ED Retreat Builds Teamwork, Sets Goals

Walking a tightrope by yourself takes good balance. Walking a tightrope with more than 25 people on the rope with you takes trust and teamwork. That’s the message physicians, physician assistants, nursing staff and ED tech leaders took away from a two-day, Swedish/Edmonds Emergency Department (ED) retreat held in January.

While navigating tightrope courses and swinging from trees at the Waterhouse Center Ropes Course in Monroe, the ED team focused on breaking down barriers and setting goals to enhance ED throughput and operations, patient and staff safety, employee engagement and patient satisfaction.

“Our goals encapsulate the core of an emergency department,” says Gregg Miller, M.D., medical director of the Swedish/Edmonds ED. “Patient safety is the cornerstone of what we need to focus on, but to be efficient in the ED we must also focus on throughput. And our ultimate goal is to have happy patients, so patient satisfaction and the patient experience is important as well.”

Patient satisfaction is improving in the ED according to recent Press Ganey patient survey results, but to boost satisfaction even more, Dr. Miller says the ED will be emphasizing scripting by hospital staff and physicians, discharge phone calls and thank you notes to patients and new signage in the ED that lets patients know average wait times for lab tests, CT scans, X-rays, etc. Changing the process of bedside hand-offs (when a new nurse or provider is briefed on a patient’s care during a shift change) is also a priority.

“Bedside hand-offs typically happen outside of the patient’s room, but there’s no reason why they can’t happen in front of the patient,” says Dr. Miller. “It involves the patient more actively in their care, it helps the patient understand that they’re going to see a new face taking care of them and it also gives the patient an opportunity to add in any key details that might have been missed by the provider or nurse during the handoff.”

Shortening the average length of stay for discharged patients will also be addressed by focusing on communication between physicians, nursing staff and patients.
The Center for Wound Healing & Hyperbarics at Swedish/Edmonds is the first facility in the Puget Sound area with monoplace chambers to be awarded accreditation by the Undersea and Hyperbaric Medical Society (UHMS) and is one of only three facilities in the state of Washington to receive the UHMS accreditation. The UHMS is an international, nonprofit association serving some 2,000 physicians, scientists, associates and nurses from more than 50 countries in the fields of hyperbaric and dive medicine. It’s recognized as a leading authority in the field of hyperbaric medicine, supported by Medicare and private health-care insurance companies.

“Accreditation by UHMS indicates that we are meeting the criteria for evidence-based use of hyperbarics and that we are taking all necessary measures for patient safety,” says Nilufer Norsworthy, M.D., the primary physician with the Center for Wound Healing & Hyperbarics at Swedish/Edmonds.

In order to receive accreditation, the facility underwent an intense review by a team of experts. The team examined staffing and training, equipment installation, operations and maintenance of the facility, patient safety and standards of care. Accreditation by the UHMS recognizes a center’s commitment to patient care and safety, and is validation that the center meets the most rigorous industry standards. There are approximately 1,200 wound care and hyperbaric medicine centers nationwide. Only 130 have earned the UHMS accreditation.

“This accreditation is confirmation that we’re doing a good job according to industry standards and that I’m doing my job well,” says Darren Mazza, CHT and safety director of the Center for Wound Healing & Hyperbarics at Swedish/Edmonds.

“The staff and providers have offered high quality, safe patient care for years,” adds Celeste Sather, Center for Wound Healing & Hyperbarics program manager. “We are very proud to be formally recognized for our efforts.”

Hyperbaric oxygen treatment allows patients to breathe 100 percent oxygen at pressure two to three times greater than normal sea level pressure. At Swedish/Edmonds, two

**Congratulations…**

These physicians were mentioned by name in the November Press Ganey Patient Satisfaction Surveys and complimented for their great work.

**Alex Chung, M.D.**
Hospitalist

**Ann Begert, M.D.**
Edmonds Family Medicine

**Anny Soon, M.D.**
Swedish Internal Medicine at Edmonds

**Brian Fong, M.D.**
Western Washington Medical Group

**Bryan Chow, M.D.**
Emergency Services

**Catherine Zeh, M.D.**
Birth & Family Clinic

**Darcy Foral, M.D.**
Edmonds Orthopedic Center

**Elena Geamanu, M.D.**
Swedish Edmonds Specialty Clinic

**James Pautz, M.D.**
Swedish Heart & Vascular Institute

**Jeffrey Remington, M.D.**
Edmonds Orthopedic Center

**Judith Babcock, M.D.**
Birth & Family Clinic

**Katrina Erickson, M.D.**
Birth & Family Clinic

**Keith Luther, M.D.**
Swedish Internal Medicine at Edmonds

**Khanh Nguyen, M.D.**
Swedish Internal Medicine at Edmonds

**Kurt Harmon, M.D.**
Surgical Associates of Edmonds

**Linda Strong, M.D.**
Swedish Internal Medicine at Edmonds

**Marc Nelson, M.D.**
Birth & Family Clinic

**Martha Moe, M.D.**
Sound Women’s Care

**Maurene Cronyn, M.D.**
Birth & Family Clinic

**Thomas George, M.D.**
Hospitalist

**Timothy Little, M.D.**
Puget Sound Gastroenterology

Please See Wound Healing Accreditation on Page 5
A diagnostic imaging test of the heart or cardiac stress test can be, for a lack of better words, stressful on a patient, especially emotionally.

"Patients aren’t just worried about the stress test, but the ramifications of the test," says Michelle Hill, BSN, MN, ARNP. "I try to put them at ease by describing what’s going on before, during and after the stress test."

Michelle will oversee cardiac stress testing at the Cardiovascular Diagnostic Imaging Center at Swedish/Edmonds and will be the newest member of the imaging team when she begins caring for patients at Swedish/Edmonds in March.

"My role isn’t to perform the stress test, but to work with the nurse or medical technologist who is performing the test to help ensure that this is the right test for the patient and that it’s performed well, so that good diagnostic information about the patient’s heart is available to the referring physician," says Michelle.

Good communication is the key to a great patient experience and so is working as a team according to Michelle.

"Getting to know your co-workers helps with communication and providing a seamless experience for the patient," Michelle says. "I look forward to getting to know the team at Swedish/Edmonds."

Michelle has a Master of Nursing degree from the University of Washington and a Bachelor of Science degree in Nursing from Seattle University. In addition to caring for patients at Swedish/Edmonds, Michelle supervises cardiac stress testing at the outpatient diagnostic imaging center at Swedish/Cherry Hill. When she’s not caring for patients, Michelle enjoys boating, kayaking, hiking and traveling. She’s is planning a trip to Spain and hiking the El Camino de Santiago trail - a pilgrimage route to the Cathedral of Santiago de Compostela in Galicia. She’ll bicycle and walk between 100 and 200 miles.

Clinical Documentation Integrity Program (CDIP) Report: December

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December’s Top 2 Clarifications:
1. Congestive heart failure
2. Encephalopathy

Thank you to the medical and surgical staff for taking the time to respond to these queries. Please contact Melanie Westerinen, Documentation Integrity Liaison, at 425-640-4378 with any questions.
What a Difference a Word Makes - Clinically

By: Jennifer Woodworth, R.N., BSN, CCDS, director, Clinical Documentation Integrity Program (CDIP), Swedish

In the December 2012 edition of In the News, ACP Hospitalist Weekly, it was reported that two studies have found that hyponatremia predicts longer hospitalizations, higher costs and 30-day readmissions, and in the preoperative setting is linked to greater 30-day mortality. Where do research studies get this data? Well, they certainly do not review 888,000 charts. Researchers get this data from ICD-9 codes of course. This is just one example where physicians documenting one diagnosis, hyponatremia, made a critical impact in research that will also impact patient care.

In the first study, a retrospective analysis according to the ACP Hospitalist Weekly article, researchers used the Premier Hospital Database to examine health-care utilization and costs among hyponatremia patients. Eligible inpatients were discharged between Jan. 1, 2007 and March 31, 2010, were older than 18 years at admission, and had either a primary or secondary diagnosis of hyponatremia or hyposmolality. Researchers matched these patients to a non-hyponatremia cohort and used bivariate/multivariate statistics to evaluate the differences in costs, readmission and lengths of stay. Results were published online Sept. 7 by the Journal of Hospital Medicine.

Length of stay (LOS) was greater for the hyponatremia versus non-hyponatremia patients (8.8 ± 10.3 vs. 7.7 ± 8.5 days; P<0.001), as were hospitalization costs ($15,281 ± $24,054 vs. $13,439 ± $22,198; P<0.001), intensive care unit (ICU) admissions (23.1% vs. 22.1%; P<0.001), ICU length of stay (5.5 ± 7.9 vs. 4.9 ± 7.1 days; P<0.001), and ICU costs ($8,525 ± $13,342 vs. $7,597 ± $12,695; P<0.001).

Patients in the hyponatremia cohort were also more likely to be readmitted to the hospital for any cause at 30 days (17.5% vs. 16.4%; P<0.001). Hyponatremia “represents a potential target for intervention to reduce health-care expenditures for a large population of hospitalized hyponatremic patients,” the authors wrote.

In the second study, researchers assembled a cohort through the American College of Surgeons National Surgical Quality Improvement Program Participant Use Data Files to identify 964,263 adults undergoing major surgery between 2005 and 2010; then observed them for 30-day outcomes. They used multivariable logistic regression to estimate risks for death, wound infections, pneumonia and major coronary events within 30 days of surgery and quantile regression to estimate differences in average length of stay. Results were published online Sept. 10 by the Archives of Internal Medicine.

The 75,423 patients with preoperative hyponatremia (sodium level <135 mEq/L) had a higher risk of 30-day mortality than the 888,840 patients with normal baseline sodium levels of 135-144 mEq/L (5.2% vs. 1.3%; adjusted odds ratio [OR], 1.44). The finding was consistent in all subgroups and particularly strong in patients undergoing non-emergency surgery (OR, 1.59; P<0.001 for interaction) and American Society of Anesthesiologists class 1 and 2 patients (OR, 1.93; P<0.001 for interaction). Hyponatremia was also associated with a greater risk of perioperative major coronary events (1.8% vs. 0.7%; OR, 1.21), wound infections (7.4% vs. 4.6%; OR, 1.24) and pneumonia (3.7% vs. 1.5%; OR, 1.17) and longer median lengths of stay by about one day.

The preoperative hyponatremia cohort had a 44% higher risk of 30-day perioperative mortality after adjustment for all other risk factors and excess risk existed even for patients with mild hyponatremia the study authors noted. They cautioned that further research is needed to determine whether correcting preoperative hyponatremia will mitigate risks. Large or rapid changes to sodium levels could be harmful they noted. Underlying causes of hyponatremia should be determined in these patients, and preoperative hyponatremia “should be considered a prognostic marker for perioperative complications” and should alert physicians to a situation “necessitating closer surveillance in the perioperative period,” researchers wrote.

Sweden CME Events

Below are Swedish CME activities. Please visit Swedish.org/CME for locations, times and the most up-to-date information about upcoming CME activities.

Clinical Research Investigator Training
Friday, March 15

High-Risk Obstetrics: Tools for the Family Physician
Friday, March 22

Multimodal Treatment of Spinal Tumors 2013
Friday, March 29
Wound Healing Accreditation *(continued from page 2)*

state-of-the-art, monoplace hyperbaric chambers are supported by a knowledgeable and experienced clinical team.

Wounds are naturally hypoxic or without oxygen. Research has shown that increasing oxygen to the body’s tissues can help to create new blood vessels, reduce edema and boost the body’s immune response stimulating a host of other factors that promote faster healing. In many cases, hyperbaric oxygen therapy avoids amputations that would have been inevitable with traditional modalities. The Center for Wound Healing & Hyperbarics at Swedish/Edmonds treats non-acute, non-emergent patients with the following conditions:

- Non-healing diabetic foot ulcers of Wagner Grade III or greater
- Complex arterial ulcers and gangrene
- Compromised flaps/grafts
- Soft tissue necrosis and/or osteoradionecrosis from effects of radiation therapy
- Chronic refractory osteomyelitis
- Prophylaxis for dental procedures in patients with previous radiation therapy to the head and neck

For more information, call the Center for Wound Healing & Hyperbarics at 425-673-3380.

ED Retreat *(continued from page 1)*

during bedside handoffs and with “team discharges” – when a physician and nurse are together, in a patient’s room for the discharge process instead of visiting the patient separately. Similar to team discharges, the process of “team care” is also being explored.

Currently, ED nurses and physicians assess patients separately. With team care, the ED team would assess a patient together, at the same time.

“If the physician and nurse can have the initial interaction with the patient at the same time, it will potentially speed up the patient’s care and ensure good communication between nurses and physicians,” says Dr. Miller.

Dr. Miller says the ED department will be implementing new processes throughout the year. They’re currently revamping the Rapid Medical Evaluation (RME) process to help staff better understand tasks, where and how information should be communicated and the flow of patients. Staff scripting, communication and bedside hand-offs will be addressed in March. Through all of it, Dr. Miller says the success of process changes will be measured by tracking throughput and monitoring Press Ganey patient comments. He’s confident results will be positive.

“We have a great team in the ED and the retreat helped us realize that there are challenges, but if we work together we can accomplish anything we set our minds to,” he says.

Create Your Swedish Web Profile

All active Swedish/Edmonds physicians are eligible to create a physician web profile at www.swedish.org. Follow the steps below to create your profile today and attract new patients.

Go to www.swedish.org/physician or www.swedish.org/CMSDesk and enter your user name and temporary password:

- User name: Firstname.Lastname
- Password: Lastname (case sensitive)

It’s recommended that physicians provide their login information to clinic managers to maintain office information on profiles such as office hours, address/phone changes, etc.

If You Need Help

Please contact Suzanne Iversen-Holstine, Director of Business Alliances & Service Optimization at Swedish/Edmonds, at 425-343-8961 or suzanne.iversen-holstine@swedish.org.
To Admit a Patient to Swedish/Edmonds, Call 425-640-4444

For Medical Staff information on the web, visit: www.swedish.org/EdmondsMedicalStaff