

ACADEMY FOR EXCELLENCE IN HEALTHCARE

IMPACT ASSESSMENT PAPER

Bridge Builders at Society of Cardiovascular Patient Care and Community Health Systems

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Bridge Builders

Accreditation provider and health system collaborate for improved cardiac care

Transforming cardiovascular care and improving heart health is the mission of the American College of Cardiology (ACC) and its accrediting body, the Society of Cardiovascular Patient Care (SCPC). As a nonprofit institute within the ACC, the SCPC helps healthcare systems operationalize processes of care and ensure consistent use of current evidence-based guidelines across the continuum of care. Guidelines as well as focused updates are released as new evidence comes to light. Healthcare providers usually seek reaccreditation as they approach the anniversary date of their previous accreditation in order to continue offering the highest level of expertise when dealing with cardiovascular patients.

SCPC offers Atrial Fibrillation (AF), Heart Failure (HF), Cardiac Cath Lab (CCL), Free Standing ED Cardiac Care (FSED), and Chest Pain Center (CPC) accreditation services. Elizabeth Stokes, SCPC Accreditation Conformance Research Manager, has helped a number of hospitals within Community Health Systems (CHS) navigate through the accreditation process: reviewing documents, validating metrics, and identifying problems or needs for more accreditation information. CHS is an operator of 159 mostly rural and suburban acute-care hospitals in 22 states. Stokes says she would frequently hear from hospitals that had completed their accreditation process, and fielded questions such as, “What do we do now?”

Stokes along with CHS executive sponsors began to discuss a structure by which SCPC could review provider metrics *after* accreditation to know where they are meeting expectations for their next accreditation, as well as regularly communicate and deliver guideline recommendations throughout the term of the accreditation. This exchange heightened a growing awareness within SCPC that there was a three-year gap in active order-set advancement. Order sets are standardized guidelines for a specific diagnosis or type of care that have been developed by physicians based on medical literature for evidence-based standards. Order sets serve as a healthcare provider’s objective of best medicine.

Society of Cardiovascular Patient Care

The Society of Cardiovascular Patient Care (SCPC), an Institute of the American College of Cardiology (ACC), is a nonprofit organization dedicated to improving the care and outcomes of patients worldwide with suspected acute coronary syndrome, heart failure, and atrial fibrillation through innovative cross-disciplinary processes: accreditation services, registry services-ACC, quality initiatives, and education. The SCPC accreditation program provides hospitals with the tools necessary to improve and transform their cardiovascular care by ensuring that systemic quality-of-care measures are met by hospitals and that the requisite protocols, processes, and systems are put in place.

Community Health Systems

Community Health Systems (CHS) is one of the nation’s leading operators of general acute care hospitals. The organization’s affiliates own, operate, or lease 159 hospitals in 22 states, with approximately 27,000 licensed beds and more than 123,000 employees, as of Aug. 9, 2016.

“Community Health Systems” is a registered trade name of CHSPSC, LLC.

Most organizations with which SCPC works are at the “top of their game when they achieve accreditation, but then historically fall off,” says Donna Hunn, Accreditation Clinical Manager for SCPC. Hunn oversees all SCPC service lines and communicates with customers about guideline recommendations and components when they start their accreditation journey. “[Guidelines] that come out, anything that changes, anything that happens often are not addressed until the next three-year mark when they are about to start all of their initiatives for re-accreditation.”

Often a coordinator and a small team within a hospital work to fulfill the requirements for accreditation, submit their paperwork, manage an SCPC site review, and then disband, adds Hunn. “They went off and worked on other stuff until it was time to do it again.” It was also common that once a site was accredited, the SCPC field managers assisting and reviewing the sites moved on to other assignments.

CHS has a team that works with its hospitals on all types of order sets, updating and maintaining order-set content in a common library. Updates typically occurred every three years, unless the order-set team was notified that guidelines had changed, says Brandon Almand, former Evidence-Based Medicine Content Integration Specialist for CHS. That department within CHS’ Franklin, Tennessee, office would periodically look for updated guidelines and better content, but changes were often not incorporated until a scheduled update.

SCPC leadership saw the value in partnering with the health system — its largest client — to develop a program to build a “bridge” from one accreditation cycle to the next. This project, says Hunn, could set the stage for an improved approach by SCPC with facilities, “to not just be one and done, but rather have a mechanism to stay engaged with them throughout their term of accreditation.”

Stokes is building a department to provide a watchful and supportive eye to SCPC customers, helping them to sustain or improve practices compared to their previous accreditation. She and others from SCPC and CHS looked to the Academy for Excellence in Healthcare (AEH) at The Ohio State University for help in getting the initiative — named the “Bridge Builders” project — off the ground.

Reviewing the Problem at AEH

During a one-week AEH training program in September 2015, the SCPC/CHS team learned about and improved their understanding of lean tools and techniques that could help them evaluate and address continuity re-accreditation for all participating hospitals, not only those affiliated with CHS. The team returned for follow-up training in February 2016, at which time they reported their initial improvement project findings.

Bridge Builders Improvement Team

Community Health Systems:

- Carol Scott, Director of Cardiovascular Services
- Brandon Almand, former Evidence-Based Medicine Content Integration Specialist

Society of Cardiovascular Patient Care:

- Donna Hunn, Accreditation Clinical Manager
- Keri Morris, ACS Service Line Specialist
- Elizabeth Stokes, Accreditation Conformance Research Manager

Stokes says the Academy presented an opportunity where the SCPC/CHS team “could all get together in one location, and really talk about what was going on.”

“We talk all the time to our hospitals about doing process improvement and actually drilling down and figuring out what’s wrong and fixing it,” says Hunn. “But we did not have any real internal mechanism to be able to do that ourselves... Certainly for me, everything that I learned there was new. It was just a great opportunity for us.”

The team’s initial problem statement going into AEH focused on better coordinating the impact of new guidelines, from the American College of Cardiology/American Heart Association (ACC/AHA) with the development of order sets at hospitals gearing up for accreditation. But since guidelines are updated by ACC (to a great extent driven by the publication and acceptance of new evidence-based standards) and order sets are largely hospital-driven (and rarely hospital-system-driven), the team concluded that it was an unsolvable issue.

“We were going to save the world, and we recognized that the scope was a little big,” adds Hunn. “The [AEH] faculty really helped us to narrow our focus to something that was a little bit more measurable and achievable.” The team instead began to focus on ways that SCPC could assist hospitals with guidelines and metrics after their accreditation.

The joint team examined the success rates for all hospitals with Chest Pain Center (CPC) accreditation, which is an operational model for the care of an acute coronary syndrome (ACS) patient. The accreditation is designed as a process improvement tool to help facilities integrate successful practices and the newest paradigms into their cardiac care processes. The CPC accreditation offers a consistent approach to risk stratification of ACS patients based on guideline-driven medical therapy (GDMT) recommendations from ACC/AHA peer-published research and best practices and, thus, is an opportunity to improve quality outcomes.

Stokes describes the CPC accreditation as a “three-year cardiovascular strategic plan.” Hunn says the rigorous accreditation process is not merely a “certificate on a wall,” but helps hospitals achieve increased use of evidence-based guideline recommendations, increased Emergency Department (ED) volume, increased efficiencies, increased throughput, decreased length-of-stay, improved metrics such as door-to-balloon time, etc. “Some hospitals improve more in different areas than others. Some may already be at one metric, and then the accreditation process is used to help them with other metrics.”

“From a hospital standpoint it is based on the latest guidelines, it is evidence-based,” says Carol Scott, Director of Cardiac Services for CHS. “It does show areas of opportunity to identify and follow the latest guidelines or areas... I think accreditation also does a beautiful job of bringing together departments within your hospital system — your ED, your cardiology, your EMS system, your lab system, your quality department, your hospital administration. It’s a lot of different teams within a hospital working on the accreditation process. And not only is it just within the hospital, but there are criteria that require a hospital to go out into the community, the community of hospital employees and also the community

where they live. That is a huge benefit. You are able to show your community that you are invested in providing the best cardiac care possible for them.”

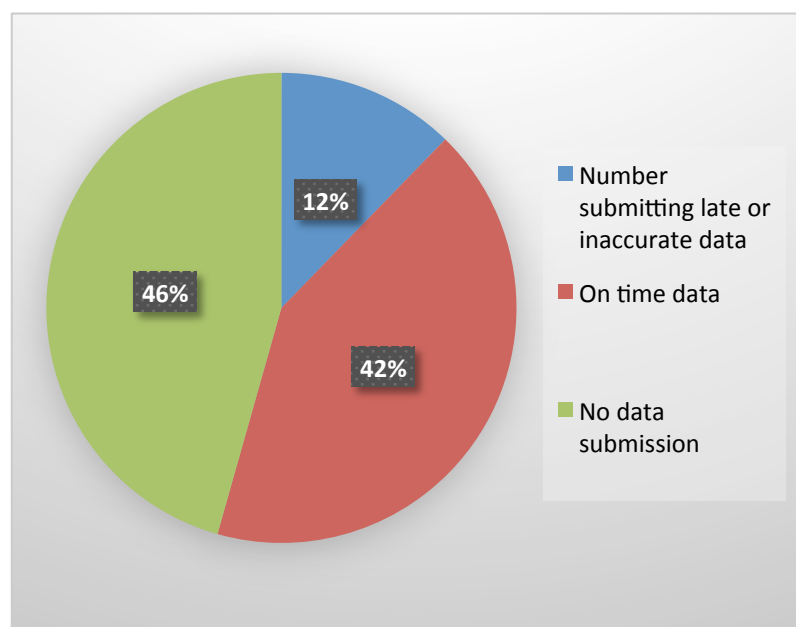
When examining all CPC accreditations, the SCPC/CHS team found that 96 percent of hospitals seeking a Cycle IV CPC accreditation achieved it. But when the team examined the remaining 4 percent that were not recommended for accreditation and which had to be remediated over six months, 95 percent of those hospitals had been accredited previously. “CHS was willing to work with us,” says Stokes, “and as a healthcare system across 22 states, they are a reflection of how hospitals in suburban and rural areas operate.”

The improvement team also found that 46 percent of all accredited hospitals had not submitted data in the interim, between one cycle and the next, and 12 percent submitted data that was late or inaccurate (see *Healthcare System Data Submission Findings*). Even among those that had submitted data, many metrics were getting worse while patient volumes were increasing, which could potentially be affecting quality of care. For example, another healthcare system reported that 86 percent of cardiovascular patients received an ECG within 10 minutes from August-December 2014, vs. 75 percent from January-July 2015.

The lack of follow-up interaction by accredited hospitals was surprising to both SCPC and CHS staff on the improvement team. For example, only 59 hospitals of 703 submitted metrics to SCPC during the three-year period in which they held the accreditation; less than

1 percent contacted the SCPC “Ask the Expert” support line; and less than 8 percent attended a webinar designed to support guideline dissemination as well as best practice standards for those working through their Cycle IV accreditation. The improvement team believed that many hospitals worked hard to gather substantial data required for the previous accreditation as they established a three-year roadmap for their CPC programs, but the momentum for keeping current was rarely sustained for several reasons, in particular personnel who led hospital accreditation teams who needed to return to other responsibilities once it was complete.

Healthcare System Data Submission Findings



Source: SCPC and CHS

“As I began to collect measures, data, and information and report it back to our executives, it was more and more shocking that it was not brand-new facilities that were not passing accreditation,” recalls Stokes. “Previously accredited hospitals were falling short. And the shock was, ‘Well, how can that be? I mean, you’ve already done this once.’ So much of what is in our tool are things they had seen before.” The 279 CPC guidelines to which hospitals are accredited are grouped into 90 categories; hospitals were not missing on one item or one group, they were missing as many as 20 groups. “Huge categories of things they just didn’t have.”

The improvement team’s problem statement became, “After accreditation, hospitals reduce or stop conformance with Guideline Driven Medical Therapy (GDMT) as well as accreditation standards.”

Reasons behind the Accreditation Gap

The team contacted hospitals and took a 5-Whys approach to uncover the root causes for why providers floundered in subsequent CPC accreditation efforts. They found that many realized that their CPC data, if and when collected, was declining. Some hospitals did not know how to address their deficits and often relied on old guidelines data from cardiovascular registries for assistance. Many also cited staff turnover (i.e., the person responsible for the initial accreditation had moved on) as an excuse for the lack of follow-up and interaction with SCPC. For example, with a new leader in place (e.g., chest-pain coordinator), accreditation became a difficult, anxiety-filled process.

“In reality, the coordinators who are responsible for the chest pain accreditation have other responsibilities and other duties,” says Scott, who had previously led an academic medical center through a Cycle IV accreditation. “Some of them are directors of the Emergency Department, and when [CPC accreditation] is over, they go back to their other jobs and their other roles. Or we might have one person who is responsible for both chest pain and stroke [accreditation], so once they finish with chest pain they’re moving on to stroke accreditation.”

For hospitals, other reasons for failed accreditation included:

- Out of sight, out of mind
- Voluntary nature of the three-year cycle
- No federally mandated reporting system or penalty
- Healthcare focus on acute illness
- Hospital incentives still based on patient volumes and fee-for-service.

The improvement team also identified issues related to SCPC’s role:

- Similarly, out of sight, out of mind
- No one person assigned the task of continuing an accreditation relationship and following up with a specific hospital (reviewers are assigned new sites, but this connection was not leveraged for follow-up)
- No infrastructure to support ongoing communications and to even look for proof of sustainability

- Competing strategic priorities among staff, such as developing new service lines rather than perfecting existing accreditation programs.

Stokes says the team quickly realized that the 5-Whys they explored on the SCPC side were quite different than the 5-Whys perspectives of the customer. Customers believed they were not obligated to attend to accreditation beyond the announcement that they had completed the process, which clearly left many hospitals falling through the cracks. SCPC began to understand that it was not addressing the needs of the customer in a way that was beneficial to the customer.

Bridge-Building Countermeasures

The improvement team established a goal to maintain an engaged relationship between facilities and SCPC, supported by a visual management system (i.e., data). To achieve this, the improvement team developed a program intended to help hospitals that would move from CPC Cycle IV to the new Version V that was coming online.

“We began to realize that [hospitals] needed a road map,” says Stokes. “They needed something specific.” The team developed a checklist in a documented format that would incorporate the approximately 120 CPC criteria that needed to be maintained on an *ongoing* basis. “We took a copy of the [CPC accreditation] tool, we broke it down into every single mandatory item that had a timed requirement on it, we built a program, and named it, very simply, the ‘Bridge Program.’ The idea was to engage systems of hospitals that had been led through accreditation, and to pilot it to see if it would even work.” The format for the ongoing data submission and authentication consists of Excel worksheets in which hospitals can check off requirements/criteria as they are met. It has also helped hospitals that the criteria have been consolidated to 120 ongoing items that support Cycle IV accreditation (see *Bridge Program Example*).

Bridge Program Example

Bridge Program moving from Cycle IV to Version 5

Start by reviewing your tool that you received in hardcopy/or from your reviewer after your site visit. This is an example of the executive summary for one key element:

No.	Key Element #	Item #	Page #
10	Assessment of Patient with Low Risk for ACS and Its Appropriate Cause for their Symptoms	4.0.0.0	

Comments:

Noteworthy Observations:

- Action items to remove the gray zone and activate a guideline driven process for triaging with consensus support from Lab/Cardiology and Laboratory.
- Consideration improvement in QRS TQT determining time from CT minutes to 38.7 minutes using a laboratory protocol. High evidence work.
- You have achieved an increase in QRS where leading or over 100% prior to discharge.

Opportunities:

- QRS software includes a triage matrix rule, but consider a similar matrix utilized to reduce laboratorian man hours as well as streamline decision making in the ED and reduce costs as a result of this.
- Consider a triage leading model (not in available 7 days a week, by using either an call staff or others that are staff trained on this process).
- QRS website needs to run longer than the national benchmark of 16-18 hours. QRS to IP connection to see case this benchmark recommendation or over 1 years to allow. An your operation zone, both increase your QRS has increased in context.
- Check the type of where leading you are performing, are nearly identical numbers are getting a standard and a number that, some that is erroneous.

Open Key Element # **Open Key Element #** **Open Key Element #**

4.1.3 | 4.1.4 | 4.1.5 | 4.1.6 | 4.1.7 | 4.1.8

You will notice that there are noteworthy observations and opportunities.

Completed	Not completed	Have you reviewed your tool/report with your entire CPC-C team?
Completed	Not completed	If NOT, do so now. The entire report is close to 70 pages, it has comments under many of the KEs felt to be of importance to your facility. You might want to email your CPC-C team members a PDF copy to review for the next CPC Committee meeting. Assign the Lab KE4, the ED KE3 and EMS/Rescue KE 3 for example.
Completed	Not completed	Once you have reviewed the tool, with its suggestions, opportunities, and observations of excellent work, make a list of all the opportunities listed within the report and present this to your CPC-C group, try to get to consensus related to your priorities for the coming year. Bringing your executives to the table will help strategically focus your cardiovascular program to align with GDMT.
Completed	Not completed	Place these priorities under the tab marked Priority Goals by Year .
Completed	Not completed	Send an email to all members of the CPC-Committee to share these priorities.
Completed	Not completed	Define how you will educate your staff regarding these goals for year one. And write down those educational action items on the Year 1 tab.

120 required items to maintain accreditation conformance and adherence to GDMT as well as define CV Strategic Planning:

- 34 Annual requirements
- 18 Quarterly requirements
- 55 Item Quality Dashboard collected quarterly/semi-annually
- 13 Reperfusion Metrics

Source: SCPC and CHS

The Bridge Program was introduced to 49 of the hospitals that did not meet Cycle IV. One national healthcare system liked the concept so much they made the program mandatory. Ten additional hospitals *asked* to be included in the program. “They were thrilled,” says Stokes. “Regardless of which system we presented it to, they were absolutely thrilled. ‘Thank you so much. We now have a road map. We now have a checklist that we can follow.’ Now they have a dedicated contact person, and they have continued metrics that they’re submitting. And they have continued expectations that they can get help in real time.”

The Bridge Program also consists of:

- Startup webinars to define the program, to build an understanding and excitement, and to encourage growth and participation
- Support from the cardiovascular service line or executive champion to identify other hospitals in need of assistance, to provide support for ongoing process-improvement initiatives, and to assist with data reporting and alignment
- Support from SCPC staff with oversight, ongoing quarterly education, review of hospital metrics, and program maintenance.

All of these efforts — as well as quarterly conference calls to share best practices, new GDMTs, and new data resources from a consistent source — allow SCPC staff to quickly get to and assist hospitals struggling with the accreditation process. Implementation of the Bridge Program has also helped to reconnect SCPC with many hospitals seeking Version V CPC accreditation. For example, distribution lists of hospitals seeking accreditation are now nearly 100 percent accurate, and, if not, they are adjusted in real time.

Results and Next Steps

By February 2016, the program had achieved 54 percent data compliance from participating hospitals. The program also has dealt with struggling hospitals that would be unable to submit in a non-punitive manner. The improvement team believes the Bridge Builder program will decrease variation of hospital CPC practices and require less work, money, and resources for hospitals to be accredited.

“There weren’t a lot of touch points,” says Keri Morris, ACS Service Line Specialist with SCPC. “The Bridge Program can really engage hospitals in an ongoing relationship, maintaining that momentum and not having them climb Mt. Everest every three years. [This] was a great segue into keeping those committee members engaged... It really helped hospitals just maintain the momentum instead of things falling off the map.”

Morris says that SCPC’s experienced reviewers are familiar with the challenges providers face because they are regularly in communication with coordinators at provider facilities. The Bridge Program is validating what reviewers have seen for years and is also revising the manner in which SCPC staff conduct site visits and the messaging they impart to customers — coordinators, administrators, and the decision makers who set aside budgets and allocate resources and personnel. “We are not just looking at

this accreditation as a project with a start and an endpoint, but really as the beginning of a journey that will not stop once past the site visits and final accreditation.”

The Bridge Program message is repeated often, especially during the accreditation summation, and the hospital coordinators have bought in. “We’re helping the facility coordinators feel supported, so that they can maintain that engagement and the committee buy-in and restructuring, from restructuring their quarterly meetings to having standing agenda items of reporting out these metrics. [We] set them up for success from the get-go,” adds Morris.

Some of the initial results may be due to the Hawthorne effect and the sense that “Big Brother is watching,” notes Hunn. That is not necessarily a bad thing from a hospital perspective because it helps to counteract the problem of coordinator turnover — the coordinator for one accreditation is likely to move on to other sites for accreditation or other types of accreditation, take a different role, or leave the system. The Bridge Builder program brings awareness and promotes accreditation beyond a single individual. “It puts a mechanism in place not only for the hospital, but a mechanism for us to be able to support them on our end.”

SCPC plans to expand the Bridge Program to all CPC Cycle IV hospitals accredited in the previous 12 months. It has also given SCPC a positive marketing position for its accreditation services and an opportunity to further the development of other service lines. And SCPC will look to expand the support program for Atrial Fibrillation and Heart Failure accreditations.

AEH Commentary

The Bridge Builder project is unique among AEH initiatives in that it involves a large healthcare provider partnering with a non-profit process improvement organization to enhance the effectiveness of the accreditation process, which ultimately means more providers adopting and being held accountable to an improved standard of care. While unusual, the project illustrates how parties at two ends of a relationship — the provider as customer and accrediting body as supplier — can have a similar awareness of a problem but contribute to the solution in very different ways. This is where lean tools of qualitative analysis (e.g., 5-Whys interrogation techniques) help to move an improvement team from quantifying a problem to understanding the cause-and-effect relationships necessary to develop successful countermeasures.

For healthcare providers, the project also underscores an overarching lean tenet: continuous improvement is not “an event” or a goal that is reached, celebrated, and then forgotten. It is an ongoing journey that, ideally, involves every individual in the organization on a daily basis.

About AEH

The Academy for Excellence in Healthcare blends in-person class time with hands-on project work, interactive simulations, and recurrent coaching, all aimed at helping healthcare teams spark actionable change at their organization. At the heart of this program is a real-world workplace problem each participant team selects and commits to solving through five intensive days on campus, followed several weeks later by two days of project report-outs and lean leadership training. This project-based approach pays immediate dividends and lays the groundwork for transformational change.



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