how you decide to proceed. However, we strongly encourage you to consider one of the two options we have outlined. We do not recommend that you maintain the status quo with your current survey, or even not survey your outpatient surgery patients. Early adoption will allow you to prepare before the survey becomes required.

Outpatient & Ambulatory Surgery By The Numbers
According to CMS statistics, Medicare payments to ASCs have increased by 24%, from $2.9 billion in 2007 to $3.6 billion in 2012. Also, Medicare spending on outpatient services grew from $29 billion in 2006 to $46 billion in 2011 (Medicare Payment Advisory Commission’s 2014 Report to Congress on Medicare Payment Policy). The Ambulatory Surgery Center Association also notes an increased volume of ASCs and hospital-based outpatient surgery departments from approximately 14.5 million in 2005 to 17 million in 2010 (ASCA, 2011).

Considering the growing number of ASCs and the increasing Medicare expenditures, CMS says the implementation of the new OAS-CAHPS Survey will provide “much-needed statistically valid data from the patient perspective to inform quality improvement and comparative consumer information about specific facilities” (CMS, 2014).

ED-CAHPS
CMS is conducting a mode experiment on the new ED-CAHPS Survey in 2015, which is a necessary step prior to national implementation. The survey could become required possibly in 2016, but more realistically in 2017. Eventually, ED-CAHPS will be required for hospital emergency departments. Our assumption is that if a hospital is required to participate in HCAHPS and they have an emergency department, they will likely be required to field the ED-CAHPS survey. The survey will be fielded among patients discharged, as well as those who are admitted through the ED. How this will interact with HCAHPS is still to be determined.
HealthStream has prepared our customers for the new mandate by creating a transition survey. Our ED-CAHPS Transition Survey includes the scored questions from the CMS survey that have the highest correlations, and that cover all of the major topics. Similar to our recommendation for OAS-CAHPS, we recommend that you begin fielding our ED-CAHPS Transition Survey now. This will allow you to prepare in advance of the mandated survey.

**HCAHPS**

While CMS has not released any significant changes to the HCAHPS program this year, it is important to note that as this particular CAHPS program is maturing CMS is placing more emphasis on strict compliance with the protocols. Discrepancies that may have been overlooked previously are starting to get footnotes on the Hospital Compare website. During a recent training session, CMS encouraged vendors to work with HCAHPS customers to improve the quality of the patient lists that they submit. Specifically, CMS is closely examining those records to ensure that patient records are:

1. Submitted in time to initiate the first attempt within 42 days of discharge.
2. Age and DRG (or other means to determine Service Line) are populated for all patients. These are used for the Patient Mix adjustments.

CMS has always said that hospitals are responsible for providing complete, accurate, and valid patient files that include all of the information vendors need to administer the HCAHPS Survey. CMS uses several of the data elements that hospitals provide in their patient files to adjust the HCAHPS data prior to public reporting. Ultimately, the goal of the adjustments is to ensure that HCAHPS scores are fair and that hospitals are not rewarded or penalized for things that are outside of their control.

**In-Center Hemodialysis CAHPS**

CMS has released the tentative schedule for the 2015 Fall ICH-CAHPS Survey. For this third round of the survey, the sample will be based on visits between April 1 and June 30, 2015. Despite numerous issues with the patient sample from the CMS database for the 2015 Spring Survey, we do not expect the schedule to deviate significantly from the timeline specified.

CMS has not yet announced when public reporting of ICH-CAHPS Survey results will begin on the Dialysis Facility Compare website. However, we do know that a facility will be required to have submitted ICH-CAHPS Survey results from two survey periods before their data is publicly reported.

**Home Health CAHPS**

CMS has proposed to implement a Home Health Value-based Purchasing (HHVBP) model in selected states starting on January 1, 2016. If finalized, all Medicare-certified home health agencies (HHAs) in Arizona, Iowa, Florida, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington will be required to participate in the model. The HHVBP model being proposed will offer greater potential reward for high-performing HHAs, as well as greater potential downside risk for low-performing HHAs. The model will apply a reduction or increase of up to 8% of Medicare payments depending on the HHA’s performance on the selected quality measures, including the HHCAHPS Survey, relative to its peers. If implemented, 30% of fee-for-service Medicare payments will be tied to quality or value-based payments in the selected states by the end of 2016. That percentage will gradually increase to 90% by 2018.

In the proposed rule CMS says, “we expect that tying quality to payment through a system of value-based purchasing will improve the beneficiaries’ experience and outcomes. In turn, we expect payment adjustments that both reward improved quality and penalize poor performance will incentivize quality improvement and encourage efficiency, leading to a more sustainable payment system.”
What is Your CAHPS IQ?

1. Which CAHPS survey will start on a voluntary basis in 2016?
   A. Hospice CAHPS
   B. ED-CAHPS
   C. Outpatient & Ambulatory Surgery CAHPS

2. For FY 2015 Hospital Value-based Purchasing scoring, HCAHPS represents what percentage of a hospital’s Total Performance Score?
   A. 20%
   B. 25%
   C. 30%

3. For HCAHPS, hospitals are allowed to give inpatients a satisfaction survey during their hospital stay.
   A. True
   B. False

4. For which CAHPS programs are non-Medicare patients eligible to be surveyed?
   A. CAHPS for PQRS
   B. HCAHPS
   C. CAHPS for ACOs
   D. All of the above

5. For which CAHPS program(s) are we allowed to survey proxies (someone other than the patient)?
   A. Home Health CAHPS
   B. CAHPS for ACOs
   C. Hospice CAHPS
   D. HCAHPS
   E. A, B & C

6. For Hospice CAHPS, hospices are allowed to mail letters or postcards after the patient’s death to inform caregivers about the CAHPS Hospice Survey.
   A. True
   B. False

7. What is the minimum number of completed surveys per year that CMS requires for HCAHPS?
   A. 100
   B. 200
   C. 300

8. What percentage of a hospice’s annual payment update is at risk for failure to administer the Hospice CAHPS Survey?
   A. .5%
   B. 1%
   C. 2%

9. Which CAHPS program allows facilities to self-administer the survey?
   A. HCAHPS
   B. Home Health CAHPS
   C. Hospice CAHPS
   D. None of the above

10. What data points are used in the HCAHPS patient-mix adjustments that CMS applies prior to public reporting?
    A. Age
    B. Gender
    C. Service Line
    D. Language spoken at home
    E. All of the above
    F. A and C

CAHPS Knowledge Quiz Answers

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<th>Answer</th>
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</tr>
<tr>
<td>2.</td>
<td>C – 30%</td>
</tr>
<tr>
<td>3.</td>
<td>B – False</td>
</tr>
<tr>
<td>4.</td>
<td>B – HCAHPS</td>
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<tr>
<td>5.</td>
<td>E – A, B &amp; C</td>
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<tr>
<td>6.</td>
<td>B – False</td>
</tr>
<tr>
<td>7.</td>
<td>C – 300</td>
</tr>
<tr>
<td>8.</td>
<td>C – 2%</td>
</tr>
<tr>
<td>9.</td>
<td>A – HCAHPS</td>
</tr>
<tr>
<td>10.</td>
<td>E – All of the above</td>
</tr>
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</table>

Your CAHPS Skill Rating

9-10 correct answers. You are a CAHPS Master!
5-8 correct answers. Not bad!
0-4 correct answers. You are a CAHPS Novice, but HealthStream has your back!

Want to know more? Contact us about our CAHPS PX solutions, and join us in September for our quarterly Re-CAHPS webinar. Register online at: http://www.healthstream.com/resources/webinars
With so much negative press coming out daily about compliance and so many sweeping changes being enacted in the human resources realm, there is no better time to make sure that your organization is in order. Compliance in HR generally falls into the following buckets: payroll, benefits, risk & safety, hiring, employee relations, and terminations. Issues related to each of these buckets are in the press every day, including an outcry around nursing shortages (Robbins, 2015); increased union activity (Hoover, 2015); traveling nurses and temporary staffing hitting a 20-year high (Galewitz, 2015); federal task force focused on uncovering fraud in the healthcare industry (Caldwell, 2015); a recent report citing that 40 percent of hospitals fail on nursing workforce safe practices (The Leapfrog Group, 2014), and much more. With so much to think about, what do you tackle first?

It is highly recommended that every organization complete a compliance health check. This health check can uncover any areas of weakness that may need to be improved upon and provide a baseline of where your organization is today. It can be conducted through several different methods—i.e., an internally created assessment or checklist, a mock survey, or an audit conducted with third party assistance. Whichever method you choose, this is an important step. Many organizations believe they understand the largest issues and areas of risk but are surprised when a check-up uncovers additional areas of focus that are even more important.
What you do with your results is what makes the difference. Christi Blanchard, RN, MS, PHR, Director of HR Analytics & Effectiveness at Wentworth-Douglass Health System, currently serves as chairperson of her organization’s HR Compliance Committee. This Committee was formed after results from a mock Joint Commission survey conducted almost 10 years ago identified important gaps and areas of improvement for HR compliance. “Wentworth-Douglass recognizes the vital role that HR plays in keeping the organization compliant and fully supported the creation of a cross functional Committee to bring clinical and HR together,” says Blanchard. Many compliance issues affect human resources, so it is important to invite HR to the table early for any discussions. Blanchard’s Compliance Committee meets for 90 minutes every other month to monitor prior issues, evaluate new issues that arise, and ensure that everything is documented and resolved in a timely manner.

It is important to prioritize your compliance improvement list in order of risk to minimize your exposure and sustain improvement. Two areas Wentworth-Douglass has addressed this year include an audit verifying that all employees have completed department-specific orientation and also that employees have signed off on their most recent job description. Both of these areas needed additional focus to increase compliance rates. Blanchard says that having such a successful committee in place for almost a decade has resulted in repeatedly receiving 100% Joint Commission survey results.

Lastly, it is important to keep the work going and that human resources remain an active participant in compliance discussions 365 days a year. It is no secret that healthcare is a constantly changing environment, and much of this is directly attributable to increasingly numerous and complex compliance regulations. Surveys and compliance assessments must be done regularly and improvements be done iteratively as new or changing regulations dictate.

TIPS FOR MANAGING HR RISK:

• Form a committee
Make sure that your committee is cross-functional. Compliance is part of everyone’s job, and everyone has a stake.

• Use internal audits and repeat on a regular basis
It is important to review action items and check problems before they become a serious and costly mistake.

• Create a project plan
Make sure that you prioritize and take action on your survey and assessment results. Document the actions taken to resolve any issues and successfully close any outstanding concerns before they come up with a hefty fine attached or worse cause harm to your patients.

• Documentation, Documentation, Documentation
This is important for all areas of HR compliance. Collect data and build cases for each issue that needs to be tackled. Get any important hallway conversations documented. Make sure that all actions, corrective or otherwise, are documented.

• Communication and creation of a safe compliance culture
Many issues in HR can be prevented with proper communication and by making everyone feel that it is their duty to keep an eye out for potential compliance issues. “It is important that people feel safe and that you have a culture where it is okay to speak up,” says Blanchard.

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.

References


Conflicts of Interest…An Evolving Notion

With the publication in 2014 of the CMS “Open Payments” database, which makes all payments to physicians from Pharmaceutical and Medical Device companies available in a searchable database, conflicts of interest has become a hot-button issue in healthcare.

In fact, those individuals in the healthcare community who are closely involved with compliance and ethics have watched the evolution of the topic over the last four decades from dismissive denial (“How dare you imply I could be influenced by payments from industry!”) to a clear recognition of the potentially insidious influence of industry payments to physicians and hospitals.

Hospitals and other healthcare organizations are compelled to manage their conflicts of interest for several reasons. Their fiduciary responsibility motivates them to ensure that purchasing decisions are not being made based on which vendors (of pacemakers and cardiac stents, for example) give the best gifts. If they are non-profit organizations, the IRS dictates that they annually complete the Form 990, which requires that steps are taken to manage conflicts of, and between, board members and key employees. If federal funds are received for research or clinical trials, the National Institutes of Health requires the identification and reporting of “Financial Conflicts of Interest” of research investigators.
The relationship between medicine and industry is and has always been important. It is appropriate, in many cases, for industry to fund research and medical education, and to provide free or subsidized drugs for the indigent. It is essential, however, that such funding does not influence the outcomes of research, the techniques being taught, the specific treatments received by patients or the drugs being commonly prescribed. Such potential conflicts of interest must be managed.

The management of conflicts of interest involves annual (or more frequent) surveys to solicit financial disclosures from employees, physicians, and researchers. These disclosures are then evaluated by appropriate reviewers to determine whether real or perceived conflicts of interest exist. When such conflicts are identified, management plans are devised to mitigate or eliminate the conflicts. Historically this entire process was conducted on paper.

In 2009, several Academic Medical Center (AMC) clients approached HCCS, now a HealthStream company, to automate the cumbersome, manual, and labor intensive process of managing conflicts of interest. They complained that they were spending all of their time and effort chasing paper and not enough managing conflicts. With the AMCs contributing their intellectual capital, HCCS agreed. The result of their combined effort, the cloud-based COI-SMART, was introduced in 2010.

**COI-SMART**

COI-SMART is an acronym for “Conflict of Interest System for Management and Realtime Tracking.” It is an online relational database tool, which allows clients to develop flexible COI surveys, targeting questions to people based on their roles within the institution. Financial and other disclosures are forwarded to assigned reviewers, who are then able to take various actions, communicate with respondents, escalate issues to higher level review, and develop management plans. Those plans can then be sent to appropriate supervisors for approval, and/or to the respondents to accept them.

Since its introduction, COI-SMART has been shown to be the most comprehensive and widely used system in the country for management of conflicts of interest.

All of these steps are automatically documented and maintained in the history for each questionnaire. Data is completely searchable, for example, to identify anyone within a hospital or medical center who has disclosed a relationship with “Pfizer.” The system provides comprehensive reporting and dashboards for management of the COI process.

Since its introduction, COI-SMART has been shown to be the most comprehensive and widely used system in the country for management of conflicts of interest. It is currently in use in over 500 locations around the country, including large healthcare networks from coast to coast. Systems like Providence Health and Services (Seattle), the Henry Ford Health System (Detroit), Allina Health (Minneapolis), and Novant Health (Winston Salem, North Carolina) have all experienced how COI-SMART can improve the management of conflicts of interest while reducing labor costs, meeting all government requirements for reporting, and giving senior management the tools to effectively and efficiently oversee the COI process.

Please send any comments to PXAdvisor@healthstream.com or tweet us @HealthStream.
Patients have a tremendous influence on their own health outcomes. Their level of compliance in taking medications, adhering to treatment regimens, and making healthy lifestyle choices can directly influence not only their longevity but their quality of life along the way. Here are some startling statistics (Assistmed, 2015).

- Approximately 125,000 people with treatable ailments die each year in the U.S. because they do not take their medication properly.
- About 50% of the 2 billion prescriptions filled each year are not taken correctly.
- Up to 21% of patients never fill their original prescriptions.
- 60% of all patients cannot identify their own medications.
- As many as 40% of patients do not adhere to their treatment regimens.

- 23% of nursing home admissions are due to patient noncompliance (380,000 patients).
- 10% of hospital admissions are due to patient noncompliance (3.5 million patients).
- 30-50% of all patients ignore or otherwise compromise instructions concerning their medication.
- 12-20% of patients take other people’s medicines.

Clearly, there is an opportunity to improve patient outcomes by positively influencing patient compliance. Baptist Health Care’s Cynde Gamache is all about improving patient outcomes. In this article, she answers key questions about patient compliance, based on more than 30 years of personal experience as a Registered Nurse, Chief Nursing Officer, and healthcare system executive.
1) How big an issue is patient compliance for most hospitals?
Patient compliance is an important concern for inpatient and outpatient providers across the continuum of care. It is a systemic challenge that impacts patients and their loved ones and has financial repercussions for both patients and providers. Every U.S. health system is aware of the impact of patient compliance on the health of our communities, workforce, families, unnecessary hospitalizations, Emergency Department visits, and further resource utilization. Our challenge is to improve patient compliance through personalized patient care, in order to mitigate these downstream consequences.

2) What are the biggest challenges you face with patient compliance?
As providers we must understand individual patients and what drives them. All too often we may get frustrated with patients we see as “non-compliant.” Look at the person in his or her entirety, taking into account social, environmental, and medication details. We have to understand their perceptions of what is important in order to work with them to increase compliance.

Creating Behavioral Awareness
It is imperative that we ensure patients are aware that compliance is necessary (or that they are not complying with recommended treatment). Patients will not pay attention to compliance with their treatment regime if they do not understand they suffer from a chronic illness and that there are implications if they are non-compliant.

It is quite difficult to modify behaviors that are problematic—especially those influenced by social settings. Our roles as care providers often involve asking patients to make major lifestyle changes and potentially to give up a behavior seen as enjoyable (e.g., giving up smoking or eating healthy). There is tension inherent to this purpose that can put our teams in the position of influencing new behaviors that may be viewed as unfavorable by the patient.

Medication Compliance
Compliance with medication is a major issue; challenges may include getting patients to fill their prescriptions, to take their medicines (and as prescribed), and to continue to take medicines after symptoms subside.

Our roles as care providers often involve asking patients to make major lifestyle changes and potentially to give up a behavior seen as enjoyable.

3) In which clinical areas is it most difficult to get patients to comply with their treatment regimens?
Compliance is not necessarily tied to demographics, diagnosis, or illness. I have seen challenges across the board. Some areas in which you see them are more common: for example, diet, lifestyle, smoking, diabetes, and obesity. Compliance is also challenging from patient to patient due to lack of health insurance, high deductible consumer plans, and education. Again, it comes back to determining what patients want to accomplish.

4) Are there certain types of patients or certain demographics who are less likely to be compliant with their treatment?
We need to get beyond categories and focus on personalized patient care. Developing trust between patient and the provider is critical. If we can empathize and understand what patients are thinking, they will begin to trust us.

It’s important to see the situation through the patient lens, and inquiry is a critical skill needed by our teams to uncover individual patient needs. How do they perceive us? Do they understand? We must be vigilant to eliminate jargon and not assume or believe a patient should understand. Uncovering the real problem is imperative. For instance, the real problem may not be diabetes management—it could be the patient does not like the shot.

5) What are some of the techniques you have learned or innovated to help increase patient compliance?
We focus in the following areas:
TIME. We need to spend time to understand what patients think. Appreciative inquiry is critical, and we work to explore their values. It is vital to acknowledge if we are not on the same wavelength.
**CONTROL.** Everyone benefits when we find ways to give patients some form of control. We also need to re-emphasize with the loss of autonomy when someone becomes a patient or has to manage a chronic condition. Our goals as providers may be different from the patient. We are most successful when we understand the patient’s paradigm and values.

**LISTENING.** Acknowledge that patients do know their own bodies. We trust our patients, listen to them, and understand the meaning underneath what is said.

**GOALS.** Work on small goals that patients can control. Ask them a question—If you could change one small behavior, what would it be? Identify a single step towards the goal and demonstrate success, celebrating it. Be aware that resistance is normal and not just a person being obstinate. What drives that? Is it fear or the social environment with which they work? We cannot take it personally as a provider. We try everything in our power to make them better. We have not failed. We have to allow patients to be responsible for their own progress.

**FOLLOW UP.** Connect with the patient through a discharge call or email. That check-up will further develop the provider-patient relationship and help create accountability, as well as allow them to share a concern that what was prescribed cannot be done.

6) **How do patient compliance issues differ in the inpatient vs. outpatient environments?**

At Baptist Health Care, our 2020 nursing strategy includes getting nursing caregivers to start dialoguing and opening up lines of communication across our continuum of care. First and foremost, as leaders we need to make communication and information flow more supportively across the care continuum. We also need to make certain we give caregivers in the primary care office, inpatient, and outpatient settings the same, beneficial access to all patient information.

7) **What advice/coaching do you give doctors, nurses, and other caregivers to try to improve patient cooperation?**

Communication channels are critical. We cannot be too rushed and hurried. As we are talking we need to use open-ended questions and ensure patient understanding.

I have not only seen this professionally, but in my own family where there can be a reluctance to ask healthcare professionals important questions and get clarifications. Sometimes patients feel they did not have the time or would be judged as unintelligent. Emphasize that we are there with them and not judging them if initially they do not understand.

Use reflective listening. Summarize your understanding and confirm it with the patient. It is easy for us to say “xyz” and for the patient to say “xyz”—but are they really the same? Have the patient demonstrate his or her understanding.

Lastly, motivation to change must come from the patient.

8) **Are there any other comments you would like to make?**

Look at patients in their total environment—family, culture, etc. These details factor into whether patients can be compliant. If the patient needs to stop smoking and lives with smokers, this only sets up the patient to fail. Get the family to quit. Look deeper into the situation and consider it in the entirety. These environmental factors significantly influence the ability to comply. Find small successes. How have patients approached previous health issues? Are there keys to unlock what was done previously that can be applied to the current situation?

Work closely with the individual. Whether we agree or not, the patient has the ability to accept or decline the advice and care we give. Quality may be more important than quantity to understanding the ramifications of every behavior.

The **BEST** way to change behavior and drive compliance is through the use of stories. It helps us to insert ourselves into the situation and understand. Using stories helps us make the connection or connect with another human being about the same challenge—i.e., someone needing to quit smoking can learn about a smoker who has successfully quit.
Research in the past twenty years has shown a strong relationship between a providers’ empathy and a patient’s response to treatment recommendations. One empirical study showed improved compliance and reduced complications in diabetic patients who felt their physicians demonstrated empathy (Del Canale et al., 2012). RELATE, our model for communication, differentiates itself from other models by emphasizing our first step, Reassure. We believe that it is best to begin by making a personal connection, by demonstrating empathy to a patient’s current condition, and by making a proactive effort to reduce fear so a patient and their family are “able” to hear the importance of a recommended treatment, course of care, or medication. This is of paramount importance in improving compliance in the healthcare setting. The most important benefit of adopting the RELATE model for communication is it is a natural way to begin to build the trust and confidence of the patients and families we need to influence.

Reassure- Be present in body and mind. Sit down. Put patient at ease and make personal connection. Manage up your own experience in such situations.

Explain- In simple language narrate your plan. Advising patient and family not only what you are recommending but why you are recommending medication. Explaining how a medication works and the expected results of taking medications is critical. Explain what will happen if patient does not take meds as prescribed. Link to patient safety and explain the importance of complying with the treatment regimen. Share concerns you have about specific non-compliance.

Listen- Demonstrate active listening by using simple terms, such as “Let me make sure I heard you …

Even if patient/family does not offer questions, stop and ask “what questions can I help you with? What might be hard for you in taking this medication? Or; What concerns or fears can I help you address? What are the environmental, social, behavioral and lifestyle factors?

Answer- Validate questions with “Great question or Glad you asked about that”… and then restate information and ask the patient/family to repeat the instructions to validate clear understanding provide guidance.

Take Action- Build a plan with the patient; find milestones to celebrate. Ask patient to demonstrate back.

Express Appreciation- Thank the patient for taking this step. Build mutual agreement. Tell patient how you will be following up.

References

References
RESUSCITATION CHALLENGES:
A Discussion with HealthStream Experts
Marnie Kelly and Rachel Askew

Please define your positions and tell us what you like best about your roles at HealthStream.

KELLY: As Vice President of Healthcare Workforce Solutions, I oversee the products within the Resuscitation portfolio, working with the American Heart Association (AHA), Laerdal Medical, and the American Academy of Pediatrics (AAP) to bring their products to HealthStream’s customers. The most fulfilling part of my role is hearing back from our customers about the tremendous successes they’ve achieved with our products—whether saving money or improving the flexibility of training options for busy nurses and physicians. The best outcome is when healthcare providers have the confidence to perform the highest quality CPR and as a result, they have saved more patient lives.

ASKEW: As Senior Product Manager, I interface with the more than 25 people dedicated to supporting HeartCode customers and work very closely with both Laerdal and the American Heart Association to discuss feedback and ongoing product improvement. What I love about my job is that I have the ability to truly impact patient care.
What challenges do healthcare organizations struggle with in implementing strong resuscitation training programs for their employees?

**KELLY:** The biggest challenge our customers face is reluctance to change current CPR training processes, which haven’t fundamentally changed in decades. It can be hard for healthcare providers to accept that high quality CPR is challenging and physically demanding. Over time, most learners appreciate the increased flexibility and higher level of competence that result from taking HealthStream’s courses.

**ASKEW:** The biggest challenge I see is inconsistency in training. There are great instructors and there are not so great instructors, but even the great ones cannot truly determine that a learner is administering high quality CPR. Given all of the skills required to provide high quality CPR, it seems unlikely that any human could precisely measure learner performance. How can anyone ensure that a learner is compressing at least 2 inches and staying within the narrow compression rate window, while ensuring complete recoil? I’d like to see all organizations taking steps to implement tools and resources to objectively measure CPR quality.

How is HealthStream able to help address those challenges?

**KELLY:** First, HealthStream helps customers to understand the research that supports our resuscitation products, underscoring the need to provide a higher level of competency in CPR, with the ultimate goal of improving patient outcomes after a cardiac arrest. In addition, HealthStream provides hands-on training to our customer administrators, providing them with all the tools they need to launch the products initially and sustain a successful program over time.

**ASKEW:** HealthStream offers American Heart Association Courses HeartCode & RQI. These courses provide standardized and objective ACLS, BLS, & PALS (HeartCode Only) training. Both include a cognitive portion and skills components with a Voice Assisted Manikin (VAM). The cognitive portion uses eSimulation technology and provides a series of patient cases that the learner must navigate while applying the algorithms for ACLS, BLS or PALS according to the American Heart Association Guidelines.

RQI is the AHA’s newest course offering and it was developed based on scientific findings regarding knowledge retention and decay over time. Essentially, they found that after 3 months, learners had not retained their skills and their skills continued to decline over time. As a result, the AHA decided to take a scalpel to the HeartCode courses and dissect them into smaller doses that would be delivered at a higher frequency. By completing skills quarterly instead of every two years, not only does retention increase, but skill recall and knowledge improves over time.

HealthStream joined forces with the AHA & Laerdal to develop proprietary software that facilitates the delivery of the RQI program and other Maintenance of Competency offerings. When learners complete their quarterly skills, their expiration date automatically pushes out by 3 months from the previous expiration date. The program also offers an eCard to simplify the card processing component.
What role do you typically see HR play when it comes to implementing resuscitation training programs and driving improved resuscitation outcomes?

**KELLY:** Our customers usually have policies requiring clinicians to have a valid AHA card to provide patient care. In this setting, the HR department is often primarily concerned with tracking compliance rates to ensure that all clinicians have the appropriate unexpired AHA card. HealthStream’s platform is ideally suited to this purpose, providing administrators with reporting tools to easily and accurately determine which employees are out of compliance with the organization’s requirements.

**ASKEW:** You can walk into most hospitals and find reams of paper and cabinets stuffed with copies of AHA cards and class rosters. HealthStream allows HR departments to eliminate paper records, make online assignments, and run reports to see learner progress and delinquencies, as well as run one simple report showing staff expiration dates. HR departments and Educators alike love these programs because of the easy automation and information available to support both day-to-day operations and AHA or Joint Commission audits. In some organizations, their policies state that if you can’t pass these courses, you cannot work. HR departments also like that participants in HeartCode & RQI are more confident and competent, and better able to provide high quality CPR when it counts.

How have you seen customers improve their resuscitation rates by using the HeartCode Program through HealthStream?

**KELLY:** We have had some customers report an increase in their resuscitation rate after using HeartCode. Gathering and reporting publicly on this data can be a challenge for many organizations—our customers are often able to share data related to improved employee confidence in their CPR skills, improved compliance rates, and decreased training costs. All of these are important metrics that may be more attainable for customers to collect and share.

**ASKEW:** Here’s what some HeartCode customers have shared with us:

- “I had a small group of students in our hospital system that were in need of BLS training. I assigned them the HeartCode BLS program. A week later they came to me thanking me for the HeartCode experience. They had a patient code on their unit the very next day after completing Part 2 with the VAMs, and they stated they felt more confident and prepared than in previous codes having gone through instructor-led courses that seemed to just “push them through” to renew their card.” - Aaron Clevenger, OhioHealth
- “A fairly new RN had just taken HeartCode BLS and the next night someone collapsed in front of him. He was able to perform the step of CPR and get the person off to the ED.” - Rita Goodman, John Muir Health
- “The precision required to pass has been an eye-opener for staff who thought they were doing BLS correctly for years.”
What insights have you gained recently from customers who successfully implemented HeartCode?

**Kelly:** The key to any successful implementation is having a strong champion at the customer organization who believes in the product and is empowered to overcome internal barriers to its adoption. HealthStream is available to assist the customer champion with all the tools and advice we have gathered over many years of working with similar healthcare organizations.

**Askew:** HeartCode has been in use by HealthStream customers since 2006. During that time period, 2M people have completed the cognitive online portion and 750K of those went on to complete the Voice Assisted Manikin skills practice and testing successfully. During this time we have learned a lot about how to improve CPR training successfully, including:

- Anticipate the pushback you will receive and establish policies and procedures to address them. Ensure that leadership will support you in the policies you develop.
- Make a big splash when rolling out the program. Everyone impacted should know exactly what you are doing and why you are doing it.
- Maintain focus on the patient. Patients deserve quality CPR and if you aren’t providing quality CPR, you are harming your patient.

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**About Marnie Kelly and Rachel Askew**

**Marnie Kelly** has overseen the resuscitation and simulation product portfolio since 2006. As part of HealthStream’s leadership team, Marnie is also a member of the Innovation and Growth committee, which is committed to initiatives that support HealthStream’s goal of bringing innovative solutions to healthcare customers.

Prior to working at HealthStream, Marnie worked at AIM Healthcare, assisting healthcare payers in the identification and recovery of overpayments.

Marnie attended Vanderbilt University’s Owen Graduate School of Management in Nashville, TN, earning an MBA in 2003 with an emphasis in marketing. Marnie also earned a BA from the University of Western Ontario in London, Canada and a post-graduate diploma in International Business from Sheridan College in 1999.

**Rachel Askew** is currently the Senior Product Manager for HealthStream’s Resuscitation portfolio and loves working for a company where she finally feels that she is truly making an impact on patient care.

Rachel earned her MBA from Owen Graduate School of Management at Vanderbilt University where she concentrated in HealthCare and Strategy. She also earned a BS in Marketing and a BA in International Business with a focus in French from the University of Tennessee in Knoxville, TN.

Rachel has twelve years of healthcare experience spanning Marketing, Operations, and Strategy and has worked for companies ranging from Health Insurance to Healthcare Providers and Systems to Healthcare Consultancies.
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