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INSIDE

AHC Media

FEBRUARY 2016 Vol. 41, No. 2; p. 13-24

Meaningful use presents opportunity for measuring quality

Make sure data is timely, clear, transparent

So you spent all that time and effort to gather meaningful use data, and now you've shown that your use is… meaningful. Now what do you do with this wealth of information and the system that produced it? One health system is showing that meaningful use strategies can be used to measure and improve quality.

Providence Health & Services, a not-for-profit Catholic healthcare ministry that provides services in Alaska, California, Montana, Oregon, and Washington, with its system office located in Renton, WA, achieved 100% compliance with meaningful use in 2014 but didn't want to just set aside the accumulated data. Providence's Director of Government Programs, **Ray Manahan**, says Providence leaders wanted to capitalize on not just the data itself but the infrastructure that had been created to collect it.

> "MEANINGFUL USE IS NOT GOING AWAY, BUT IT REALLY HAS TEED US OFF AS AN ORGANIZATION TO BE SUCCESSFUL WITH OTHER QUALITY PROGRAMS."

By applying the data and methodology to other projects, meaningful use information helped the 34-hospital system start collaborating around data, Manahan says. With such a large health system, collaborating around data to improve quality can be a challenge, he says.

"Meaningful use was our springboard to a lot of data coordinating and also collaboration

Financial Disclosure: Editor **Greg Freeman**, Managing Editor **Jill Drachenberg**, Associate Managing Editor **Dana Spector**, and Nurse Planner **Kay Ball** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor **Patrice Spath** discloses she is author of by Health Administrative Press, and a stockholder of both General Electric and Johnson & Johnson.

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Hospital Peer Review®
ISSN 0149-2632, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST registration number R128870672.

POSTMASTER: Send address changes to:
Hospital Peer Review
P.O. Box 550669
Atlanta, GA 30355.

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Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year: $519. Add $19.99 for shipping & handling.
Online only: 1 year (Single user): $469
Outside U.S.A.: Add $30 per year. Total prepaid in U.S. funds.

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This activity has been approved for 1.25 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 15 Contact Hours. This activity is valid 24 months from the date of publication.

The target audience for *Hospital Peer Review®* is hospital-based quality professionals and accreditation specialists/coordinators.

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across our very large system. Meaningful use is not going away, but it really has teed us off as an organization to be successful with other quality programs," Manahan says. "With a system of this scale, trying to streamline how we obtain, interpret, and disseminate data can get very complex. One region may be doing it completely different than another region."

The core measures and menu measures of meaningful use have now become the core measures in other quality programs, Manahan notes, so Providence has been able to leverage the meaningful use data in areas such as payer contracting and accountable care organizations. "We got them on our radar because of meaningful use, but now we're expanding them to these other areas that are so reliant on data," he says.

Benchmarks established for other concerns

The effort began five years ago when Providence developed a scorecard to track meaningful use measures. One goal of that effort was to create a simplified snapshot for senior executives to indicate each hospital's progress toward meaningful use. Green, yellow, and red notations told the executives that hospitals were on target, struggling, or way behind. With transitions of care for stage 2 meaningful use, for example, providers had to create 10% of records electronically. That was challenging for Providence, Manahan says, but the job was made easier by the scorecards that told each hospital where it stood on that measure. Red meant the hospital was below 10%, yellow meant 10-15%, and green meant more than 15%.

That scorecard concept was then applied to other top concerns, such as hospital-acquired conditions, value-based purchasing, and readmission reduction.

Providence established benchmarks for each of those concerns, monitoring them with weighted quality measures and tracking progress just as it had done with meaningful use data. Providence now tracks about 300 quality measures for the areas of concern. The tracking can yield some useful information immediately, before any long term analysis can be completed. For instance, tracking the quality measures can reveal that certain information or prompts should be added to the EHR, as well as whether information is being gathered because it helps improve quality or because there is a potential penalty for not gathering that data.

"We wanted to be able to see a snapshot of where we stood on these issues, which regions might be doing well and which regions aren't, and then have that dialogue," Manahan explains. "When we see that Oregon is doing well with this issue and Washington isn't, we can go to Oregon and ask what they're doing differently to get those good results. Having that discussion at a granular level was very useful to us, but in order to get there we had to have a good analysis of the data."

The effort arose partly from the way Providence hospitals relied on the health system's leaders to guide them through the meaningful use requirements, Manahan explains.

Meaningful use is an all-or-nothing proposition, with health providers either achieving the required measures completely or failing, so hospital leaders often wanted to cut through all the details of the requirements and just know where they stood: "Where am I coming up short and what do I need to do to fix it?" he says.

"Our technical folks read the hundreds and hundreds of pages from CMS, but what people needed at the hospital level was an understanding of the best practices that would get them across that threshold," Manahan says. "We ran the reports and held a meaningful use summit where we could exchange information among regions. If the California region went from red to green, we would ask them to share how they turned that around, to uncover what they did that made the difference."

Data must be timely and clear

Several lessons emerged soon after adopting the meaningful use strategy. First, the data must be timely, clear, and transparent if it is to be useful in improving quality. The data also should identify areas of risk and produce specific goals for improvement. System leaders must clarify ownership with regard to those goals, Manahan says, in order to facilitate collaboration across the many institutions. Providence leaders also learned that applying the meaningful use model to other topics can be tricky. Much of the data needed for meaningful use could be obtained through Providence's electronic health record (EHR), but even there the system had three versions. That necessitated additional data collection steps to accommodate the differences, and that challenge was even greater when the same approach was applied to other concerns. Obtaining and massaging data for the clinical issues required more cooperation from parties throughout the health system, especially quality professionals.

"We had to take into account that a public health department in California may differ in their requirements for syndromic surveillance versus the health department in Oregon," Manahan says. "I stressed that we needed a project manager who understands the rules related to this given measure, where we can dive into it but understand the variability of it from state to state."

In addition, the benchmarks for quality in patient care can change more often and more rapidly than did similar measures in EHR adoption, Manahan says. A system-wide clinical quality measure crosswalk helps keep track of the factors that apply to each clinical concern, listing all clinical quality measures across provider and hospital quality programs.

Time has proven the value of applying the meaningful use framework and data to other concerns, but Manahan notes that not everyone in the Providence system was enthusiastic about the idea initially. Some criticized the scorecard system as simplistic and providing an incomplete assessment of progress in the areas of concern. Most of those critics have come around after seeing that the format does help keep Providence facilities on track with quality measures, he says.

"What was hugely hard for us was transitioning ownership of this EHR incentive program from an IT system project mode to an approach that involved the rest of Providence just as directly and hands-on," Manahan says. "Although the foundation was laid through the meaningful use experience, the lesson learned was that we need boots on the ground to continue the success when we expand the approach from meaningful use to quality overall." ■

Health system screens all patients for suicide risk

Use of tool does not require mental health background

In what appears to be a first for a health system, Parkland Health & Hospital System in Dallas recently implemented suicide screenings for all patients.

The program is the first of its type in the nation, according to **Kimberly Roaten**, PhD, director of quality for safety, education and implementation in the department of psychiatry at Parkland and associate professor of psychiatry at The University of Texas Southwestern Medical Center, also in Dallas. A clinical psychologist working with Parkland patients, Roaten is one of the leaders who developed the new program.

"The Joint Commission requires healthcare providers screen all patients with psychological problems for suicide risk," Roaten notes. "But we believe it's important to screen everyone because some of this risk may go undetected in a patient who presents for treatment of non-psychiatric symptoms. We decided to move beyond what is required by The Joint Commission and screen all patients who enter our system for care based on the evidence that patients who die by suicide often present for treatment to EDs or primary care in the months leading up to their deaths. The timing was right in the fall of 2014 to reconsider the screening."

In 2014, Parkland dedicated the resources needed to make this possible, which included hiring 12 psychiatric social workers, selecting a standardized and validated suicide screening instrument, building an algorithm in the electronic health record that triggers the appropriate clinical intervention depending on the patient's answers to a few simple questions, and training all nursing staff to implement the program.

Parkland implemented suicide risk screening with all emergency department patients and hospital inpatients in February 2015, says **Celeste Johnson**, DNP, APRN, PMH CNS, director of nursing in psychiatric services at Parkland.

"In late May, we transitioned from the previous screening program to the standardized suicide risk screening at all Parkland community oriented primary care health centers and also at the correctional health division for all inmates at the Dallas County Jail," Johnson says. "Our goal is to screen every patient using proven screening tools that can help us save lives."

Parkland has screened more than 100,000 patient encounters at the hospital and emergency department, and more than 50,000 patient visits in outpatient settings. Parkland uses the Columbia Suicide Severity Rating Scale (C-SSRS), a validated screening tool, with adults 18 and over and the ASQ (Ask Suicide Screening Questionnaire) with 12- to17-year-olds.

The Parkland algorithm sorts patients into three suicide risk categories based on their answers to the screening questions: no risk identified, moderate risk identified and high risk identified. Those at high risk are immediately placed under one-to-one supervision, suicide precautions are implemented and an evaluation by a behavioral health clinician is initiated. Patients at moderate risk are automatically referred to a psychiatric social worker and usually are seen during the same visit. If a patient chooses not to speak with a psychiatric social worker during the visit, they will receive a follow-up phone call to provide additional support and resources.

> "THE PRIMARY BENEFIT IS THAT WE HAVE IDENTIFIED PATIENTS WHO ARE POTENTIALLY AT RISK THAT MIGHT HAVE BEEN MISSED WITHOUT UNIVERSAL SCREENING."

For instance, a patient may come in with a sprained ankle or sore throat, but if his or her suicide risk screening shows moderate risk, Parkland's clinical algorithm immediately alerts a member of the behavioral health team to come and speak with the patient. Before discharge, both moderate and high-risk patients also are given information about suicide warning signs, suicide crisis center hotline numbers, and Dallas County community mental health resources.

So far, the suicide risk screening in the emergency department and inpatient units at Parkland has found 1.8% of patients to be at high risk and approximately 4% at moderate risk for suicide.

"To our knowledge we are the first big hospital system in the U.S. to implement a universal screening program for suicide risk and the data we are gathering will be significant for other organizations in the future," Roaten says.

Implementing such a plan required far more than simply writing a new policy, Roaten notes. Parkland leaders considered screening completion time, who would complete the screening, when the screen would be completed, behavioral health provider response to patients who were identified to be potentially at risk, whether the health system had enough resources, and the effect on ED throughput. The Parkland team did not want the plan to slow the flow of patients through the ED.

Roaten and her colleagues determined that there several positive aspects of the plan. The screening instruments are easy to

use, in the public domain, reliable and valid, and educational modules and video are available online for standardized training. Using the tool does not require a mental health background.

"And it's the right thing to do for patients," she says.

The Parkland team identified no real downsides to screening all patients, as long as the appropriate resources were in place prior to initiation of a screening program.

"The current evidence suggests that there is no iatrogenic harm associated with screening for suicide risk. We are not making our patients feel worse by asking about suicide," Roaten says. "The opposite is true: Patients experience providers as empathic and appreciate their concern."

The planning phase required a significant time commitment from multiple stakeholders prior to implementation, Johnson notes. The most time-consuming phase of the process was developing a specialized clinical response algorithm and building the screening tool in the EHR. It was important that the screening items be implemented in a way that was simple, user-friendly, and efficient, Johnson says.

Additionally, the clinical response algorithm unfolds in the EHR on the back-in, significantly improving patient care without complicating the user/provider experience, she explains. The planning phase also involved rolling out the education to all clinicians. The planning and implementation team consisted of dedicated physicians, psychologists, nursing staff, IT support, clinical educators, social workers, nursing leaders, and hospital administration who supported this initiative.

Data from the initial phases are now being used to estimate the needs in the final phase of implementation. Parkland expects there will be additional cost associated with the final phase as clinicians are hired to respond to at-risk patients.

"The primary benefit is that we have identified patients who are potentially at risk that might have been missed without universal screening," Johnson says.

Parkland officials considered the possibility that a formal policy of screening everyone creates more obligation to detect suicidal patients, raising the possibility that if someone does commit suicide, the policy could make it easy for a plaintiff's attorney to say that Parkland should have detected the risk. That risk does not outweigh the positive reasons for screening patients, says **Paul Leslie**, JD, executive vice president and general counsel for Parkland.

"While we cannot comment on what the plaintiffs' bar may or may not argue, we believe that use of the new process will enhance the opportunities for identifying patients potentially at risk and will lead to better outcomes," he says. ■

Money-back guarantee aimed at patient satisfaction

"Surgery with a warranty" seeks to right any wrongs

In the retail world, a money-back guarantee is offered as proof of quality and a dedication to customer service. Why can't the same reasoning be applied to healthcare?

That is the idea behind Geisinger Health System's ProvenExperience, a program that offers refunds to patients whose expectations weren't met based on kindness and compassion. President and CEO **David T. Feinberg**, MD, MBA, unveiled the Danville, PA-based health system's mony-back guarantee recently.

"The way I see it, if you go into Starbucks and you're not happy with your order, they don't sip your latte and argue that they made it correctly. They just take care of you on the spot," Feinberg says. "What matters to me is that every patient is satisfied with their treatment and so I started thinking, 'What is our guarantee? What is our refund?' We need to be disruptive to move the practice of providing great patient experience forward and so the decision was made to give unsatisfied patients their money back."

A pilot of the program has been introduced at Geisinger Medical Center, the health system's main campus in Danville. A key component of the program is a patient app developed by Geisinger that allows certain surgery patients enrolled in the pilot to determine the amount of the refund they want based on their copay. *(For another health system's patient satisfaction app, see story on page 19.)*

For example, if a spine surgery

patient paid a $1,000 copay and they weren't pleased with how office staff treated them, they can log into the app and select from a sliding scale how much of their co-pay they want refunded. They can choose from $1 to $1,000 and the refund request is processed within 3 to 5 business days.

More about being heard

Feinberg doesn't anticipate the system will be abused and instead foresees patients sticking to the honor system.

"Ultimately, they just want to be acknowledged and to spare other families any pain they might have experienced," he says.

Feinberg explains that ProvenExperience is an evolution of Geisinger's ProvenCare portfolio, which gained attention in 2006 by proving that applying evidence-based protocols could reduce mortality rates, improve outcomes, and reduce costly readmissions. Some called it "surgery with a warranty" because if certain surgery patients are readmitted within 90 days with a preventable complication, they are taken care of at no extra charge.

"Historically, Geisinger's reputation has been based on transforming the way healthcare is delivered," Feinberg says. "We've been held up as a national model for providing both high-quality and cost-effective medical care and our ProvenCare program has garnered national — and international — praise for eliminating unwarranted variation and applying scientific best practices. Now is the time to focus on compassion."

He predicts ProvenExperience will transform the healthcare industry. But he acknowledges that the idea of giving money back to patients, without asking questions, will seem radical to most healthcare leaders.

"In the beginning, I talked to other health system CEOs and industry leaders about ProvenExperience and they all said, 'Don't do it.' I really felt dejected," Feinberg explains. "Then I thought about Kodak executives discussing digital photography. And Blockbuster talking about online video options. Were they also told 'Don't do it?" That's when I said to myself, 'We're doing it.'"

> "WE FOUND THAT SOMETIMES PATIENTS JUST WANT TO TELL THEIR STORY ... THEY WANT SOMEONE WHO CARES AND WANTS SOMEONE TO LISTEN TO THEM."

Patient input steered project

The guarantee is in keeping with the philosophy that Geisinger has always had toward patient satisfaction, notes **Susan M. Robel**, RN, BSN, MHA, NEA-BC, executive vice president, system chief nursing officer, and system chief patient experience officer. The health system has long had a policy of waiving a patient's copay when it seemed Geisinger had not fulfilled its promise to provide the best possible patient experience, Robel says. That process was reactive, however, in that the patient had to first complain and then Geisinger would look into the claim.

"We wanted to know how we could further engage our patients and put our trust in them, to help us do better," Robel says. "Sometimes we believed those phone calls to a patient advocate came when the patient was very frustrated and emotions were running high. We wanted to be much more transparent and proactive in letting patients tell us that they were not satisfied, without waiting until it reached that point."

Geisinger put together a team to develop the app, including clinicians, IT professionals, risk managers, and representatives from billing and reimbursement. The initial ideas for the app were presented to the health system's patient advisory council, which provided useful feedback. *(For more advice from Geisinger's patient advisory council, see the story on page 19.)* The patient representatives said the app should be simple and easy to use, and it should provide a way to contact someone about the patient's experience.

"We found that sometimes patients just want to tell their story," Robel says. "They want someone who cares and wants someone to listen to them. They said this is not really about the refund; it's about someone listening and wanting to fix the issue. That was a big wow for us, so we wanted

to incorporate that process into the app."

Geisinger began with a pilot aimed at bariatric and some spinal surgery patients. The limited roll out was intended to test and refine the technology before offering it to all patients. The surgeons in those areas agreed to participate in the pilot, and their patients were made aware of the app and the offer for a refund. The app was designed to be simple, asking patients if they were happy with their surgery. If the patient selects happy, there is an option for providing information about a particular staff member or aspect of the experience that improved the experience.

If the patient is not happy, there is an option of describing why and then to choose the refund amount.

"As a nurse leader, I have a huge commitment to staying in touch with both our patients and our employees," Robel says. "The more leaders can stay in touch and solve problems to allow staff to take the best care of our patients, the better the overall patient experience is going to be. The app is one of many ways that we are trying to do that." ■

Uniformity of uniforms one way to improve patient experience

Uniform colors will identify roles in care team

In addition to developing an app that offers no-hassle refunds to unsatisfied patients, Geisinger Health System in Danville, PA, is taking other steps to improve the patient experience.

Feedback from Geisinger's patient advisory council has led to several recent and ongoing initiatives, says **Susan M. Robel**, RN, BSN, MHA, NEA-BC, executive vice president, system chief nursing officer, and system chief patient experience officer. Professional appearance was a frequent concern for patients, for instance. A patient's room may seem like just part of the workplace for staff, but for the patient it is a personal space, though with limited privacy, and the patient wants to know who is coming and going.

"Patients don't know who is entering their rooms when everyone is wearing the same scrubs or if everyone is wearing something different with no rhyme or reason to it. Their identification badges aren't enough because the patient can't read that from across the room," Robel explains. "So we are transitioning team members to uniform colors that identify their role in the care team. The patient will be able to identify who is a lab tech, a physical therapist, or an RN."

Staff at Geisinger also are putting more emphasis on communicating with patients, identifying themselves promptly, and explaining why they are in the room. Geisinger leadership also is rounding more to interact with patients and hear their concerns.

"We feel at Geisinger that we have mastered the clinical focus, but how people feel they are treated is also a big part of what we do and the service we provide," Robel says. "Exhibiting compassion and caring is also an important part of the patient experience." ■

App lets patients check ED wait times before leaving home

App also allows patients to make appointments

Mobile apps seem to be all the rage in healthcare these days, and Renown Health in Reno, NV, is offering patients access to a host of information on the go. One of the most popular features allows patients to check the wait time at different urgent care centers before deciding which one to use. The app also allows patients to run errands or wait elsewhere until being notified that they are about to be called.

The mobile site offers the convenience of making an appointment for lab services,

X-ray and imaging, and doctor appointments, as well as providing a call line to Renown's Nurse Navigators, a cancer patient support network. Additionally, the Renown mobile site offers patients quick facts for everything from major medical issues such as neurological and stroke to information about healthcare reform.

Thirty-four percent of visitors are accessing Renown.org using a mobile device, notes Stacy Kendall, manager of Web and emerging media at Renown Health. The analytics also show a high rate of returning users and a time on-site of more than three minutes.

"Our mobile site has been live for a little over a year," Kendall says. "We wanted to be early adopters of the mobile trend and engage with our patients viewing our site on their mobile devices. The mobile site saves patients time and improves their overall healthcare experience."

The Renown mobile site was designed for portable devices, with a clean, user-friendly site and mobile features based on items users continue to navigate to the full website to find. The app providing urgent care wait times was inspired by a Renown team member's visit to the local department of motor vehicles, which offers a similar function to let customers know how long the lines are at that office, notes **Mark Behl**, vice president of Renown Health and CEO of Renown Medical Group.

"Typically, you go to an urgent care center and you sign in, then you wait there for an hour or more in a room full of sick people," Behl says. "It's very frustrating, something we always hear about from patients. The number one complaint is the wait time."

The waiting time estimates were first offered in March 2014 and patient response has been enthusiastic, Behl says.

"From day one, patients have loved it," Behl says. "We target the app in some of our surveys on wait times, and our satisfaction scores show that it works. For satisfaction with wait times, we used to be in the 30th percentile on Press Ganey surveys, but after introducing the app we are around the 80th percentile consistently for all our clinics." ■

NPSF says patient safety still a serious concern

Report recommends total systems approach and culture of safety

Fifteen years after the Institute of Medicine brought public attention to the issue of medical errors and adverse events, patient safety concerns remain a serious public health issue that must be tackled with a more pervasive response, according to a report released recently by the National Patient Safety Foundation (NPSF) in Boston.

The report — titled *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human* — calls for the establishment of a total systems approach and a culture of safety. *(The report is available online at http://www.npsf.org/?freefromharm.)*

The report proposes eight recommendations for achieving total system safety and calls for action by government, regulators, health professionals, and others to place higher priority on patient safety science and implementation. These are the eight recommendations:

- ensure that leaders establish and sustain a safety culture,
- create centralized and coordinated oversight of patient safety,
- create a common set of safety metrics that reflect meaningful outcomes,
- increase funding for research in patient safety and implementation science,
- address safety across the entire care continuum,
- support the health care workforce,
- partner with patients and families for the safest care, and
- ensure that technology is safe and optimized to improve patient safety.

The new report is the work of a panel of experts brought together by NPSF to assess the state of the patient safety field and set the stage for the next 15 years of work. The panel was led by co-chairs **Donald M. Berwick**, MD, MPP, president emeritus and senior fellow at the Institute for Healthcare Improvement (IHI) and lecturer in the Department of Health Care Policy at Harvard Medical School; and **Kaveh G. Shojania**, MD, director of the Centre for Quality Improvement and Patient Safety at the University of Toronto and editor-

in-chief of the journal *BMJ Quality & Safety*.

Patient safety has not improved enough, despite definite progress having been made, says **Tejal K. Gandhi**, MD, MPH, CPPS, president and chief executive officer of NPSF. "Healthcare is still not nearly as safe as it can and should be, and the recommendations of this expert panel set a path for achieving total system safety and making safety a primary focus," he says.

Announcing the release of the report, Berwick said that despite some significant successes, "we know that far too many people still suffer from avoidable injuries in care. One of the objectives of this new work was to identify the gaps and outline the actions to save far more lives and avert far more harm."

The report notes that much of the work done in patient safety to date addresses hospital care, whereas most care today is provided outside of hospitals. Moreover, while deaths from medical errors make headlines, morbidity — in the form of lasting effects of harm, additional care, or lengthier hospitalizations — also demands attention. The report argues for centralized oversight of patient safety, in part to facilitate sharing best practices and knowledge.

"Fifteen years ago, patient safety represented a new endeavor for healthcare — focusing on how to prevent avoidable harm while delivering routine care," Shojania says. "Today, interest has shifted toward value, patient-centered care, and other domains of quality. These are also important, but we have a long way to go with patient safety. This report provides clear recommendations for what we need to do to achieve the original vision of the IOM report." ■

Discharge planning proposed rule focuses on patient preferences

Proposed changes will "modernize" the discharge planning process

The Centers for Medicare & Medicaid Services (CMS) has proposed to revise the discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies, must meet in order to participate in the Medicare and Medicaid programs. CMS says the proposed changes would modernize the discharge planning requirements by bringing them into closer alignment with current practice, helping to improve patient quality of care and outcomes, and reducing avoidable complications, adverse events, and readmissions.

The proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which is intended to improve consumer transparency and beneficiary experience during the discharge planning process. The IMPACT Act requires hospitals, critical access hospitals, and certain post-acute care providers to use data on both quality and resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

> CMS SAYS THE PROPOSED CHANGES WOULD MODERNIZE THE DISCHARGE PLANNING REQUIREMENTS BY BRINGING THEM INTO CLOSER ALIGNMENT WITH CURRENT PRACTICE.

CMS Acting Administrator Andy Slavitt announced the proposed rule and said CMS is proposing a simple but key change that will make it easier for people to take charge of their own healthcare. "If this policy is adopted, individuals will be asked what's most important to them as they choose the next step in their care — whether it is a nursing home or home care," he said. "Policies like this put real meaning behind the words 'consumer-centered healthcare.'"

As called for in the IMPACT Act, hospitals, including inpatient

rehabilitation facilities and long-term care hospitals, critical access hospitals, and home health agencies would be required to develop a discharge plan based on the goals, preferences, and needs of each applicable patient. Under the proposed rule, hospitals and critical access hospitals would be required to develop a discharge plan within 24 hours of admission or registration and complete a discharge plan before the patient is discharged home or transferred to another facility. This would apply to all inpatients and certain types of outpatients, including patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and emergency department patients who have been identified by a practitioner as needing a discharge plan. In addition, hospitals, critical access hospitals, and home health agencies would have to do the following:

- provide discharge instructions to patients who are discharged home (proposed for hospitals and critical access hospitals only),
- have a medication reconciliation process with the goal of improving patient safety by enhancing medication management (proposed for hospitals and critical access hospitals only),
- for patients who are transferred to another facility, send specific medical information to the receiving facility, and
- establish a post-discharge follow-up process (proposed for hospitals and critical access hospitals only).

The proposed rule also calls for increased patient participation in the discharge planning process, emphasizing the importance of the patient's goals and preferences during the discharge planning process. These improvements should better prepare patients and their caregivers to be active partners for their anticipated health and community support needs upon discharge from the hospital or post-acute care setting. Hospitals and critical access hospitals would be required to consider several factors when evaluating a patient's discharge needs, including but not limited to the availability of non-healthcare services and community-based providers that may be available to patients post-discharge.

THE PROPOSED RULE ALSO CALLS FOR INCREASED PATIENT PARTICIPATION IN THE DISCHARGE PLANNING PROCESS, EMPHASIZING THE IMPORTANCE OF THE PATIENT'S GOALS AND PREFERENCES.

In addition, patients and their caregivers would be better prepared to select a high-quality post-acute care provider, since hospitals, critical access hospitals, and home health agencies would be required to use and share data, including data on quality and resource use measures. This results in the meaningful involvement of patients and their caregivers in the discharge planning process.

"This rule puts the patient and their caregivers at the center of care delivery," said CMS Deputy Administrator for Innovation and Quality and Chief Medical Officer **Patrick Conway,** MD, MSc. "Patients will receive discharge instructions, based on their goals and preferences, that clearly communicate what medications and other follow-up is needed after discharge, and pertinent medical information will be communicated to providers who care for the patient after discharge. This leads to better care, smarter spending, and healthier people."

The proposed rules can be found at http://bit.ly/1LE4Fiy. ■

Readmissions are focus of Joint Commission resources

The Joint Commission has developed two new resources to help healthcare providers in their efforts to reduce patient readmissions and improve the discharge process. The resources are a new Speak Up campaign for providers and organizations to educate patients, including an infographic, animated video, and podcast; and a Quick Safety newsletter for healthcare professionals that includes suggested actions for improving transitions. *(The Speak Up campaign is online at http://tinyurl.com/j6bxdkw, and the Quick Safety newsletter is online at http://tinyurl.com/z6ys4yb.)*

The importance of transitions

in improving patient safety is illustrated by The Joint Commission's sentinel event data compiled from January 2014 to October 2015. The data show a total of 197 sentinel events — from suicide to falls to wrong-site surgery — and the root causes included failures in patient communication (127 incidents), patient education (26 incidents), and patient rights (44 incidents). The majority of the patient education failures were related to not assessing the effectiveness of patient education or not providing education. The patient rights failures included absent or incomplete informed consent, and lack of the patient's participation in their care.

The new public service campaign, "Speak Up: Avoid a Return Trip to the Hospital," uses easy-to-understand language to help patients understand the steps they should take after they are discharged to avoid returning to the hospital. The materials are free and available on The Joint Commission's website. They were developed so that healthcare organizations and providers can easily display and distribute them to patients and caregivers in their facilities, online, and in printed materials.

The pre-discharge information in Speak Up includes facts patients need to know about their treatment and diagnosis, medication, follow-up care, and information on where and how to get help if they need it. The post-discharge recommendations explain to patients the steps they may go through depending on their condition and the location they are discharged to. The infographic includes tips and bulleted lists describing the different settings where a patient might receive care following discharge including a doctor visit, home care, community services, therapy, hospice, and a nursing care center.

The Quick Safety newsletter, "Transitions of Care: Engaging Patients and Families," focuses on ways to improve transitions and involve patients and their families in the process. The publication includes suggested actions to consider for positively affecting patient transitions, such as organizational policies that enable families to visit around the clock, conducting physician and interdisciplinary rounds at the patient's bedside, having nurses give their change of shift report at the patient's bedside, patient-centered discharge planning, and EHRs that patients can access and edit. ■

Hospital-acquired conditions decreasing, says HHS report

A recent report from the Department of Health and Human Services (HHS) indicates that an estimated 87,000 fewer patients died in hospitals and nearly $20 billion in healthcare costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2014.

Hospital patients experienced 2.1 million fewer hospital-acquired conditions from 2010 to 2014, a 17% decline over that period. HHS previously reported in December 2014 that 50,000 fewer patients died in hospitals and $12 billion in healthcare costs were saved between 2010 and 2013.

HHS notes that although the precise causes of the decline in patient harm are not fully understood, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events. The report, *Saving Lives & Saving Money: Hospital-Acquired Conditions Update* is available online at http://tinyurl.com/jh9gg6z. ■

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CNE QUESTIONS

1. According to Ray Manahan of Providence Health & Services, what was one goal of the scorecards developed during the system's meaningful use efforts?

A. To create a simplified snapshot for senior executives to indicate each hospital's progress toward meaningful use.
B. To determine which regions would be exempted from meaningful use requirements.
C. To provide a paper trail showing that Providence monitored progress toward meaningful use.
D. To hold individual executives at hospitals responsible for failing to meet meaningful use benchmarks.

2. Regarding how Providence Health & Services quality improvement efforts use meaningful use strategies, what does Manahan advise regarding ownership of goals?

A. Ownership is to be discouraged in favor of a communal effort.
B. System leaders must clarify ownership with regard to goals in order to facilitate collaboration across the many institutions.
C. Goals must be owned by the steering committee.
D. Hospitals must own the goals that most involve their quality measures.

3. When Parkland Health & Hospital System in Dallas implemented suicide screening for all patients, what was one necessary step?

A. Hiring 12 psychiatric social workers.
B. Hiring 12 psychiatrists specializing in suicide prevention.
C. Requiring a liability waiver before patients were screened.
D. Requiring the presence of a physician for all screenings.

4. Which of the following is true of the Geisinger Health System's ProvenExperience refund offer?

A. Requests for refunds must be made in person at a Geisinger facility
B. Patients may request a refund of up to $1,000.
C. Patients must apply for the refund through a patient advocate.
D. Refunds are available only to patients without private health insurance.