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AHC Media

Stage 3 EHR meaningful use proposals include eight core goals

Alignment, simplification, and flexibility are the bywords

Get ready for interoperability, simplified meaningful use measures, and program alignment. These are the highlights of the proposed rule for Stage 3 of the incentive programs — with an estimated $1.6 billion in incentive payments for hospitals — for Medicare and Medicaid Electronic Health Records (EHRs) released by the Department of Health and Human Services (DHS), Centers for Medicare & Medicaid Services (CMS), and Office of the National Coordinator for Health Information Technology (ONC) in late March.

The proposals include criteria that will become final, if implemented as written, in 2018. However, the comment period is open through the end of May, and some changes may occur.

"For hospitals, the proposed rule focuses on three main issues," says **Kate Goodrich**, MD, MHS, the director of the Quality Measurement and Health Assessment Group at CMS in Baltimore. Some organizations may be ready by 2017, but others may need another year to begin that reporting."

> "IT IS VOLUNTARY, BUT IF YOU DO IT NOW, YOU CAN BENEFIT FROM ONE-TO-ONE ASSISTANCE THAT WE ARE PROVIDING THROUGH THE END OF NOVEMBER."

In no case will organizations be given leeway to wait to report beyond 2018, however.

Second, meaningful use measures have been simplified and now focus on eight core goals that everyone has

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to achieve. *(To see a breakdown on the goals, their objectives, and the proposed measures associated with them, see pages 51-52.)* Three of them have multiple measures within them, and organizations can choose among the measures within those core objectives, she says. Those objectives — health information exchange, patient engagement, and public health reporting — are viewed as the most difficult objectives to meet. "They focus on advanced use of EHRs," Goodrich explains.

Other elements that change in meaningful use measures include removing some requirements that have "topped out" — measures with widespread adoption; organizations routinely score 100% on these — or they are paper based. These remain part of the base EHR, she says, and include data points like height and weight, or blood pressure readings. "They just no longer have to report these to us."

Lastly, it features changes related to interoperable data sharing between organizations and advanced use of EHRs to improve outcomes, efficiency, and effectiveness, she says.

"We are not proposing any quality measures, but we are looking at electronic measures in the payment rules, the inpatient prospective payment system," she says. "That will give us more flexibility to update measures each year and build them into the base quality programs."

The proposal is 300 pages, but Goodrich says she hopes it is widely read by stakeholders like those in quality improvement and patient safety, and she hopes they comment. "We look at public feedback and read every comment. There will undoubtedly be changes based on what comes back to us."

In addition, Goodrich would like hospitals to look through the rule and assess readiness for the changes to come. Even if there are tweaks, it is unlikely they will be wholesale to the document as it stands, she says. It was put together with people from throughout the healthcare world who have a vested interest in what's in it, and she says it may be finalized much like it looks now.

Even if you are doing well on the advanced measures, take a look at the proposals, start working with your EHR vendors, and even consider submitting your electronic measures data to CMS now, Goodrich suggests. "It is voluntary, but if you do it now, you can benefit from one-to-one assistance that we are providing through the end of November."

Those interested in that program can contact the CMS Quality Net help desk (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/HelpDeskSupport.html) for assistance, she says. "We want you to get used to submitting this data, and we are standing by to assist you."

The focus of the proposed Stage 3 rules for hospitals is the advanced objectives, and Goodrich stresses that most facilities will have some work to do to ensure success come 2017. "It is not that far away," she says.

Getting it right is not just important for the potential $1.6 billion in incentives available that first year, either. Goodrich emphasizes that the rule all leads back to quality and safety: engaging patients,

sharing information, improving communication. And it does that while striving to reduce the burden on providers and the administrative staff that supports them. "We want you to focus on the measures that really matter to patient safety and quality," she notes. "We do not want you to be distracted by things you are already achieving but have to report, or multiple reporting periods. We want you to focus on the measures that matter to patient safety and quality of care. And also on engaging patients, because we know that when they are more engaged in their care, it can significantly improve outcomes."

"FIRST, THERE WILL BE A SINGLE REPORTING PERIOD FOR EVERYTHING. IT WILL BEGIN IN 2017 OR 2018 AT THE LATEST."

The complete proposed rule can be found at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-06685.pdf.

For more information on this topic, contact Kate Goodrich, MD, MHS, Director, Quality Measurement and Health Assessment Group, Centers for Medicare & Medicaid Services, Baltimore, MD. Email: Kate.goodrich@cms.hhs.gov.

Proposed: Eight Stage 3 meaningful use objectives and their measures

1. **Goal: Protect electronic health information**

Objective: Added language to security requirements to include administrative and physical safeguards.

Measure: Annual risk analysis or review.[1]

2. **Goal: Electronic Prescribing**

Objective: No changes from Stage 2.

Measures: Now more than 25% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using the EHR.[1]

3. **Goal: Clinical Decision Support**

Objective: Implement clinical decision support interventions and improve performance for high priority health conditions.

Measures: As at Stage 2, and implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. If four such measures are not available, then clinical decision support interventions must be related to high priority health conditions. Also, the provider or hospital has enabled and implemented the functionality for drug/drug and drug/allergy interaction checks for the entire EHR reporting period.[1]

4. **Goal: Computerized Provider Order Entry (CPOE)**

Objective: Use CPOE for medication, lab, and diagnostic imaging orders, directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who is allowed by state, local, and professional guidelines to enter such orders into the medical record.

Measures: All three must be met: more than 80% of medication orders by eligible or authorized providers of the inpatient or emergency department are recorded using CPOE; more than 60% of lab orders created by such providers in those departments are recorded using CPOE; and more than 60% of diagnostic imaging orders must meet those same criteria.[1]

5. **Goal: Patient Electronic Access to Health Information**

Objective: For Stage 3, there are two policy goals: that patients have timely access to their full health records and important health information, and that the healthcare system engages in patient-centered communication to enhance care planning and coordination.

Measures: For more than 80% of all unique patients seen in inpatient or emergency departments, the patient or his or her representative has access to view online, download, and transmit their health information within 24 hours of its availability to the provider.

Alternatively, the patient or representative is provided access to a certified interface to retrieve that information within the same 24-hour period of its availability. Second, the provider or hospital must use clinically relevant information to identify patient-specific educational resources, and electronic access to those resources to more than 35% of unique patients.[1]

6. Goal: Coordination of Care through Patient Engagement

Objective: Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care — i.e. for secure dialogue between providers, care team members, and/or patients about health status or treatment or care planning. Also, use this as a way to capture and record patient-generated health data and information outside a clinical setting, such as weight or blood pressure taken at home.

Measures: Numerators must be attested for all three measures, but only two need be met for success.

First, more than 25% of unique patients seen as inpatients or in the ED actively engage with the EHR, either viewing it themselves, or downloading or transmitting to a third party. They can also meet this requirement if more than 25% do the same using a certified interface.

Second, more than 35% of unique patients — inpatients or emergency department — receive a secure message, using that function of the EHR.

Third, more than 15% of all patients (discharged by the ED or inpatient department) include self-generated health data, or data from a non-clinical setting in the EHR.

7. **Goal: Health Information Exchange (HIE)**

Objectives: Provider or hospital provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology.

Measures: Providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three proposed measures to meet the Health Information Exchange Objective.

Measure 1: For more than 50% of transitions of care and referrals to another setting of care or provider of care, the provider creates a summary of care record using and EHR and electronically exchanges the summary of care record.

Measure 2: For more than 40% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the provider incorporates an electronic summary of care document into the EHR from a source other than the provider's own EHR system.

Measure 3: For more than 80% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, there is a clinical information reconciliation for three clinical information sets:

- Medication Review, including the name, dosage, frequency, and route of each medication,
- Medication Allergy, and
- Current Problem List, including current and active diagnoses.[1]

8. **Goal: Public Health and Clinical Data Registry Reporting**

Objectives: To be in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice. The emphasis in Stage 3 is on "active engagement" rather than "ongoing submission".

Measures: Hospitals have to choose from the following six measures, and would be required to attest to any combination of four of them. They are: immunization registry reporting; syndromic surveillance reporting; case reporting; public health registry reporting; clinical data registry reporting; and electronic reportable lab results.

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ICD-10 is finally on the horizon

Implementation begins in October

At a time when the Centers for Medicare & Medicaid Services is putting extreme value on high-quality data *(see story on the Stage 3 meaningful use proposal, page 49)*, the repeated delays to the implementation of ICD-10 are impeding progress toward that very goal.

Originally slated for implementation in October 2013, the new clinical codes have been delayed twice, each time costing the industry between $1 billion and $6 billion, according to the American Health Information Management Association (AHIMA), a Chicago-based trade group.

But it looks like this October, the new coding practices will, indeed, go

through. Most stakeholders believe the chances of another delay are slim — although the second delay last year, just on the cusp of implementation, was also deemed unlikely — and would be disastrous for healthcare. The insurance companies that have spent millions to ensure their computer systems could deal with the new codes, and hospitals that have spent like amounts as a group on staff training would likely raise a ruckus loud enough to discourage such action if there was even a suggestion of it, says **Angie Comfort**, RHIA, CDIP, CCS, senior director of health information practice excellence at AHIMA.

Current ICD-9 codes have been used for 35 years, and the United States is all but alone in continuing to use them. The nation had 14 years' notice for ICD-10, but delayed so long that the World Health Organization (WHO) has already begun creating ICD-11, which is due to be released in just two years, she says.

And just as the country is lagging, so are many hospitals who have been sitting back waiting to see what happens next before making any commitment to a change, says Comfort.

However, the time to move has come, she says. The recent passage of the Medicare sustainable growth rate (SGR) repeal bill by Congress, which provides a permanent fix to physician pay and included no mention of ICD-10, seems to indicate that it really is going to happen this October. "There are still opponents to it," Comfort says, "and there are probably more hurdles." At press time the Senate had yet to pass the SGR bill, leaving a little bit of doubt still hanging over the implementation of the coding procedures.

There are just a few short months to ensure your systems and your staff are ready, says Comfort. There are still opportunities to help get your staff trained. "It is not just your coding staff that has to know this," she says. "Others have to, too." Registration, providers, anyone who does orders, data analysts, case management, and utilization review will all have to be familiar with the new coding at some level.

And the new system is quite different — it is not just numbers, but numbers and characters. Generally, Comfort says it takes about six months to train staff adequately, and "we are well under that time period before the new system goes live."

> "HOW WILL YOU HAVE CONTINUAL OPERATIONS WITH PAYERS IF YOU HAVE TO SUBMIT PAPER CLAIMS? HOW LONG WILL THAT TAKE AND WHAT WILL THE IMPACT BE?"

Vendors also need to be ready, and it is up to hospitals to make sure that their systems are ready to go and handle the changes come October 1, she says. "You want to test ahead of time. CMS has already done testing to make sure they can accept the new codes, and so far, so good."

Contact payers to make sure they are ready, too, Comfort advises. "Are your contracts up to date? Have you done any testing with your third party payers? You have to worry about more than just CMS." Many of the big insurers have already announced their readiness, like the Blue Cross Blue Shield organizations. "They were very upset about the delays," she says. "They have been ready for a while."

Do you have a contingency plan if things do not work? Comfort says even if all your testing runs smoothly, be sure you have an idea of how things will work if there is a problem when things go live. "How will you have continual operations with payers if you have to submit paper claims? How long will that take and what will the impact be?"

It is about more than money, too, because all those numbers being input into computers — or if things go wrong, written on forms — are important data points that need to be available for quality reporting programs. If you can't extract the information from the new coding electronically for some reason, will your staff be ready and up to the task to abstract the data manually?

It all circles back to training, she says. AHIMA has ongoing classes, both in person and online. There are past webinars on the organization's website, as well as a checklist — albeit created when everyone thought ICD-10 would be implemented in 2013. You can find the checklist at http://journal.ahima.org/wp-content/uploads/ICD10-checklist.pdf. Information on the classes is available at http://www.ahima.org/education/onlineed/Programs/ICD10.

"WHO says we can't skip from ICD-9 to ICD-11," she says. "There can't be another delay."

For more information on this topic, contact: Angie Comfort, RHIA, CDIP, CCS, Senior Director, HIM Practice Excellence, American Health Information Management Association. Chicago, IL. Telephone: (312) 233-1915. ■

Medication reconciliation: Make it somebody's job

Study finds ownership key to ensuring key task is done right

Medication reconciliation is so important to the wellbeing of patients that proof it is done is something that is required by accreditors. But who should do it? Is there someone who is best placed to do it? And if there are multiple people who could do it, do any of them know who is doing it?

A research letter in the March issue of the *Journal of Hospital Medicine* looked at how various providers — pharmacists, physicians, and nurses — felt about medication reconciliation, who they thought should be doing it, and the problems that arise when there is a "lack of role clarity" surrounding the issue.[1]

Survey results

Almost 80 clinicians completed a survey that included questions on whose job it was to complete medication reconciliation at different points during a hospitalization, attitudes about the issue, and barriers to getting the job done, and done well, according to the study. There was little agreement among the respondents about whose job it was from admission through discharge, although most agreed a doctor should decide what drugs a patient should be on during hospitalization and after discharge. There was some disagreement between the kinds of physician — attending and resident — on who got to make that decision, but that it was a doctor was fairly well agreed upon.[1]

Pretty much everyone agreed that having an accurate list of medications improved patient care, but when asked if any clinician aside from yourself should be responsible for a medication list, 73% of nurses and 52% of pharmacists said yes, but just half of residents and 29% of attending physicians agreed.[1]

"ELECTRONIC RECORDS HAVE A CHECK BOX FOR IT, BUT THAT DOES NOT TELL YOU HOW WELL THE PROCESS HAS BEEN DONE. AND THERE IS NO BENCHMARK FOR IT. THERE IS NO METRIC FOR COMPLIANCE OR FOR DOING IT RIGHT."

"I think everyone knows this is important, and most doctors do this, even if they do not always write it down," says lead author **Kirby Lee**, PharmD, MA, MAS, associate professor of clinical pharmacy at University of California, San Francisco (UCSF) and a clinical pharmacist at the university's medical center. "Electronic records have a check box for it, but that does not tell you how well the process has been done. And there is no benchmark for it. There is no metric for compliance or for doing it right. Everyone struggles with it. And there are other things that are hot topics now that have replaced this issue in the public eye."

The process, done well, is time consuming, Lee admits. Medical records are often outdated, patients go to multiple doctors in multiple health systems with computer systems that do not talk to each other. Sometimes the patients are old and confused. Sometimes the patients do not speak English and there is no medical translator readily available.

And yet, he says, you still have to endeavor to do this and do it right.

Divide and conquer

In an ideal world, Lee says physicians or other prescribing providers like nurse practitioners would be the ones to do all the medication reconciliation because they are the ones who make the decisions on what a patient is taking, "and the only way to make a good decision on what to prescribe is to look and see what they are already on," he says.

In a hospital, where there are multiple physicians and other providers involved, it is better to have a multidisciplinary team which then divides up the task. One member may handle the job on admission, another may look at it on discharge. Different people may have different levels of expertise, he says.

While this is not one of

those hot topics like unplanned readmissions, it is something that should be on the quality radar, and you can run a good quality improvement project on it. Lee says a good benchmark to use is discrepancies. "Look at how accurate the person who takes down the medication list is compared to what the patient actually takes. Do they include vitamins or other supplements that patients often do not think of as drugs? Do they include over-the-counter drugs like ibuprofen?"

It is easy to do random audits of a few patients a month and provide constructive feedback. "The issue of forgetting vitamins is a low risk discrepancy," he says. "But if you forget to write down Warfarin, or put an inaccurate insulin dose, the risk goes way up."

Lee says that kind of project is "a great use of quality improvement resources and can really help physicians." You can zero in on patients who take a lot of medications, have multiple comorbidities, or take medications with a high risk of interactions. Patients with chronic illnesses, frequent ED flyers, and those who are more likely to have unplanned readmissions are also good patients to consider auditing. "You do not have to audit every patient, but focus on the panels of patients with the highest risk," he says.

The general cut-off for "a lot" of medications is 10, he adds, and high-risk medications include those like insulin and anticoagulants, and other medications where the dosages change regularly.

At UCSF they have considered doing a medication list clinic, telling patients they would do a free comprehensive medication interview, but "the patients are not that interested," he says. "They do not want to come back to the hospital after discharge, and only 20% of them bite." They are trying again, but this time having physicians refer patients to the clinic.

Use interviews, EHRs

Another idea Lee says they are toying with is to use nursing assistants and pharmacy techs to interview patients and update the electronic health records of patients while they are in the hospital. "In the general medicine hospitalist world, you get all comers, and they really struggle with this issue," he says. "If you develop a small service of people who are not making decisions about what patients take, but who are just cleaning up the medical record for the physician and inputting clean information, that could be very helpful to the doctors."

> "YOU GET THIS RIGHT ON ADMISSION AND AGAIN ON DISCHARGE AND YOU REALLY DO SAVE TIME AND IMPROVE QUALITY OF CARE."

More than one program like this was done in emergency departments using pharmacy technicians with good results, according to published studies.[2,3]

"This seems like one of those tasks that is a pain in the butt," says Lee. "But from a patient safety standpoint, and an efficiency standpoint, it is vital. You get this right on admission and again on discharge and you really do save time and improve quality of care. Think outside the box regarding medication reconciliation. You do not have to do something for every patient. But for the patient on 25 meds who has heart failure and diabetes? Medication reconciliation could make a life or death difference."

For more information on this topic, contact Kirby Lee, PharmD, MA, MAS, Associate Professor of Clinical Pharmacy, Department of Clinical Pharmacy, University of California, San Francisco. Telephone: (415) 502-8182. Email: kirby.lee@ucsf.edu.

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Successful sepsis program leads to national award

North Shore-Long Island Jewish wins Eisenberg Award for efforts

It has been five years since **Martin Doerfler**, MD, came to North Shore-Long Island Jewish Health System as senior vice president for clinical strategy and development and associate chief medical officer. When he started, the 18-hospital system based in Great Neck, NY, had a sepsis rate that was above the national average. Healthgrades noted the system was "underperforming" in the area. Before he started, sepsis was the largest single contributor to mortality in the health system. They created a task force to try to deal with it, he says.

As a critical care physician, sepsis was something that Doerfler had seen plenty of, too much of. While he was not brought in specifically to address that problem, he was as keen as anyone else at North Shore to try to get a handle on it, and soon was deeply involved, he says. His work, and that of the rest of the team involved in reducing sepsis in the North Shore system, paid off. This year, the health system was given the National Quality Forum/Joint Commission John M. Eisenberg Award for Patient Safety and Quality (other winners included Mark Graber and the American College of Surgeons, as reported in the April issue of *Hospital Peer Review*).

"Most of the research on sepsis has been focused on septic shock," Doerfler explains. "That is when you can see it." Mortality is as high as 50% when sepsis moves to severe sepsis and septic shock.

When he started at the system in 2009, the work to reduce sepsis had begun, but had not had much traction. "There was a lot of controversy about the best way to care for people when they progress to septic shock," he says. "Our critical care folks were in a debate with the emergency department. If the ED sees septic shock, they go right to the intensive care unit. But the guidelines that were out then referred to sepsis, even though the items that were in the guidelines were things you mostly saw once sepsis progressed to septic shock." The emergency physicians rightly noted that sepsis, severe sepsis, and septic shock are all different things.

> "THERE WAS A LOT OF CONTROVERSY ABOUT THE BEST WAY TO CARE FOR PEOPLE WHEN THEY PROGRESS TO SEPTIC SHOCK."

"A 22-year-old college student with a severe sore throat and a high heart rate has all the elements required to meet sepsis according to those old guidelines from Surviving Sepsis," he says. "That kid, who looks fine and is being given ibuprofen and sent home, could have been sent to the intensive care unit under those guidelines. You can't apply those rules to everyone."

Doerfler's boss at the time, the chief quality officer, asked him to get involved in the project, and when he joined the team they started to modify those guidelines. "That was the key to us moving forward," he says.

Time zero

One of the first things that had to change was the definition of "time zero". "The ED would tell you if a patient comes into the department in shock, you start the clock from when the patient showed up," he explains. But let's say there is a 55-year-old with pneumonia, a fever, and a cough. The nurse checks his vitals and they are fine and he goes into a cube. If you have an hour to get something done, when is the zero time? Under the National Quality Forum and Surviving Sepsis rules, time zero is when the nurse first saw the patient, or triage time, if the patient is very sick. For other patients, it is after certain vitals are taken by the nurse and the doctor orders a serum lactate test. That indicates a physician is considering a diagnosis of sepsis.

"There are about a dozen things that you have to do in the first six hours of a sepsis patient coming in," he says. "Some have to be done in 12. But there are four things you need to do in the first three hours. We decided to ignore everything but those first four items, as they were the most important."

The four items were getting blood cultures before ordering antibiotics, starting antibiotics

within those three hours, sending serum lactate tests, and for patients that meet severe sepsis/septic shock criteria, ensuring they get appropriate fluids.

"Then we started looking at how to ensure those things were getting done, barriers that existed, and how to break through them," he says.

The lactate test was one of the simpler problems to solve. "We do not just want to send the test out, we want to get it back, so we need the lab to understand that this is a priority and that they should call us with results fast," says Doerfler.

The antibiotic choice can't wait several days for a culture, so other factors have to come into play for a physician to make a decision on what bug he or she is treating. There might be X-rays to see if there is evidence of pneumonia, which can take 90 minutes, he says. "So we have to look at what are the things that might slow that process down."

Strategic partnership

During this process, the North Shore system created a strategic partnership with the Institute for Healthcare Improvement to focus on a couple issues related to the project, and used the IHI's method for process improvement during the remainder of the project. Doerfler says they also decided to focus efforts on the emergency department, as most cases came in the front door, and did not originate within the hospital.

"We worked on a lot of little pieces," he says. "How long does it take you to get a patient from coming in the door to getting a central temperature? How can we work to cut a few minutes off of that? If we cut a few minutes off of every step, it adds up. And we continue to do that work." As an example, they looked at what antibiotics were commonly kept in the ED and made some changes so that the most likely antibiotics a physician would need were available on demand, and there were fewer instances of waiting for someone from the pharmacy to bring a needed drug.

Key to those efforts was asking frontline teams to participate in the project and all its pieces. "They are the people who know where the slowdowns are and where there are opportunities for improvement," he says.

> "EMPOWER YOUR NURSES, PHARMACISTS, AND LABS TO DO THIS WORK. THEY ARE THE TRUE EXPERTS. THEY ARE THE ONES WHO CAN SOLVE THE PROBLEMS AROUND THIS AT YOUR FACILITY."

The results were impressive. In 2009, mortality for sepsis was 32% in the system. Currently, it is 16.1%, although in March it was as low as 13%, Doerfler says. "We see a thousand patients a month that meet the criteria for sepsis, so that is pretty good," he says. "The goal is to get it to single digits. Intermountain Healthcare in Utah is in the high single digits. They are smaller than we are, but we think it is possible and that we will reach that goal in the next few years."

Doerfler says they are also pretty reliable on three of the four items that need to be done in those three golden hours. Scores are in the 80-90% range for those metrics for patients that come through the emergency department. They are starting to work on the inpatient sepsis population next, which accounts for about 15% of the total. And they also only hit about the 50% in mark in making sure that the right patients get the appropriate fluids before that 180 minutes are up. "This is the year of the fluids for us," he says. "We want it to meet the level of reliability the other metrics do."

Sepsis is a problem at every hospital, whether it is seen and counted and considered or not, he says. "Not everyone is focused on this problem. But just because you do not see it, does not mean you do not have it."

He says that any hospital can focus on getting the four items of the three-hour bundle done for sepsis patients. "And if you want to focus on just one part, it is the antibiotics. The evidence is unequivocal that this is what will decrease mortality."

Then work on making all the moving parts run more efficiently. "Empower your nurses, pharmacists, and labs to do this work. They are the true experts. They are the ones who can solve the problems around this at your facility."

For more information on this topic, contact Martin Doerfler, MD, Senior Vice President, Clinical Strategy and Development, Associate Chief Medical Officer, North Shore-Long Island Jewish Medical System, Great Neck, NY. Email: mdoerfler@nshs.edu ■

Alarms top safety list again

ECRI annual list also mentions patient violence

At press time, ECRI released its annual list of top 10 patient safety issues. At the top again was alarms; something that has been a concern for ECRI over the course of several lists. This time, the issue list focuses on the policies and practices around alarms. Other familiar items on the list include Health IT — a concern to regulators like The Joint Commission, which issued Sentinel Event Alert related to Health IT last month. *(For more information on the Sentinel Event Alert, see story on page 59.)*

Mixing up IV lines, medication reconciliation, and issues surrounding the inadequate process of endoscopes and surgical equipment have all appeared before.

But among the familiar were some new issues: managing patient violence, opioid-related events, medications errors related to metric conversions of weight, and handoff problems related to patient transport.

Next month, *Hospital Peer Review* will have a complete story on the top 10 list and will talk with one of the authors about the new included items and which did not make the cut.

The full list can be found at the ECRI website, www.ecri.com. ■

ICU program gets patients moving sooner

Those patients have better outcomes, creators say

The intensive care unit is that place you think of for the sickest patients, full of tubes and wires — patients who are comatose, unmoving, unaware. Yet a collaborative through Partners Healthcare in Massachusetts has created a program — now in its fifth year — that has critically ill patients getting up sooner rather than later, getting rid of those tubes and wires, and getting better sooner because of it.

Colleen Ryan, MSN, RN, CCRN, a nurse educator in the intensive care unit at Newton-Wellesley Hospital in Newton, MA, and her colleagues Michele Wescott, BSN, RN, CCRN, Ann Mulligan, RN, and Maureen Sullivan, RN, created the program after attending a conference in 2011 put on by the Institute for Healthcare Improvement (IHI) that covered the very topic. Speaking at the conference were people from Vanderbilt University in Tennessee and Intermountain Healthcare in Utah who implemented early mobility programs in their critical care units.

Ryan went with her nursing colleagues as well as a physical therapist, a respiratory therapist, and a critical care physician. "I was sold," she says. But not everyone was. The group created a survey to find out what some of the concerns were among other providers and staff. They tried to address them through education, but what worked best was seeing the program in action, Ryan says. One patient off the vent and doing well was the best way to create converts and evangelists.

The program focuses on the ABCDE bundle: Awakening and Breathing Coordination, Delirium Monitoring and Management, and Early Mobility, she says.

Effects of being in the ICU can be long term, particularly for patients who experience delirium, something that is more likely to happen to patients who are sedated for long periods of time in order to be on a ventilator. Studies have shown that sedated, intubated patients who become delirious, even if they are young, often are not back to their old selves a year later, Ryan says. One study she remembers of more than 100 patients who were critically ill found that over half did not return home, nor were they able to function normally a year after they were discharged.

What's physically good for the patients is also mentally good for the patients and their families, Ryan says. They want nothing more than to be out of the ICU, if not the hospital. "They think they are going to die on the ventilator," she says. "They want to be out of bed, and are so appreciative when they get up."

The core group of nurses and physicians was very engaged in 2012, and early mobility was given to 80% of eligible patients in 2012. In 2013, things slowed down a bit, and the enthusiasm waned, Ryan says. Only half the eligible patients got the early mobility treatment. However, a grant from the American Association of Critical-Care Nurses (AACN) helped regain the momentum, identify barriers, and promote best practices has put the team back on track, she says. They are excited and engaged enough to be doing

poster presentations across the country during the year, Ryan says.

At Newton-Wellesley at the peak of the program, ventilator days were down an average of 4.2 per patient, about the same as the reduction in the length of stay in the ICU. The total savings was over $1.5 million. There, 60% of eligible patients were moving early as part of the program. At Massachusetts General Hospital, early ventilator removal saved $300,000, and at North Shore Medical, 81% of patients were out of bed early.

Another benefit of the re-engagement is a follow-on project being planned to help patients sleep better at night with fewer interruptions, Ryan says. This could help decrease delirium further, she hopes.

For more information on this topic, contact Colleen Ryan, RN, MSN, CCRN, Nurse Educator, Intensive Care Unit, Newton-Wellesley Hospital, Newton, MA. Email: cryan@partners.org. ■

The Joint Commission issues Sentinel Event Alert on health IT

Patient safety risks are the focus

It is hard to imagine health information technology as a potential safety hazard, but The Joint Commission is pointing out some of the ways hospitals and health care organizations should reconsider the potential risk to patients as a result of health information technology (HIT).

The commission released a Sentinel Event Alert on March 31 that looks at issues that might be of concern, as well as potential solutions to those problems.

According to the alert, there have been 120 reported sentinel events between January 1, 2010, and June 30, 2013, including situations such as a patient being given the wrong mediation because a drug name was autopopulated by the computer system. Another event involved a child whose weight was entered as 34, but the pharmacist did not know if it was pounds or kilograms and the computer system did not indicate age. Medication dosing was again a factor.

The largest share of the problems are caused by human computer interface — 33%, according to the alert. Only 6% can be blamed on software or hardware. A quarter come down to communication.

The Joint Commission suggests several ways to mitigate risk, including the following:

- Identify and report health IT-related hazardous conditions, close calls or instances in which no harm has occurred.
- If a patient is harmed, involve IT staff members and vendors in the comprehensive systematic analysis of the adverse event.
- To the extent possible, make health IT safe and free from malfunctions. This includes making sure new technology is properly installed and tested, and proper training is provided to make sure technology is used safely.
- Health IT should be used to monitor and improve safety.
- Organization leadership should be fully committed to safe health IT, providing oversight to planning, implementation and evaluation.

The sentinel event alert is available at http://www.jointcommission.org/assets/1/18/SEA_54.pdf.

The Joint Commission is offering a free continuing education course, "Investigating and Preventing Health Information Technology-Related Patient Safety Events," that teaches how to identify, report, and address health IT-related safety concerns in a health care organization. More information is available at The Joint Commission website, www.jointcommission.org. ■

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- Top 10 safety concerns
- The latest in fall prevention
- New grading system comes to Hospital Compare

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CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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CNE QUESTIONS

1. **Which one of these is thought to be one of the difficult goals to meet of the eight listed in the proposed Stage 3 Meaningful Use rule?**

   a. CPOE
   b. Health information exchanges
   c. Electronic prescriptions
   d. Clinical decision support

2. **ICD-11 is due to be released in what year?**

   a. 2015
   b. 2019
   c. 2018
   d. 2017

3. **How many medications does Kirby Lee says is considered by pharmacists as "a lot"?**

   a. 25
   b. 10
   c. 6
   d. 5

4. **What percentage of sepsis patients come to North Shore through the emergency department?**

   a. 85
   b. 95
   c. 75
   d. 65

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.