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INSIDE

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Different Approach to Falls Improves Patient Safety

Patient safety is seen as a quality of care issue more and more lately, and one of the biggest threats to patient safety is the risk of falling. Healthcare organizations have sought to reduce the risk of falls for many years, with an assortment of policies, procedures, and devices, but one approach is showing success with its emphasis on changing how an entire culture addresses falls.

The experience of 17 hospitals using the approach suggests that the gadgets and devices so often used to reduce falls are not nearly as effective at improving patient safety as broader, systemic changes to the organization.

Some specific procedures and tools are necessary, but the overall attitude toward preventing falls is what makes the difference in this program.

A program developed at the University of Nebraska focuses on creating a culture of safety and teamwork, and making sense of the risks associated with falls. The program is called Collaboration And Proactive Teamwork Used to Reduce (CAPTURE) Falls, and it has been implemented in 17 Nebraska hospitals, 16 of which are critical access hospitals with 25 or fewer beds.

> A PROGRAM AT THE UNIVERSITY OF NEBRASKA FOCUSES ON CREATING A CULTURE OF SAFETY AND MAKING SENSE OF THE RISKS ASSOCIATED WITH FALLS.

A team lead by **Katherine J. Jones**, PT, PhD, associate professor in the Division of Physical Therapy Education at the University of Nebraska Medical Center (UNMC) in Omaha, implemented a fall risk reduction that, according to UNMC's website, addresses "inpatient falls at three levels: the patient, the microsystem (unit), and the organization."

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"We take the approach that falls are complex. There are three sources of risk: the patient, the environment the patient is in, and the system," Jones says. "What does your system look like for your organization to mitigate fall risk? That's what we've really focused on because that seemed to be the component that had not received enough attention in previous efforts."

Coordination of Teams

The Nebraska experience demonstrates that when trying to address a complex problem (like falls) that involves many different aspects of the healthcare process, the most important factor is the coordination between teams, Jones says. CAPTURE Falls involves three different teams. The core team is made up of the clinicians at the bedside, including nurses and therapists. The coordinating team includes the professionals — such as quality improvement leaders — who are responsible for the structures, processes, and outcomes of the fall risk reduction program. The coordinating team also conducts audits to assess the efficacy of training and interventions.

The third is the contingency team that comes together for a short time, almost like a code team. They conduct the post-fall huddle to evaluate an incident and derive lessons. *(See the sidebar on page 63 for more on post-fall huddles.)*

The participating hospitals first look at how they use teamwork to manage fall risk, conducting a gap analysis in which they look at not just what is done at the bedside but at 21 specific processes that the program groups under the term "coordination." That word has a specific meaning in industrial organizational psychology literature, referring to all of the activities done to plan, standardize, and adjust a process in real time.

"So we look at these 21 processes that plan, standardize, and adjust these processes in real time. The hospitals rate themselves as to whether they do or don't do it, and if they do it, they rank themselves in effectiveness," Jones explains. "What we found is that it was the extent of implementing these 21 coordinating processes that significantly predicted unassisted and injurious fall rates. What was done at the bedside — bed alarms, chair alarms, low beds, nonskid footwear, all those bedside interventions — the frequency of implementing those interventions did not affect unassisted and injurious fall rates."

That may be a surprise to a lot of quality improvement leaders, Jones notes. That finding should not be taken to mean there is no value in those bedside assistive devices, she notes, but rather that the processes had more direct impact on preventing falls. The CAPTURE Falls program emphasizes the proper use of one device in particular — gait belts — to assist patients with mobility issues or risk factors for falling.

"Everyone falls for the same reason: their center mass is outside the limits of stability. If you ask a nurse why a patient fell, you get answers like they didn't put their call light on," Jones says. "Other patients don't fall when they don't put their call lights on, so that shows a lack of understanding of the biomechanical basis for falls."

Jones is preparing to publish research showing those results, but the CAPTURE Falls program materials are available on the university's website. *(See the sidebar on page 64 for more on the program and links to the program materials.)*

Compare Risk Assessment Tools

The 21 processes that do make a difference include things such as informing frontline staff about actions taken to improve systems as a result of reported falls.

The hospitals' experiences showed the importance of being deliberate about the use of the fall assessment tool, Jones says, determining the positive predictive value of their current tool and then comparing it to at least two other tools.

"They pulled the records for 20-30 patients who had fallen and the same number for patients who had been in the hospital at the same time who had not fallen, looking at the fall assessment risk scores with the tool they were using and then with other tools," Jones says.

"They could see which tools better identified the tools that better identified the risk of falling. The hospitals that did that generally opted to change their tool from one that is well known and in use for a long time to one that is newer but links interventions to fall risk factors."

That step, investigating the effectiveness of their current tools and adopting a new one if necessary, set off the next series of events in which staff are trained to use the fall risk assessment tool.

"We find that over time there may be vast differences in how any given nurse scores a patient on a risk assessment tool. There was a very nice relationship between actually teaching nurses to use that fall risk assessment tool and lowered injurious fall rates," she says.

Report All Falls

The program also emphasizes the importance of reporting all falls, both assisted and unassisted. Assisted falls are those in which a caregiver is assisting the patient's mobility, perhaps by steadying him or her while walking or by transferring the patient from bed to wheelchair.

Fall programs can focus excessively on unassisted falls, seeing them as the "worst" example of what can happen and what might have been prevented with

Post-Fall Huddles Reveal Good and Bad

Conducting post-fall huddles is an important part of the CAPTURE Falls program implemented by the University of Nebraska Medical Center in Omaha. **Katherine J. Jones**, PT, PhD, associate professor in the Division of Physical Therapy Education, says they are an important part of the learning process because the participants can learn both what is working in the program and what might need more attention.

"The purpose of the post-fall huddle is not to identify who did something wrong and punish them. Rather, the goal is to assess the overall situation, including what happened with that particular patient in that one fall and also what might be learned about the program overall, such as how staff are trained," Jones say. "We're looking for ways to help prevent another fall with that one patient, but also how to improve our program so that we can protect other patients as well."

The concept does run into some practical challenges. Hospitals participating in the CAPTURE Falls program have reported difficulty getting the huddle completed in a timely fashion because it can be hard to get the appropriate staff members together in one place soon after the fall, she notes. This problem is seen most often on nights and weekends when some desired members of the post-fall huddle, such a physical therapist, may not be available.

One way around that problem is to conduct the post-fall huddle immediately with the team members who are available and then seek input from others afterward, she says. That way, the patient can benefit from any care improvements that are recognized in the huddle without having to wait until everyone is available.

Hospitals also have reported that attaching huddle documentation to the fall event report is useful in ensuring that the huddle team's observations about possible improvements are carried out.

The CAPTURE Falls program offers two videos showing the right and wrong ways to conduct post-fall huddles. They are available online at https://bit.ly/2jqiM3D and at https://bit.ly/2rl5FnZ. ■

assistance, Jones says, while paying too little attention to assisted falls. Patients still fall when assisted and there are lessons to be learned from those experiences as well, she says.

Jones notes that unassisted falls are most commonly associated with patients 65 or older and cognitive impairments. Unassisted falls occur most often in the bathroom.

Hospitals are encouraged to mobilize patients as early as possible, but that can increase the risk of falls, Jones notes.

"It is important to remember that it is not all falls that hospitals are penalized for. They're penalized for falls with serious injury," Jones says.

"So if we are mobilizing patients at the earliest possible opportunity to prevent secondary deconditioning and pressure ulcers, patients will fall," she adds. "But if we are with them and trained to appropriately assist ambulation and transfers with assistive devices and the use of a gait belt, then an assisted fall is much less likely to result in harm than an unassisted fall."

Not all falls can be avoided with assistance, but when a facility reports assisted falls, that is feedback on their assistive training, Jones says.

The repeat fall rate also is a key factor to study, derived by dividing the number of falls by the number of patients who fell. If the rate is greater than one, that means some patients are falling more than once.

"We found that one of the things that primarily affected the repeat fall rate is training in how to conduct the post-fall huddle. This is a quick meeting of all the staff caring for the patient immediately after the fall to discuss what happened, how they are going

CAPTURE Focuses on Coordination, Gait Support

This summary of the CAPTURE Falls program is provided by **Katherine J. Jones**, PT, PhD, associate professor in the Division of Physical Therapy Education at the University of Nebraska Medical Center in Omaha.

CAPTURE Falls includes the idea that there are eight "rights" of fall risk reduction. A good risk reduction program must include:

1. **The right frame of reference.** The CAPTURE Falls solution depends on collaboration and proactive teamwork to improve the structure and coordination of organizational processes, as well as to standardize definitions for reporting and benchmarking. This approach views fall risk reduction as an organizational goal that multiple teams coordinate to achieve.

2. **The right team.** The Coordinating Team typically consists of a quality improvement leader, a nurse champion, a certified nurse anesthetist, a pharmacist, a physical therapy or occupational therapist, and a senior organization leader. This team manages resources, coordinates the fall risk reduction program and interventions, and holds the core team accountable for reliably implementing evidence-based interventions. The team should span locations, status/hierarchies, and knowledge boundaries across disciplines.

3. **The right coordination of the program.** The Coordinating Team oversees other component teams of the program that: achieve proximal goals and organizational goals; develop and coordinate the fall risk reduction program; conduct and implement targeted and universal interventions at the bedside; and make real-time adjustments to the care plan. The nursing team, for example, assesses fall risk based on observations and implements interventions at the bedside, while the pharmacy team assesses fall risk based on medication side effects and medication debridement. The physical therapy and occupational therapy team assesses fall risk based on performance and ensures competency in safe transfers and mobility.

4. **The right training.** Clinicians and others in the organization must be trained in the overall fall risk reduction program (purpose, interventions, outcomes), administration of the fall risk assessment tool, safe transfers and mobility, mechanical lifts, and post-fall huddles.

5. **The right risk assessment.** The program uses these questions to improve risk assessment: Does it facilitate critical thinking about targeting interventions to risk factors? Do you know the sensitivity, specificity, and predictive value of your tool?

6. **The right event reporting and learning system.** CAPTURE Falls encourages the reporting of falls in four categories: unassisted falls that result in injury, unassisted falls that do not result in injury, assisted falls that result in injury, and assisted falls that do not result in injury. Unassisted falls represent a system failure and are more likely to result in injury, while assisted falls that do not result in injury to patient or staff represent system success.

(Continued on page 65)

to prevent it happening again, and what can be learned for the system," Jones says. "Training in conducting post-fall huddles is associated with a lower repeat fall rate, as is the post-fall huddle rate. The more often a fall is followed by a post-fall huddle, the less likely the patient will fall again." ■

SOURCE

- Katherine J. Jones, PT, PhD, Associate Professor, Division of Physical Therapy Education, University of Nebraska Medical Center, Omaha. Phone: (402) 559-8913. Email: kjonesj@unmc.edu.

(Continued from page 64)

7. **The right interventions.** These include universal, purposeful hourly rounding, toileting schedules, and using gait belts. The organization should make it easier to assist mobility.

8. **The right response to a fall.** The post-fall huddle is the key component of responding to a fall. Members from various teams should conduct post-fall huddle immediately after a fall to determine what happened, why it happened, and what will be done differently in the future to prevent such a fall. The goals of the post-fall huddle are to decrease the risk of future falls for an individual patient, apply what is learned to decrease risk across the system, build trust, and share knowledge.

More information on the CAPTURE Falls program, including free tools and guidelines for implementing it in any healthcare facility, is available online at: https://bit.ly/2rddVqX. ■

Critics Say Single-payer Healthcare Could Lower Quality of Care

A single-payer healthcare system is still being proposed on Capitol Hill. Several proposals are pushing for hospitals and physicians to be paid through some expansion of Medicare or Medicaid. However, such plans, if implemented, could significantly degrade quality of care, critics say.

Sen. Bernie Sanders (I-VT) has his "Medicare for All" plan that calls for moving to a single-payer health system, while Sens. Michael Bennet (D-CO) and Tim Kaine (D-VA) have a bill supporting their "Medicare X" plan, which would greatly expand Medicare availability.

Sens. Chris Murphy (D-CT) and Jeff Merkley (D-OR) have a new Medicare buy-in plan called the Choose Medicare Act, and the Center for American Progress proposes "Medicare Extra for All."

Sen. Brian Schatz (D-HI) and Rep. Ben Ray Luján (D-NM) have proposed the State Public Option Act, which would expand access to Medicaid, not Medicare.

The Sanders plan is the most far-reaching, but the senator says it will cost roughly $6 trillion less than the current healthcare system over the next decade.

"The United States currently spends $3 trillion on health care each year — nearly $10,000 per person. Reforming our health care system, simplifying our payment structure, and incentivizing new ways to make sure patients are actually getting better health care will generate massive savings," the Sanders plan says. The plan is available online at https://bit.ly/2f2H3y7.

Sanders says the typical middle class family would save more than $5,000 with a conversion to single-payer Medicare, and that businesses would save over $9,400 a year in healthcare costs for the average employee. The plan has been estimated to cost $1.38 trillion per year.

Passage of any of these bills would threaten the quality of healthcare in the country, says James D. Schutzer, vice president of JDM Benefits, a company based in White Plains, NY, that provides assistance with insurance and claims.

He notes that incorporating a public option has been the goal all along for some politicians. An attempt was made during the Affordable Care Act negotiations, but the public option ultimately didn't make it through.

There is no negotiation for prices with Medicare rates, unlike the private market, where one of the competing factors between the insurance carriers is the size of their network.

"Therefore, they are forced into paying a much higher percentage of the Medicare fee schedule to keep the providers in network. Contrarily, these same providers rely on the private market payers to balance their income statement," he says.

"Therefore, none of these Medicare expansion bills really does

anything to address the rising cost of healthcare. It simply is piling more Americans onto Medicare, which pays providers lower reimbursement rates. This is not real reform. It is just a transferring of the risk to a lower payer."

Medicare rates are so much lower than private reimbursement that hospitals will be hard-pressed to provide the same level of care they currently provide, Schutzer says.

Schutzer was speaking recently with a hospital executive about recent state-level efforts to adopt "Medicare for all" in New York. The hospital leader told him that depending solely on Medicare would dramatically change the way his hospital operates.

"He told me they lose money on government programs and balance their books with people who have private insurance. So if reimbursement rates are all based on a federal or state figure, the quality of care could suffer because healthcare is a business and there is a cost to providing good care," he says.

"And if this is a system with few restrictions on where you can go for treatment and no co-pays, are we going to see an increase in demand at the same time hospitals are paid less?"

Quality has to suffer in that scenario, he says.

"It's going to be unprofitable for hospitals, so they will have to look at where they can cut costs. They can't just go on providing the same care they provide now and receive substantially less revenue," he says.

"That might mean not buying the latest MRI machine or investing in the latest technology for the OR, and in some cases it might mean closing hospitals."

Hospitals are already reporting lower profits, so reduced payments would have to affect hospitals and the quality of care they provide, he says. The effect on doctors would ripple to the hospitals, and doctors already are shying away from Medicare rates, Schutzer says.

"It's not uncommon to hear stories about doctors dropping out of Medicare," he says.

"Maybe this is currently a geographical issue, for instance in New York City, but it can have the potential to become more widespread where you, once again, create a two-tiered system — one that only uses Medicare and another that uses Medicare with the ability to pay privately for non-participating doctors." ■

SOURCE

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Health System Improves Patient Satisfaction and Experience

Sentara Healthcare has been exploring the link between increased patient experience and satisfaction with structured clinical performance improvement teams that address key patient concerns, like emergency department (ED) waiting times.

The effort is continuing, and the health system is applying lessons it has learned so far, says **Genemarie McGee**, MS, BSN, RN, NEA-BC, corporate vice president and chief nursing officer with Sentara Healthcare, a not-for-profit healthcare system serving Virginia and northeastern North Carolina. It is based in Norfolk, VA.

Sentara uses clinical performance improvement (CPI) to address patient experience and satisfaction, after the health system saw success in using that approach for financial issues. The CEO suggested applying the process to the clinical side to improve the patient experience, McGee says.

"Like any big organization we had lots of goals, but we realized that when we have 20 clinical goals we don't make as much progress on them as we'd like. So we used this process to hone those down each year to the five to eight clinical goals we wanted to get the entire company to focus on," she says.

"We have a matrix that helps us figure out how many patients this would affect, where we are compared to the rest of the country on this, and how we want to improve," she adds.

From there, Sentara leaders determine the baseline on that issue and set a goal for improvement that year in each specified area, bringing together teams to work on the goals. A CPI steering committee includes a division president, a vice president of medical affairs, and a nurse executive. That committee works with the clinical effectiveness committee to lead the teams toward their goals, she says.

Sentara also uses high-performance teams that are pulled together in particular service lines,

such as cardiovascular, hospital medicine, and oncology. Those teams assist with meeting the system's clinical goals.

Readmissions, Hospice Addressed

In the past year, the health system has addressed readmission rates, along with palliative care and hospice care. One finding was that the health system provides good hospice care, but might be slow in getting patients in that care setting.

"We were getting people into our hospice system in the last 72 hours of life, and we really should get them in earlier because the hospice care has so much to offer both patients and their family members," she says.

Readmissions were addressed by improvements in the discharge process that included assessing the patient's ability to comply with follow-up instructions and assisting with needs like transportation whenever possible. One of the major areas addressed last year was improving emergency department flow.

Responding to patient desires to get through the ED more quickly, Sentara has set internal goals for improving the flow-through. Sentara formed an ED high-performance team that oversees the improvements.

There are separate goals for treat-and-release patients and those who are admitted, with distinct workflows for each group.

"Treat-and-admit involves the entire hospital because we have to make sure we have the right bed available to admit, and we need the hospitalists responding to the emergency department to help move patients through," McGee says.

Sentara adopted a model developed by Kaiser Permanente, which relies on "hubs" such as urgent care centers to take some pressure off of the hospital ED. Such hubs can offer complex and urgent care around the clock. *(More information on the Kaiser model is available at: https://bit.ly/2JO1ad5.)*

Flow-through Goal: 120 Minutes

In 2017, Sentara set the goal of 13 of its 17 EDs meeting a through time goal of having 50% of patients seen and released within 120 minutes of arrival. The health system did not quite meet that goal, but did see meaningful improvements in 13 EDs. Sentara is pursuing that same goal this year.

"We recognized that we had some staffing challenges, so we did some significant hiring for the EDs in the past year," McGee says. "Even without meeting that goal last year, we heard from patients that we greatly improved our ability to process them through more rapidly. Across our system, we had 113,000 hours reduced and more than 22,700 patients discharged within 120 minutes."

The ED improvements included creating a "pivot" area for triage, where patients are interviewed to determine what kind of care they need — not just the severity of their conditions and their priority for care. By finding out more about how they are likely to be treated in the ED, patients can be directed to different tracks of care, McGee says.

"There is one track where we keep you upright all the time because we don't really need you to take off all clothes if you need a prescription renewal or just have a sore throat," she says. "That keeps you moving through the ED quickly and saves a lot of down time for everyone."

Sentara EDs also use what is called a "swarm."

"It used to be that you started by telling the triage nurse your condition and your history and allergies, and then when you got to the back you told another nurse the same story, and then you told the physician, and if we called in a consultant you told that doctor the same story," she says. "Now when you get to the back, the whole team arrives so the nurse, the physician, and technicians hear the story at the same time. It's things like that that have started to really improve our through time."

Make Goals Attainable

The human behavior aspect of these processes could be difficult to change, McGee says, because people are accustomed to doing their jobs in the same way over many years; even a change that seems like common sense can meet resistance. Sentara overcomes that resistance with physician leadership and accountability for measures indicating compliance with the new procedures, she says.

Sentara has learned the importance of setting goals that are clear and measurable, rather than general goals like "improve our ED flow through," McGee says. The system also avoids setting goals too high, which can be discouraging. Attainable goals keep people motivated to reach them, McGee says.

"It's also very important for everyone to understand the 'why' of why we're doing this," she says. "We've also learned that what gets measured gets improved. It also is crucial to include frontline staff and everyone involved in the care, and we have to prioritize goals and make them relevant.

"When you have 20 important goals it is hard to get everyone motivated, but if you focus on just a few and show them why it's important, you can get people to make real changes." ■

Health System Applies Lessons from Population Health

Population health initiatives involve broad goals that may not always seem applicable at the hospital level, but a health system in Nevada is finding ways to leverage the lessons learned from a statewide program.

Quality improvement professionals should embrace population health initiatives and look for the ways in which the resulting data can be put to use in-house, says **Anthony D. Slonim**, MD, DrPH, FACHE, president and CEO of Renown Health, a healthcare network serving Nevada and northeast California. He also is president of the Renown Institute of Health Innovation (Renown IHI) in Reno, NV.

Almost two years ago, the state of Nevada initiated the Healthy Nevada Project (HNP), described by HNP as "a first-of-its-kind, community-based population health study combining clinical, genetic, and environmental data with the goal of providing personalized, precision medicine for individuals while improving health statewide." Slonim says the 10,000-person pilot study provided valuable insights that are helping to reshape patient care.

According to HNP's website, the project "is making history again with the opening of phase two genomic sequencing to an additional 40,000 northern Nevadans, bringing the study's total participation to 50,000 residents and making it one of the largest population health studies in the country."

Clinical applications are being developed by research teams with the Renown Institute for Health Innovation — a partnership between Renown and the Desert Research Institute (DRI).

The first goals involve clinical programs and scientific studies focused specifically on Washoe County's high age-adjusted death rates for heart disease, cancer, and chronic lower respiratory disease, which collectively are 33% above the national rate.

"Everyone tends to focus on the genetics, but what we've created is a large data warehouse that has genetic data, clinical data, environmental data, and social data. We know that clinical care is only responsible for 20% of your overall health status, with those other factors making up the rest," Slonim says.

"This is the ultimate strategic planning process for our community, because if you can uncover things that put people's health at risk, our healthcare providers can do appropriate screening and take better care of them aside from their genetics."

Data Guide Better Care

Social determinants, particularly the area in which a person lives, can have more effect on a person's health than any other factors, Slonim says. In the Nevada project, people from lower socioeconomic status were active participants, with 40% coming from state's five most impoverished ZIP codes.

"So we're starting to understand how that factor plays into a person's health risks and how we should respond to that as a health system," Slonim says. "We also are learning a lot about health literacy. Our job is to meet the community where they are with health literacy, both in terms of what they know and understand and also what they want to understand. It is not our place to insist that everyone understand a lot about genetics, but their level of understanding about a lot of these issues can help drive how we care for them."

Renown IHI will soon begin providing advanced calcium score screenings to pilot-phase participants at higher risk for cardiovascular disease, which should allow researchers to examine the link between genetics and calcium build-up in the heart. According to the Healthy Nevada

Project, "In phase two, Renown IHI also will evaluate possible links between genetics and increased susceptibility to respiratory ailments."

Determining Community Needs

The information gained from the population health initiative can directly affect how the health system operates, Slonim says.

"If we find out from this program that a certain percentage of our population has X condition, then I better make sure we have enough doctors to treat those patients five to 10 years from now," Slonim says. "As we identify these conditions, we are identifying which health professionals we need to recruit and bring to town to effectively prepare for those patients."

Nevada ranks in the bottom half of overall health rankings in the United States, Slonim notes, so the project data represent a quality improvement opportunity for healthcare providers.

"You always need an inciting source to get you going and moving. We realized that our population here in Nevada is in effect the inverse of the value proposition in healthcare, with some of the lowest quality and the highest costs," Slonim says. "When we look at specific disease indicators like heart disease, cancer, and chronic respiratory disease, we find that our mortality rates are higher than in comparable states, so this was our call to action. We have to do something different if we want to have a healthier state moving forward." ■

SOURCE

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CMS Proposes Reduction in Quality Metrics

CMS has proposed a new rule that would remove 19 quality measures in an effort to lower the administrative burden on Medicare providers. The rule also would increase overall Medicare hospital payments, increase price transparency, and facilitate access to more provider data for consumers.

Eliminating the quality measures is intended to encourage productivity gains in the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), CMS says. In addition to removing 19 measures, CMS is de-duplicating 21 more. Those changes should lead to a savings opportunity of $75 million, CMS says.

"We seek to ensure the healthcare system puts patients first," CMS Administrator **Seema Verma** said in a statement announcing the new rule. "Today's proposed rule demonstrates our commitment to patient access to high-quality care while removing outdated and redundant regulations on providers. We envision a system that rewards value over volume and where patients reap the benefits through more choices and better health outcomes."

The proposed rule removes unnecessary, redundant, and process-driven quality measures from a number of quality reporting and pay-for-performance programs, CMS says. It would eliminate a significant number of measures acute care hospitals are currently required to report, and remove duplicative measures across the five hospital quality and value-based purchasing programs.

"Additionally, CMS is proposing a variety of other changes to reduce the number of hours providers spend on paperwork," Verma's statement says. "CMS is proposing this new flexibility so that hospitals can spend more time providing care to their patients, thereby improving the quality of care their patients receive."

The elimination of 25 total measures across the five programs should result in a reduction of more than 2 million burden hours annually, CMS says.

Verma said the policies in the IPPS and LTCH PPS proposed rule would further advance the agency's priority of creating a patient-driven healthcare system by achieving greater price transparency and interoperability, the essential components of value-based care, "while also significantly reducing the burden for hospitals so they can operate with better flexibility and patients have the information they need to become active healthcare consumers."

CMS is updating its guidelines to specifically require that hospitals make publicly available a list of their standard charges, or their policies for allowing the public to view a list of those charges upon request.

CMS also is proposing to overhaul the Medicare and Medicaid Electronic Health Record Incentive Programs, more commonly known as the "Meaningful Use" program, first by renaming it "Promoting Interoperability."

The plan is to make that program more flexible and less burdensome, emphasize measures that require the exchange of health information between providers and patients, and incentivize providers to make it easier for patients to obtain their medical records electronically.

The proposed rule reiterates the requirement for providers to use the 2015 edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use to qualify for incentive payments and avoid reductions to Medicare payments.

A fact sheet, including a breakdown of the quality measures that would be removed or altered, is available online at: https://go.cms.gov/2HYwKW2. The proposed rule is available online at: https://bit.ly/2qVhFNK. ■

Study Finds Palliative Care Reduces Hospital Stays, Saves Money

Palliative care is associated with shorter hospital stays and lower costs, according to a recent study from scientists at the Icahn School of Medicine at Mount Sinai in New York City and Trinity College Dublin in Ireland.

The effect is greatest among the sickest patients, the authors found in a meta-analysis of previous research. They looked at team-based palliative care focused on improving quality of life and reducing suffering, studying data from six prior studies involving more than 130,000 adults admitted to hospitals in the United States between 2001 and 2015.

In that group, 3.6% received a palliative care consultation in addition to their other hospital care. *(An abstract of the study is available online at: https://bit.ly/2Ky6NNI.)*

The authors say the investigation represents the largest and most rigorous study to date to demonstrate that palliative care is associated with reduced hospital stays and lower costs, particularly for patients with the most complex conditions. Previous research has found that palliative care improves care quality, extends survival, and improves family well-being.

Hospitals saved, on average, $3,237 per patient over the course of a hospital stay when palliative care was added to their routine care as compared to those who didn't receive palliative care, the study says. Palliative care was associated with a cost savings per hospital stay of $4,251 per patient with cancer and $2,105 for those with non-cancer diagnoses.

Savings were greatest for patients with the highest number of coexisting illnesses, lead study author, **Peter May**, MD, research fellow in Health Economics, Centre for Health Policy and Management at Trinity College Dublin, noted in a statement announcing the research results.

"People with serious and complex medical illness account heavily for healthcare spending, yet often experience poor outcomes," May said. "The news that palliative care can significantly improve patient experience by reducing unnecessary, unwanted, and burdensome procedures, while ensuring that patients are cared for in the setting of their choice, is highly encouraging. It suggests that we can improve outcomes and curb costs even for those with serious illness."

The association of palliative care with less intense hospital treatment was most pronounced among those patients with a primary diagnosis of cancer than for those with a non-cancer diagnosis, the study says. It also was lower for patients with four or more comorbidities compared with those with two or fewer. ■

First Week Readmissions More Preventable, Study Says

New research indicates that hospital readmissions occurring in the first week after a patient is discharged are more likely to be preventable than those occurring later. The researchers say that evidence might mean hospital

quality leaders should focus more on those early readmissions rather than the typical 30-day readmission rates.

Researchers from Beth Israel Deaconess Medical Center studied readmissions for 810 adults treated at 10 U.S. academic medical centers, finding the first week readmissions were twice as likely to be preventable as others.

Not only were the first-week readmissions more often caused by factors within the hospital's control, but they also were more responsive to hospital interventions, the study says.

Readmissions later in the 30-day window were more likely due to outside factors that could not be addressed as effectively by the hospital.

"Early readmissions were more likely to be preventable and amenable to hospital-based interventions," the researchers noted.

"Late readmissions were less likely to be preventable and were more amenable to ambulatory and home-based interventions," the researchers concluded.

(An abstract of the study is available online at: https://bit.ly/2HICB4L.) ■

Humana Will Pay More for Quality

Humana's health plan soon will reimburse hospitals based on quality improvement and performance metrics, the company recently announced.

The Hospital Incentive Program became effective Jan. 1, 2018, compensating hospitals based on patient experience, patient safety, and patient outcomes.

The insurer also will use additional measures, including healthcare-associated infection rates, care coordination, palliative care, and more to assess performance and set reimbursement rates.

The new plan was endorsed by The Joint Commission's **Brian Enochs**, JD, executive vice president for business development and marketing.

"By incorporating Integrated Care Certification and hospital-based Palliative Care Coordination Certification into its quality metrics, Humana has made a significant commitment to coordination of patient care through its Hospital Incentive Program," Enochs said in a statement accompanying the plan's announcement.

"These key Joint Commission certifications require that participating hospitals engage patients more seamlessly across the entire continuum of care, and we're pleased to work with Humana to create additional value for the hospitals that achieve them."

Humana says the plan will emphasize these elements for acute care hospital:

- "More personal time with health professionals and personalized care that is tailored to each person's unique health situation;
- Access to proactive health screenings and programs that are focused on preventing illness;
- Improved care for people living with chronic conditions with a focus on avoiding health complications;
- Leveraging technologies, such as data analytics, that connect physicians and help them work as a team to coordinate care around the patient; and
- Reimbursement to physicians linked to the health outcomes of their patients rather than solely on the quantity of services they provide." ■

Popular Tools Being Discontinued

Two tools popular with quality improvement professionals are being discontinued, at least temporarily.

The AHRQ National Quality Measures Clearinghouse (NQMC) (www.qualitymeasures.ahrq.gov) will not be available after July 16, 2018. Also, AHRQ's National Guideline Clearinghouse (www.guideline.gov) will cease operations on the same date. Announcements on the sites say federal funding will be discontinued as of that date.

Other groups have expressed interest in continuing to provide NQMC or something similar, but AHRQ says, "It is not clear at this time, however, when or if NQMC (or something like NQMC) will be online again." ■

COMING IN FUTURE MONTHS

- Better EHR Use Improves Quality
- Handoffs Still Need Better Processes
- Lessons From Accreditation Surveys
- Improving QI Visibility in Boardroom

HOSPITAL PEER REVIEW
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
2. Log onto AHCMedia.com, go to "My Account" to view your available continuing education activities. *First-time users must register on the site.*
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%.
4. After completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **In the CAPTURE Falls program implemented in 17 Nebraska hospitals, what was found to have the most impact on reducing falls?**
   a. The extent to which 21 processes were implemented
   b. Bedside interventions such as the use of bedrails and alarms
   c. Buy-in from senior administrators
   d. Funding from outside sources
2. **In the CAPTURE Falls program, which falls should be reported?**
   a. Only unassisted falls with injury
   b. Only assisted falls with injury
   c. Only falls in which protocols were not followed
   d. All falls, assisted and unassisted, with or without injury
3. **According to James D. Schutzer, vice president of JDM Benefits, a company based in White Plains, NY, how might a single-payer health system affect healthcare quality?**
   a. It likely will have little effect on quality.
   b. It could have a significant detrimental effect on quality.
   c. It probably will improve quality.
   d. There is no way to know what the effect on quality would be.
4. **How many quality measures is CMS proposing to remove?**
   a. 8
   b. 12
   c. 19
   d. 28

CE 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, healthcare workers, hospitals, or the healthcare 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.