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INSIDE

AHC Media

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CMS quality measures report finds improvement

Beware of the changes afoot, says expert

The annual National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report shows a largely positive picture of the healthcare industry and its uptake of quality measures. It's not surprising: Every report that has come out has shown good, sometimes great results for various metrics. Some have more direct impact on patients than others.

Among the findings:

• 95% of the of 119 publicly reported measures in seven programs showed improvement in rates between 2006 and 2012, with process measures most likely to be the highest performers. The report noted that the rates were so high on about a third of these measures that the return on continued investment in these measures may be "marginal" in terms of patient outcomes.

• Because of this, process measures may have a limited lifetime, and one suggested action is to work with the National Quality Forum on ways to retire measures that have done their job and leave little to improve.

"WE ARE SEEING A CLEAR MOVE AWAY FROM PROCESS METRICS."

• Few measures have a clear relationship between them and positive patient outcomes, although some related to cardiac and surgical care did have an impact. The report says more outcomes-based measures are needed.

• Disparities in care are improving but still exist, and the healthcare industry as a whole needs to work on how to best measure outcomes for

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various groups and then improve those outcomes.

"It's always gratifying to see we are getting results and measurable improvement and going in a positive direction," says **Paul L. Green**, MS, RN, CPHQ, principal for quality and safety advisory services at Premier Performance Partners, a healthcare consultancy in Charlotte, NC. "But we are seeing a clear move away from process metrics. We have seen improvement over 20 years, but not in terms of outcomes related to those process measures."

Maybe there is some improvement in mortality or injury, but not as much as the improvement that you see in the rates of the process itself, Green says. That means either process measures aren't a good way to measure outcomes, or the ones we have chosen as a stand-in aren't good enough. So look for CMS and other regulators to put a lot more emphasis on outcomes, including patient-reported outcomes, Green says.

"This will be resource-intensive for quality departments," Green says. "In the late 1990s, we tried to look at some of these in Minnesota, and it was so hard to gather data in a meaningful way that we stopped. Things have moved on since then in terms of technology, but they have also moved on in other ways. We have to figure out what happens not just within the hospital, but elsewhere on the continuum and collect data from there."

The Physician Quality Reporting System, which may be unknown to many hospitals that don't have their own physician practices, is something that all hospitals need to get to know, says Green. "You need to understand the data that physicians collect in their offices, too. You will have to be more educated in outpatient and community-based healthcare. Until now, the linkages from skilled nursing facilities, rehab, home care, and physicians have often been missing. That can't continue."

There remain some legal issues about sharing data, as well as the continuing issue of interoperability for organizations that want to share data but don't have technology that can talk to each other, says Green.

One metric he says will likely be very important in the future is the first efficiency measure for CMS, Medicare spending per beneficiary, which goes from three days before to 30 days after a hospitalization. "But most hospitals don't have the capability to get that information, and just gathering that data will require cooperation."

The biggest driver of your success in the future, Green says, will be your ability to coordinate along the continuum of care and act as a referee among all the various pieces. Staying at the center of this new wheel "will help you be more aware of what the issues are, so you can create, measure, and improve coordination efforts."

Even though the report is making these recommendations for the future, he says it's important to start now to build the relationships with the others in your community with whom you may not have a close working relationship. "The emphasis on processes will drop and outcomes will increase, and outcomes will involve everyone on the continuum."

Everyone includes the patient, which is another ingredient to the recipe that a lot of hospitals have put off adding. "The level of improvement we have seen in process measures hasn't been replicated in patient satisfaction, and that is concerning. You have to step that up," he says.

Pay attention to patient

engagement and communication, and to building partnerships with your patients. Get them involved in your quality programs — deeply involved. "Studies show that even with bad outcomes, if you are transparent and open and put the patient at the center, they are less likely to sue," he says.

The report lays out the future clearly, Green says: Focus on collaboration with every cog in the wheel, focus on outcomes, and focus on efficiency. "The places where we have spent our work lives are going away. It's a new world for everyone, and your job is to understand all the parts."

The entire report can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2015-National-Impact-Assessment-Report.pdf.

For more information on this topic, contact Paul L. Green, MS, RN, CPHQ, Principal, Quality and Safety Advisory Services, Premier Performance Partners, Charlotte, NC. Email: Paul_Green@PremierInc.com. ■

Addressing the problem of diagnostic errors

Start looking now; the issue will only get more focus in the future, experts say

At the beginning of March, **Mark Graber**, MD, got a call from The Joint Commission informing him that he was one of the winners of the John M. Eisenberg awards for patient safety and quality. *(For more on the awards, see page 46.)* This individual achievement was given to Graber because of his extensive work in the field of recognizing, measuring, and finding ways to minimize diagnostic errors in healthcare. It is a topic that hasn't gotten a lot of press up until now, but which Graber told *Hospital Peer Review* he thinks will be at the forefront of quality efforts in the near future. "The award is a fantastic honor and can only help raise awareness about the importance of diagnostic quality," he says. "This is a time for every healthcare organization to just ask: 'What are we doing here to address the problem?'"

Adding importance to the weight of the award is a pending report from the Institute of Medicine, due out sometime this year, that will look at the issue of diagnostic errors. It's a topic that is gaining momentum.

Last month, we talked to Graber about the issue of diagnostic errors, and in our conversation, he mentioned one facility, Maine Medical Center, that had done a great job at getting physicians to not just accept the notion that they might get things wrong, but to actually count their errors, report them, and then dissect each one in order to learn from it.

The effort was led by **Robert Trowbridge**, MD, director of the division of general internal medicine at the 600-bed hospital in Portland, ME. For six months in 2010, providers were educated on the issues surrounding diagnostic errors as outlined in existing literature *(see list of suggested reading in the March issue of* HPR*)*, and the potential impacts such mistakes could have on patients.

> "THIS IS A TIME FOR EVERY HEALTHCARE ORGANIZATION TO JUST ASK: 'WHAT ARE WE DOING HERE TO ADDRESS THE PROBLEM?'"

M&M conferences were redesigned, Trowbridge explained, so that the conversations spent more time focusing on issues surrounding diagnosis and potential mistakes made in that arena. Interns and medical students spent more learning time on the issue, as well. All physicians spent some time learning how to improve their clinical reasoning skills, as well as what common errors were and how to avoid them. Coupled with the learning was a more robust root cause analysis program designed specifically for situations involving diagnostic error. The new method includes looking at potential errors in cognition, as well as system-related errors.

Initially, Trowbridge says, they had trouble finding errors. "Usually, nurses are the reporters of mistakes, but physicians are the experts in diagnosis," he explains. So they corralled a couple physician champions and developed a physician reporting system. Physicians fill out a basic screen that includes the patient name, the medical record number, the type of error — missed, wrong or delayed diagnosis — and a brief description of the problem. For example, if an iron deficiency was missed over the course of a year and

the patient ended up with late-stage colon cancer, that would be a delayed diagnostic error. "Most error reporting has something like 17 fields, and is on software our physicians aren't familiar with. But this sits on the clinical desktop and is familiar to the doctors."

The reporting is completely anonymous, and the identifying information was eliminated as soon as the relevant information on the kind of error was collected, Trowbridge says. "We counted for six months and found a lot of errors we wouldn't have found otherwise," he says.

That they were finding them was gratifying. "We know that diagnostic errors run at about 10-15%, but they are rarely found in compilations of sentinel events. That means they are happening, but we are not capturing them as a means for improving quality. And if we aren't capturing them, we can't improve them." Physicians know they exist and they aren't saying anything about them. That may be due to the culture of blame in some hospitals and systems, but since physicians want to do the right thing by their patients, Trowbridge isn't sure if that explains all of it.

"I expected push-back from physicians on this and didn't get it," he says. "This wasn't in the lexicon before, but it is now. We piloted it with the adult inpatient medical group and were clear that there would be no individual attribution of errors. But some of them wanted that depth of data. But we left no electronic trail, and all paper with identifying information was destroyed. We spent a long time talking to counsel about this project before we started."

While the notion was to input your own errors, the system was designed so that anyone could input an error they saw happen. But Trowbridge says he doubts the icon they used for reporting the error would have been widely known outside the physician community, and therefore it's unlikely anyone aside from doctors ever reported an error.

It was labor-intensive, and Trowbridge says if he wasn't walking around reminding physicians to report their diagnostic errors, the reporting rate would fall off. But the issue remained in the consciousness of the physicians regardless. M&M conferences remain different, with someone talking about the contribution of diagnostic error to a case. The pilot ran for six months. People still report, but not at the rate that happened during the pilot.

They are using a different reporting system that includes a spot for diagnostic errors in the same reporting system that reports medication errors, wrong-site surgeries, and other sentinel events. It still doesn't include women's, pediatrics, or surgical specialties — just the adult inpatient population.

"You have to look at this, and the best way to do this would be a multimodal measurement system," Trowbridge says. "You should have triggers — like certain types of diagnoses — or specific presentations that you investigate. And it should include the untapped potential of patient reporting. These things, together with the hindsight of looking back at cases together are needed to identify diagnostic errors and give people and institutions the feedback on performance they need."

"You really have to raise the consciousness of this," Trowbridge concludes. "Get the medical staff and administration to understand this is a big problem that has financial, clinical, quality, and patient satisfaction implications. That Mark [Graber] won the Eisenberg award is a sign that this isn't going away. Be an early adopter, not a late one."

For more information on this topic, contact Robert Trowbridge, MD, Director, Division of General Internal Medicine, Maine Medical Center, Portland, ME. Email: TROWBR@mmc.org. ■

Quick test highlights frail patients

Study focuses on simple metrics

What if there was a test you could do on patients in under a minute that would tell you which of them were most likely to have post-surgical complications? According to a study out of Emory University in Atlanta scheduled for publication later this year in the *Journal of the American College of Surgeons*,[1] looking at just two or three simple metrics can readily identify such patients, giving you a way to manage outcomes expectations, work to reduce risks post-surgically, or potentially improve the risk profile of the patient before surgery if there is time.

The study by **Viraj Master**, MD, PhD, associate professor of urology and the quality director of the clinical research unit at the university, and his colleagues, looked at 351 patients scheduled for abdominal surgery. Patients were monitored for shrinking — unintentional weight loss of 10

pounds or more during the last year — and grip strength, along with serum hemoglobin values. Previous modes of determining frailty also included gait speed, activity levels, and exhaustion levels.

The authors looked at 30-day complication rates for participants, which included discharge to a nursing home, and found that those with weak grip and evidence of shrinking alone were more likely to suffer complications. Those two criteria were just as effective at predicting complications as the five-metric previous frailty tests, according to the study. If you add in the blood work data, the authors found they were able to create a stratification of risk for patients.

"You get the best possible information, with the most bang for the buck with weight loss, grip strength, and hemoglobin," says Master. "But even without the hemoglobin tests, you can still get a pretty good idea of who is frail and who is not."

Co-author **Kenneth Ogan**, MD, an associate professor of urology at Emory, says knowing who is frail and who isn't is something he believes should be another vital sign for all patients. "Eventually, I think we should get the heart rate, the blood pressure, and then ask everyone about their weight loss and see how they do with grip strength. You get a great deal of information in a short amount of time — and we get less and less time with our patients these days."

Patients who are extremely frail are increasingly the subject of study, says Master. While data is thin now, he thinks that in the future it will be proved that frail patients spend longer in the hospital, are more likely to be readmitted, and tend to be discharged not to their homes, but to skilled nursing facilities or rehabilitation hospitals. "Those places have a huge implication on how you marshal your inpatient resources and services in the world of accountable care," Master says.

Ogan says knowing who is frail also helps you manage the expectations of the patient and the family. "If they test frail, you can give them a much more accurate picture of what to expect out of surgery — more likely complications, a higher likelihood of discharge to a nursing home or rehab hospital. Our data will eventually show they probably have a higher risk of mortality, too. So patients and families will decide not to do a surgery, that it isn't for them."

"THIS IS IMPORTANT INFORMATION," MASTER SAYS. "FRAILTY SHOULD BE ON THE TIP OF THE QUALITY TONGUE."

It's possible, too, that they will try to find a way to "pre-hab" themselves before surgery, Ogan says: beef up their health so that they are less likely to suffer those complications. The data hasn't been collected yet on what kinds of work a patient could do to improve the odds of a complication-free surgery, but Ogan and Master are doing a trial right now where patients are given pedometers pre-surgically and told to walk 10,000 steps every day. The theory is that if they get healthier before surgery, they will do better after.

The problem is that there isn't any clear knowledge yet whether the grip strength and shrinking metrics are markers for something specific, Master says. In other words, if you have a patient put back on some weight and work to improve grip strength, will the patient then go on to do well in surgery? Or is there something else going on that those two data points are indicators of that has yet to be identified? While Master says a lot of people are working on the issue of frailty, no one has figured out anything that deep yet.

"What's important right now is to know that frail people do worse, that we should reset expectations for them and their family, that we should care for them differently post-surgically, and that we need to investigate whether there is a way to make them healthier before surgery in order to mitigate risk," Ogan says.

Master says he would like to see every hospital, starting now, treat these two signs of frailty as elements of a vital sign, and ask every patient about them. "Then analyze this data," he says. "We have hundreds of patients in our cohort, but we would like to know what it looks like for thousands."

"Maybe it won't signify the same thing on all services," Ogan notes. "But when you have data on who the frail patients are, you can analyze their outcomes, and see if there are ways you can improve them on the front end, before they enter the hospital, or the back end, before they leave."

"This is important information," Master says. "Frailty should be on the tip of the quality tongue."

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Over time, National Surgical Quality Improvement Program pays off, study suggests

But some participants still lag behind

It's the kind of study with relatively expected results: A program that takes data and uses it to improve performance shows that participating organizations, over time, do better than their counterparts who don't participate.[1]

But when you talk to study author **Clifford Ko**, MD, MS, MSHS, FACS, the director of quality programs at the American College of Surgeons (ACS), he'll explain to you that while a solid majority of participants in the National Surgical Quality Improvement Program (NSQIP) do show lower mortality, morbidity, and surgical site infections than their non-participating counterparts — 69%, 79%, 71% compared to 62%, 70%, and 65% — that still means that there are 20-30% of participating hospitals that are not showing lower rates in those areas despite eight years of participation.

"We were hoping to find what we found," Ko says, "But we don't know why we have these results. Do they improve and get bored and go back to old habits? Is their heart just not in it anymore?"

What is different about this study is the length of time they looked over — eight years — using the same measurement system as a previous study that found improvement in 80% of the participants over a three-year period — "That's still 20% not improving," Ko notes. "I think that this is a very realistic look at the surgical world. We see that complication rates are improving more than mortality rates, and that's what hospitals tell us they see," he says. "I'm a surgeon at UCLA, and when I look at records, I find it's easier to spot problems with complications that we can solve than with mortality. So this data is definitely representative of what is happening with hospitals."

> "SO YOU HAVE TO LOOK AT A LOT OF THINGS TO FIGURE OUT WHAT ISN'T RIGHT. TO DO THAT TAKES GOOD DATA, ACCURATE DATA."

It's also representative of what is happening in just 400 of the 600 hospitals that participate in the NSQIP in a country with more than 5000. "The hospitals that sign up for NSQIP are early adopters," he says. "They spend the money, hire the data collector and want to work on these issues. They may not be representative of all hospitals, but I think they are a good representation of the ones in the program."

Even with this voluntary system, though, it's obvious that not every participant puts everything into the opportunity, says Ko. Getting others to agree to participate in the kind of protocols that NSQIP has created without a mandate? It won't happen, says Ko. Nor will a mandate.

Still, over time, the information that NSQIP has gleaned has led to changes in the way surgery is done, and will continue to do so, he says.

Surgical-site infections remain the most common complication and one of the most complex problems to fix, he says. "It's multifactorial, and any one thing that can go wrong can lead to an infection. So you have to look at a lot of things to figure out what isn't right. To do that takes good data, accurate data. You need a multidisciplinary team, a good

culture, and an ability to try different solutions until you get a result." NSQIP hospitals provide that, he continues.

But he understands that not every hospital will want to put the money and time into that particular endeavor. "We have to prioritize, and each hospital is different," he says.

For more information on this topic, contact Clifford Y. Ko, MD, MS, MSHS, FACS, Director of Quality Programs, American College of Surgeons, Chicago, IL. Email: cko@facs.org. ■

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Grading hospitals like restaurants

Study suggests healthcare can learn from New York inspection program

Does the way restaurants are inspected for cleanliness in New York City have anything to teach the people who rate hospitals? Maybe, according to a study released in the February issue of the *Journal of Hospital Medicine*.[1]

The authors looked at both Hospital Compare and the restaurant inspection program and compared and contrasted them. Information on the former is housed on a website that consumers must visit, has a time lag of anywhere from one to three years, and includes 108 measures and no summary grade. There are financial penalties for not reporting data, and incentives for improvement.

By contrast, the latter provides point-of-sale information: As the customer enters, there is information on the latest health inspection, and the inspections are done, unannounced, at least once a year. A single summary grade at the location is supplemented by further information on the inspection website.

What the restaurant program provides is clarity, as well as a deterrent factor to potential customers. If customers saw a low sanitation grade, they were less likely to enter. The restaurants that do poorly are subjected to repeated inspections, and closure for severe violations.

"We don't take the right perspective sometimes, and get caught in a healthcare bubble, rather than get ideas from the rest of the world," says **Andrew Ryan**, PhD, one of the authors. "When we design things for Medicare, something is lost in translation in terms of how it's supposed to affect patient behavior. In other industries, like *Consumer Reports*, they have to appeal to human beings and how they understand information. They are more sensitive to how information is understood."

It's not new, he says, the knowledge that reports like those on Hospital Compare lack an element of easy understandability and that there are easier cues that can be used to help guide patients toward good decisions. "But Medicare hasn't gotten there with Hospital Compare." Nursing homes have gone to five stars, and while there are issues with that, consumers are paying more attention and it is more meaningful.

While acknowledging that healthcare is different from most other industries — for example, there may not be many hospitals in a market, or you might not always have the option of choice or a "shoppable moment" — Ryan says researchers who are intimately involved in these efforts have been slow to look at the problem without considering it from the consumer perspective. "Technical considerations like confidence intervals may be lost, but it's in order to make information more understandable for patients. And there is a middle ground with good science and defensible ways to form composites. You can click for more detail, for example. That would be helpful, to see a default as a letter grade, and for those with an interest in more, it's available."

Ryan focused on the New York ratings after living in New York and dining out at lunch every day with a friend who would never go into an establishment with a sub-A rating. "We really responded to the information, and he would go back to the office and look up the ratings." It got Ryan thinking about why people were so unresponsive to the healthcare ratings, while they were very responsive to the restaurant ratings.

It would be powerful to see

ratings on hospitals, Ryan says. "It's not like people would go from hospital to hospital, but if they were there, people would find out about them in a way that they don't with the ratings there on the website."

The response has been largely supportive from peers, but he isn't sure it has much traction right now. "Summary measures draw attention to information, and it's viewed as more of a risk, and hospitals are more risk averse," he says. "I think there is a feeling this could update feelings about hospitals in a bad way, not a good way, and they have a bunch of other things to worry about. But the feeling is that Hospital Compare is moving in this direction. It may not be a star rating on the front door, but who knows what it will be."

While there isn't a lot of action you can take right now in this arena, Ryan says there is a message in his work for quality professionals. "There is a lot of information out there for patients — in care summaries and plans, for example. And we know that simple messages are more easily digested."

For more information, contact Andrew Ryan, PhD, Associate Professor of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor, MI. Email: amryan@umich.edu. ■

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CMS now publicly reporting hospital flu vaccination rates

Stressing staff flu immunizations despite poorly matched vaccine

Public reporting is raising the stakes for flu vaccination. For the first time, potential patients can compare health care worker influenza immunization rates as part of the online hospital quality data provided by the Centers for Medicare & Medicaid Services (CMS) on hospitalcompare.hhs.gov.

While that may not have been a blockbuster story for the broader news media, hospital leaders have taken notice and are placing more emphasis on achieving high vaccination rates. It is now common for hospitals to require employees to receive the flu vaccine or to wear a mask during the flu season.

Of the 3,676 acute-care hospitals reporting their rates for the 2013-2014 flu season, 58 reported 100% coverage. Almost 200 hospitals reported a flu vaccination rate of 99% and another 200 reported a rate of 98%. In fact, more than a third (37%) of all hospitals reported a rate of 90% or above — the Healthy People 2020 goal that has been promoted by The Joint Commission and the U.S. Department of Health and Human Services.

The influenza immunization rates reported by CMS include all employees, licensed independent practitioners (contracted physicians and advanced practice nurses), students, volunteers, and trainees who worked in the facility for even one day during the flu season, from Oct. 1, 2013 to March 31, 2014. Unknown status or even medical contraindications would lower the rate.

"[Hospitals] clearly don't want to be outliers when it comes to this change in practice across the country as more and more institutions move to a variety of mandated programs," says **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University in Nashville, TN, and past president of the National Foundation for Infectious Diseases.

"Many of them now record immunization rates above 90%. Having your institution stuck at 72% begins to look inappropriate and no longer the norm. That motivates CEOs to say, 'We have to do better and we're going to do whatever it takes.'"

Tighter requirements = higher vaccination rates

Schaffner's own institution recently shifted from a voluntary, education-based approach to a stricter requirement.

Employees who decline vaccination must have either a medical contraindication or a strongly held religious or philosophical belief against vaccination. (They can't simply say they don't want the vaccine.) The decision was made by senior managers, including the CEO and chief medical officer, he says. "There are certain things you just have to oblige people to do," he says.

Vaccination rates immediately jumped to about 90%, even though the policy didn't include disciplinary action that would be taken against employees who failed to get the vaccine.

Even adding new requirements to a voluntary program can boost rates. At Allegheny Health Network, a multihospital system in western Pennsylvania, employees who decline the vaccine must complete online education about influenza vaccination.

That step alone raised rates from about 50% to 72%, says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, manager of employee health services. "We wanted to educate people and let them know why they need to get [the vaccine], the ethical issues of protecting themselves as well as patients, and the facts about the vaccine," she says.

At Virginia Mason Medical Center in Seattle, the first hospital system in the nation to require flu vaccination of employees as a condition of employment, the mandate has become routine. Nurses can decline the vaccine — but they must wear a mask during flu season if they are unvaccinated. Fewer than 10 nurses declined the vaccine this year, says employee health supervisor **Beverly Hagar**, BSN, COHN-S, and Virginia Mason reported a 99% immunization rate.

CMS measure presents tracking challenges

The CMS reporting has brought new attention to obstacles in flu vaccination and reporting. Tracking influenza vaccination can be challenging, especially among contracted physicians who work in multiple hospitals and employees and others who received their vaccine elsewhere.

Since "unknowns" lead to a lower rate, hospitals must methodically document vaccination status, which can be a labor-intensive process, says Gruden, who is a community liaison for the Association of Occupational Health Professionals in Healthcare (AOHP).

"If you are a big medical center or a multihospital system, it's extremely difficult to get a handle on everybody who's come through the door," she says. "You have to work with other hospital departments [to gather the information]."

At Broward Health in Fort Lauderdale, FL, the employees in the four-hospital system are culturally diverse, and many have pre-conceptions about the flu vaccine, says **John Berges**, MD, CHCQM, medical director of Corporate Employee Health. Required annual education on influenza and vaccination hasn't budged those attitudes. In the CMS reporting, the influenza vaccination rates at Broward Health hospitals ranged from 21% to 52%.

Also, the health system's billing, call center and information technology employees work in a five-story building completely separate from the hospitals. "Most of them don't feel motivated to receive the vaccination, and yet they're counted," Berges says. "It's very challenging."

The CMS reporting and the Healthy People 2020 goal of 90% vaccination have gotten the attention of the health system's leadership. This season, for the first time, employees must receive the vaccination or sign a declination statement. Vaccination rates have risen, and a task force that includes the chief medical officer and chief human resources officer is looking at other steps to improve compliance, he says.

"This past year, we've had tremendous buy-in from the CEOs of the hospitals and administration in general," says Berges. "Now they comprehend that we need to be at the 90% mark. The numbers have tremendously increased since we've gotten the CEOs involved."

Looking beyond vaccine effectiveness

Hospitals underscore that vaccination is the best available method to prevent the spread of influenza — but that message was somewhat undercut this season with a vaccine that proved to be a poor match with the prevailing strain of the virus.

For employee health professionals, that meant promoting other important measures, including respiratory hygiene and the use of antiviral medications.

For example, Vanderbilt has "cough and sneeze stations" with tissues and hand sanitizer for both visitors and employees. Hospitals also have provided Tamiflu as a prophylaxis for employees who had an unprotected exposure to influenza.

CDC reported that 70% of the circulating influenza A H3N2 viruses

had "drifted" from the strain used in the vaccine, which resulted in an overall vaccine effectiveness of just 23%. Among adults ages 18 to 49, the vaccine effectiveness was 12%, and among adults 50 and older it was 14%.

Still, CDC continued to emphasize the benefits even of an imperfect vaccine. "Even when vaccine effectiveness is reduced, vaccination still prevents some illness and serious influenza-related complications, including thousands of hospitalizations and deaths," CDC epidemiologists said in a Morbidity and Mortality Weekly Report.[1]

Hospitals need to take a longer view of influenza immunization as they hone their programs, says Schaffner.

"A lot of institutions are taking responsibility and getting their workers immunized, even though the vaccine, as we know, is imperfect," he says. "Now these institutions have to maintain that year in and year out. They can't be discouraged just because the flu strain drifted." ■

REFERENCE

1. Flannery B, Clippard J, Zimmerman RK, et al. Early estimates of seasonal influenza vaccine effectiveness — United States, January 2015. MMWR 2015; 64:9-15.

CCI launches new care integration center

The Center for Care Innovation in San Francisco has launched a new Web-based resource dedicated to care integration. Seated on its knowledge center page (http://www.careinnovations.org/knowledge-center/facilitating-care-integration/), the site was designed to help "break down the silos" says **Nwando Olayiwola**, MD, MD, MPH, FAAFP, associate director of the UC San Francisco Center for Excellence in Primary Care, one of the investigators responsible for the material on the site. "There is primary care, pharmacy, specialists, hospital — and no one knows what's going on with everyone else," she says. "But patients need great communication."

The website is an attempt to identify best practices for integration, collating strategies that have worked for other organizations, says **Ashley Rubin**, MS, evaluations analyst at the Department of Family Medicine at UC San Francisco. Rubin did a lot of the heavy lifting in terms of research and writing for the site.

Along with the best practices, there are interviews with a dozen innovators who shared problems they had related to care integration and how they solved them. More such stories will be added in the coming months.

For more information on this topic contact:

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NQF, TJC announce quality winners

The Joint Commission and the National Quality Forum announced the three winners of the 2014 John M. Eisenberg award for patient safety and quality. Among them is Mark Graber, MD, FACS, a physician who champions the cause of discovering, measuring, and combatting diagnostic errors. *Hospital Peer Review* interviewed Graber last month on the topic. After his win he told *HPR* that this recognition was gratifying, and he hoped it signaled increased attention to the subject.

Graber, a senior fellow for Healthcare Quality and Outcomes Programs at RTI International, founded the Society to Improve Diagnosis in Medicine and oversees the annual Diagnostic Error in Medicine conference.

Another winner was the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), which has been around for decades — first as a program in the Veterans Administration, then morphing into a private consortium with data from about 600 hospitals. *(For more on the latest data on those hospitals, see related article page 42.)*

Lastly, North Shore-Long Island Jewish Health System was awarded the honor for its work on reducing sepsis mortality. Next month, *HPR* will talk to the people in the system who have helmed the efforts which reduced mortality by more than half. ■

Report on hospital discharge planning tools

Hospital discharge planning tools should incorporate the judgment of clinicians and be administratively feasible, according to findings in a new report released by the American Hospital Association (AHA).

The report highlights lessons learned from five hospitals and health systems that developed innovative tools aimed at improving patient care transitions. The five tools support decision-making related to when a general acute-care hospital patient should be discharged, whether a patient will need post-acute care, and what types of post-acute care might be most suitable.

While their primary objectives vary, the tools have three cross-cutting themes: appropriate post-acute care placement, readmission reduction, and management of patient transitions from acute to post-acute care settings. Each of the tools was designed to align with the culture of the organization and providers using it, with a focus on reducing the burden on administrative staff and clinicians.

AHA convened a technical advisory panel of members and other stakeholders to examine a variety of innovative patient discharge planning tools. *(To access the report, go to http://www.aha.org/research/policy/2015.shtml?utm_source=newsletter&utm_medium=email&utm_campaign=NewsNow.)* ■

Survey of impact from first year of ACA enrollment

The number of Americans reporting they did not receive needed healthcare because of its cost dropped for the first time since 2003, from 80 million in 2012 to 66 million, according to the just-released 2014 Biennial Health Insurance Survey from The Commonwealth Fund in New York City.

Also, the number saying they had trouble paying their medical bills or were paying off medical debt fell from 75 million in 2012 to 64 million, which is the first time it declined since this question was initially asked in 2005.

The survey, discussed in the new brief, The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect, was fielded between July and December 2014.

It asked respondents about their health insurance status, access to healthcare, and medical bill problems and debt over the previous 12 months.

(The brief is available online at go to http://www.commonwealthfund.org/publications/issue-briefs/2015/jan/biennial-health-insurance-survey.)

The survey found improvements on nearly every measure, including the percentages of adults who reported that, because of the cost, they:

- did not visit a doctor or clinic when they had a medical problem, which fell from 29% in 2012 to 23% in 2014;
- did not fill a prescription, which fell from 27% to 19%;
- skipped a recommended test, treatment, or follow-up visit, which declined from 27% to 19%;
- did not see a specialist, which dropped from 20% to 13%.

In addition, the share of adults who said they had trouble paying their medical bills, or could not pay them at all, fell from 30% in 2012 to 23% in 2014. ■

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CNE QUESTIONS

1. Literature shows that diagnostic errors occur about how often?

a. 50% of the time
b. 20% of the time
c. 10% of the time
d. 5% of the time

2. CMS's report on measure usage found that what percent of measures had shown improvement between 2006 and 2012?

a. 90
b. 80
c. 85
d. 95

3. A study by Revenig et al, examined which two measures for their predictive value with regard to frailty?

A. gait speed and serum hemoglobin values
B. shrinking and grip strength
C. activity level and exhaustion level
D. none of the above

4. The difference between improvement in SSI rates of NSQIP hospitals and non-NSQIP hospitals according to a recent study is how many percentage points?

a. 10%
b. 11%
c. 6%
d. 5%

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.