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AHC Media

Do performance measures help healthcare?

Not as much as some experts had hoped

It has been more than 30 years since the Centers for Medicare & Medicaid Services (CMS) moved from using a chart review process to implementation of standardized measures as a way to determine the quality of care patients receive. In those years, there have been periodic reports of vast improvements, huge disappointments, and finding that piece of the puzzle that will make it all come together.

Meanwhile, the reality for health care organizations has been an increasing data collection and reporting burden, and a responsibility to completely change the way large organizations respond to the tales that quality measures tell. They also have to figure out which of the competing performance measures — from a variety of organizations, associations, and government bodies that demand data — they are required to collect, which they might want to gather if they have the resources, and which are just plain useless to their enterprise. Talk about the difficulty of turning a battleship around: Try changing healthcare in America in a meaningful way.

A report released in May and sponsored by the Robert Wood Johnson Foundation and the Urban Institute looks at the future of performance measures[1], and it includes seven recommendations that could be the next big thing in helping to improve quality in health care organizations. Or

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the next medium thing. But those recommendations come with caveats.

We are potentially awash in data. The problem is how to make sure what we collect is meaningful and relates to the problems we want to solve, the authors note.

And the last 30 years of data collection — has that improved anything? "We know that we are improving our performance over time on process measures, but we don't know if that translates to better outcomes," says **Peter J. Pronovost**, MD, PhD, FCCM, senior vice president for patient safety and quality and director for the Armstrong Institute for Patient Safety and Quality at Johns Hopkins University in Baltimore, MD.

Providers must believe in measures

There are instances in which the outcomes for patients have improved. If you look at central line-associated bloodstream infections in the intensive care unit, he says, the numbers have declined sharply in the last decade. That means fewer patients getting sicker in the hospital and, in all likelihood, fewer deaths.

Pronovost, one of the report authors, says there is a question about whether we are, even now, measuring the right things if we want to improve patient outcomes and the quality of care. "If you look at the top causes of preventable death in the hospital, we have things like hospital-acquired infections, decubitous ulcers, and deep-vein thrombosis. But we don't have a scorecard that measures those things accurately on a national scale."

Indeed, he says that if you ask doctors about the things that are being measured, many of the metrics are of little use to physicians and lack validity in their opinion. "If you look at CMS and how they measure complications for patients with hospital-acquired conditions, we don't know how accurate those measures are. If you show me a report of that, I would dismiss it as irrelevant to quality. And that's not just me, but the vast majority of docs. There are things we measure that we wouldn't give the time of day to except that we have to measure it; we get paid to do so."

If the providers don't believe in the measures, don't think they say anything that will help them help patients, then the battle is nearly lost. "We measure something like 280 things here at Hopkins. I'd like to see patients and physicians vote on whether each of those were valid and useful measurements that say something about their care and outcomes. And if they didn't say it was, I wouldn't do it." It could be easy to organize such a vote through social media.

"Then if patients say the measures are important, and clinicians say they have scientific

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validity, we would do it. And there wouldn't be 300 things to measure. There would be 10," he says.

Public consensus has been missing from the discussions about this. A few token lay people in committee meetings isn't enough. And you aren't going to get the public agreement and acceptance of reported data unless they see the data as clear, meaningful, transparent, and unbiased. That hasn't happened yet either, Pronovost explains. One idea is to create an overarching body that would be in charge of creating all performance measures, determining their import, looking at whether they are meaningful to stakeholders, and deciding whether and when they should be used for any pay-for-performance program. The body would operate something like the Securities and Exchange Commission does on Wall Street.

It's not how much you do

There are healthcare organizations out there that collect tons of metrics but don't provide as high quality care as an organization that measures half as many data points, he continues. "They may have the potential to be better, but measurement isn't enough. You can't lose weight just by standing on a scale. But you can't track it unless you do. Measuring all this stuff? Most of it we do because we are required to. And the physicians who need to see it to improve aren't seeing that data. So most of what those organizations that measure a lot of things are doing has little correlation with improvement."

Meanwhile, an organization that doesn't measure as much but has a leadership that has stated its interest in improving, has managers that create clear goals and programs and processes to meet them, and that measure their progress toward those goals — Pronovost says that hospital "absolutely will move the needle."

Teamwork, a culture of safety — those are other requirements for improving. But they can be ephemeral and it can be hard to determine if you have really created those things, he says. "We have to do some things that are hard to measure — or that are impossible to measure. But just because we can't measure it doesn't mean we shouldn't do it. And it doesn't mean that we pretend to measure it, and even if the number we get is junk, we report it and pretend it's fine. The cost of that kind of measure is more than the benefit you can get out of it."

The discussion that government, health leaders, and other stakeholders are having now about performance measures is healthy, he says. That people are arguing about whether a penalty for 30-day readmission rates is fair or if it penalizes the hospitals with the sickest patients is all part of what will move us toward a performance measurement system in this country that is much more meaningful and useful than what we have now.

Until the powers that be lay down whatever the new law is, though, there are things that any quality manager can do right now to make the most of the data being collected.

First, Pronovost says to create a good quality management infrastructure. That means making sure that there is accountability. "There is this notion that clinicians have profound individual accountability, yet all this preventable harm is happening," he says. "I think it's explainable by the bystander effect: If no one is assigned responsibility, no one steps up."

Ask at a meeting who is responsible on a particular unit for quality and no one raises a hand or voice. Maybe the assumption is that it is everyone's responsibility. But it needs to be an actual person's stated responsibility. There can't just be a system- or hospital-wide quality director, but someone in each unit and department. "Think of a fractal — there are horizontal and vertical linkages. You have the vertical links for accountability with someone with overall responsibility. But you have horizontal links where various units, departments, or whatever, can share learning with peers."

Think fractals

At Hopkins, they are piloting a new quality paradigm where there is a system-level quality committee that includes each of the six hospital CEOs; at each hospital level, there is a committee that includes every department head; at the department level, every unit is represented; and at the unit level, it's the clinicians who show up. At each level, there is an individual with accountability, and at each level both physicians and nurses participate. In some of the higher echelons, a tech person may also be a mandatory participant. The people who have account-

ability train for a patient safety certificate with 40 hours of coursework that includes learning about issues like teamwork, patient-centered care, Lean and Six Sigma management, and costs. The upper levels also receive training in staff evaluations.

So far, they figured that if every department supplies a nurse and a physician half time, and every unit 10% of a nurse and a physician, it will cost 0.8% of the hospital's revenue. Given that hospital margins are running about 1%, that's significant. But Pronovost says they are fairly certain this new structure will save 4-5% in hospital revenues. The pilot, at Johns Hopkins Hospital, is starting in just three departments and should continue through the end of the year. If it is as successful as Pronovost thinks it will be, it will expand to the rest of Johns Hopkins Hospital and the other five facilities in the system.

That kind of makeover may be too big a bite for some. But there are other things you can do right now, Pronovost says. First, if you are collecting data that no one uses or looks at, stop it. To figure that out, ask every department and unit to list every performance measure it collects. Talk to the users of that data about its usefulness. Have them rate it on a five-point scale for importance and validity. Determine what you can stop collecting. "This can lead to some great conversations about what might make a particular piece of data useful," he says. "Maybe you are collecting something at some point in the patient experience, and if you change it, maybe you can create some data that will be of use to providers and patients."

At the very least, you may be able to reduce your data collection burden. If you're lucky, you might find a way to make the performance measures you collect do real good for your patients.

For more on this story, contact Peter J. Pronovost, MD, PhD, FCCM, Sr. Vice President for Patient Safety and Quality, Director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine, Baltimore, MD. Telephone: (410) 502-3231.

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Patient experience: Perception is everything

It's not what you do, but what they think you do

You've had that experience before: You say something innocuous and someone takes umbrage. You meant no harm. Indeed, you did not mean it the way they took it at all. But in the end, it does not matter what you meant; it matters what they experienced. And it is the same with patient care. If you do everything exactly the way you should with a smile on your face, but a patient is having a bad day, she's not going to see it the same way.

So how do you make sure the patient experience is a good one — at least as far as you can? Some answers may lie in The National Patient Experience Study, released in May. It was conducted by J.D. Power and Associates for the Beryl Institute and focuses on the importance of "listening to the patient voice." Based on a survey of 3,500 recently discharged patients, it found that the average experience of a patient in the hospital exceeded by a small margin the experience of guests in a luxury hotel — the hotel guests gave a score of 822 out of 1000, while the average for hospital patients was 825.

The key indicators of a positive experience were:

- patients getting to their room within 20 minutes after admission, or 90 if being admitted from the emergency department;
- being able to talk to their doctor when they want to;
- nurses always describe the plan of care for the day;
- call buttons are answered promptly;
- physicians and other staff thank the patient for choosing their hospital;
- the hospital calls to check on the patient post-discharge.

Staff matter most. Nearly half the score came down to what happens with physicians and nurses, and the procedures the patient had — 19% for nurses, 15% for physicians, and 12% for tests and procedures. A quarter of the experience was measured against the discharge process. Just a fifth was down to environment — so much for all the expensive redecorating at hospitals.

Be concerned. Key to a good experience were

staff who had a good "emotional intelligence," the report states. That means staff who are empathetic, kind, and show concern are going to help give patients a much better experience than someone who is whip-smart when it comes to IQ, but not so great when it comes to personal interactions. Helping staff to improve their emotional intelligence if they are lacking could help to improve this key factor in patient experience, the study notes. Feeling your nurse or doctor has shown "genuine concern" can color the entire hospital experience — a good nurse can make 200 thread count sheets feel like 500 thread count Egyptian cotton.

Show empathy. The report talks about the importance of empathy and divining how patients are thinking. This translates into explaining things to patients in a way they understand. If providers show this level of empathy, the patient experience is much more likely to be good than if they do not.

Say thanks. One of the most telling statistics in the study related to the simple act of thanking a patient for choosing your facility. If you do this, the patient was likely to give an average of about 7 positive recommendations. If you forget, you're looking at about a half a recommendation for your facility per patient.

Ask for input, provide information. Patients who felt they were discharged at the right time were much more likely to have been asked what their goals for treatment were than not. Asking for patient input about desired outcomes makes for a better experience. Also related to positive experience were having nursing staff that gives information about the care plan for a given day, knowing that the physician is readily available to answer questions, and if the patient knows when he or she would be having tests and procedures.

It is not all about you. With about a third of the score related to admission and discharge, the report notes that hospitals should be aware that what happens before and after the patient comes to you is also important in the overall patient experience. You aren't in a bubble. Make sure that intake and outflow are smooth, too. It reflects on you even if it isn't within your control.

Leadership = patient experience

At Barnes-Jewish Hospital (BJH) in St. Louis, patient experience is important enough that there is a director-level position just for that. **Sean Rodriguez**, MBA, was hired into the position about two and a half years ago. He says that while a lot of hospitals focus on "service" when they think of patient experience, it is about much more than that. "This isn't like service excellence you hear about in the hospitality industry. This includes much more than that."

BJH uses three different metrics to look at patient experience: the HCAHPS survey, a patient satisfaction and experience survey created for them by Professional Research Consultants, and an internal database that tracks complaints and incidents and keeps trend data on both.

One thing they implemented was leader rounding on patients. At least once a day, the unit or department head will go around and step into each patient room to ask a set of structured questions of patients to determine whether anything is amiss. Questions might include something like whether the patient used the call button, and if so, did he or she get a response quickly? "Responsiveness is an area we have focused on for improvement," he says.

Leadership goes through training at least twice a year to refresh these skills and learn how to work with staff members that might be falling short of expectations. Low performers are subject to increased leadership rounding and coaching for improvement. For instance, if a particular nurse isn't remembering to fill in the patient whiteboard with his name and the patient pain score and other data, the leader will round with him and prompt the proper behavior. "It is not meant to be punitive," he says.

Leadership training leads to a lot of questions about the data that is collected, Rodriguez says. "We do not use it as statistically precise information in this instance. Instead, it is used to give us a direction, to show us where to start in our conversations with patients." If they are getting low scores on responsiveness, leadership will want to ask about the timeliness of call button response, the time of day patients called and whether there is a pattern that indicates a staff shortage or some other problem not related to a particular staff member. "It is not about a number on a scale. You have to dig deeper than that

and ask more questions."

For instance, there is a question about noise at night. Most people figure that hospitals are noisy and patient complaints about noise at night are related to ambient sounds. Not so at BJH, where further questioning pointed to a different problem: One of the occupants of a semi-private room was having visitors late at night. "That wouldn't be obvious if you just looked at the numbers on a survey response," he says.

One other way to dig deeper is to make use of family and friends of patients. Often, Rodgriguez will host a patient and family forum over lunch. "Family members notice everything. Patients are often overwhelmed or in pain or medicated. But the family sees it all."

The focus for improving patient experience has always been on changing the culture at BJH, he says. "We have leadership institute events twice a year. The first time, we talked very little about patient satisfaction, but a lot about employee engagement. We talked about values conversations and how to talk to a low performer or lagging team member. We look at how to have good conversations with anyone on the team, whether they are excellent performers or somewhere in the middle."

Barnes-Jewish also focuses on making its mission and values actions, not just words. Like all organizations, the values are full of meaningful words like integrity, respect, and excellence. Rodriguez wrote action sentences to go with each. So integrity became, "I will be positive and committed to our mission." Each of those sentences had related mandatory behaviors — following policies and procedures of the department, adhering to the privacy rules of HIPAA, for example. And each of those mandatory actions has its own toolkit, video, and training manual. This is spread throughout the organization.

And how does this impact patient experience? From the top down, Rodriguez says, the culture is all about accountability and doing everything possible to make the patient experience safe and positive. So far, so good, he says. "We have come far, but that does not mean we're done yet. We still have a ways to go as an organization."

For more information on this story, contact Sean Rodriguez, Director of Patient Experience, Barnes-Jewish Hospital, St. Louis, MO. Telephone: (314) 362-4138. ■

How is your discharge planning process?

Following discharge surveys come new CoPs

It always comes down to communication, right? In an effort to further emphasize improved communications along the healthcare continuum, the Centers for Medicare & Medicaid Services (CMS) has revised its Conditions of Participation (CoPs) for discharge planning. This comes just as the organization will begin doing surveys related to discharge planning procedures.

The revised CoPs include rules for patients being discharged home, as well as to skilled nursing facilities, rehabilitation centers, home health agencies and other post-acute service centers.

Hospitals have to have a four-stage process in place that includes requirements on screening, evaluation, and implementation. Hospitals are encouraged to get input from throughout the healthcare continuum, including nursing homes, home health agencies, primary care physicians, and clinics.

The new CoPs also include policies related to documenting patients who do not want to participate in the discharge planning process.

Hospitals should begin reviewing the new CoPs, which were released in mid-May, immediately, says **Abby Pendleton**, a founder of The Health Law Partners in Detroit. While some of the changes are merely recommendations that are not mandatory and for which you cannot be cited, Pendleton says you should consider including them in your discharge planning processes anyway. "At minimum, hospitals should ensure that the detailed requirements set forth in the document are incorporated into the discharge planning policies."

The biggest changes in the CoPs relate to the adoption and implementation of a four-stage protocol for creating discharge plans for patients. The policies hospitals create have to address each requirement of the regulation and be in writing. While it's not required, the revised CoPs recommend adopting a policy of creating a discharge plan for every single inpatient, rather than just those who risk assessment or physician and patient request bring to your attention. If that isn't

feasible, says **Jessica Gustafson**, another founding partner at The Health Law Partners, document the criteria and screening process used to identify patients likely to need discharge planning, including the evidence or basis for the criteria you choose and process used. You must also document which staff members have responsibility to carry out the screening and evaluation.

No time definitions

"This screen must take place 'at an early stage' of a patients hospitalization," Pendleton says. That "early stage" isn't defined, but she says that surveyors won't issue a citation if the screening is done at least 48 hours before the patient is discharged.

The new requirements also demand that hospitals have a way of making patients or their representatives aware that they can request a discharge planning evaluation even if an initial screen shows they aren't at risk for a post-hospitalization adverse event.

Whatever tool you use for evaluation, it has to have been developed by a nurse, social worker or "other qualified personnel or by a person who is supervised by such personnel." The hospitals ideally should use a multidisciplinary team to create the evaluation, says Gustafson.

That evaluation needs to be a detailed review of a patient's expected post-discharge needs, Gustafson continues. Specific areas that have to be addressed in the discharge plan should be noted — medication reminders, special dietary needs, or daily weighing, for example. It should include an assessment of the patient's ability or lack of ability to take care of him- or herself, with the goal being to get the patient back to the same setting from which he or she came to the hospital.

There is no specific time guideline for doing the evaluation — Pendleton notes the CoPs just say it should be done in a timely manner. But there is a suggestion that 24 hours is a good benchmark to determine if an evaluation was initiated within good time. If it was not done within 24 hours, the reason why not should be indicated.

The results of the discharge planning evaluation should be documented in the patient's medical record and must be discussed with the patient or his or her representative.

While a patient's wishes are important, the CoPs note that hospitals do not have to develop a discharge plan that cannot or should not be implemented because the patient's wishes are unrealistic, Gustafson says. But if the patient's physicians request a plan be developed, you have to complete it.

The hospital has to get the ball rolling on the discharge plan. That means providing any required in-hospital education or training to the patient or the patient's family, making any referrals for outpatient or skilled nursing care placement if appropriate, and ensuring patients that need skilled nursing or home health services get a list of providers who can give them the care they need.

The plan needs to be updated if the patient's condition alters, and that leads to a change in what would the patient requires after discharge, Gustafson notes.

Outpatients do not need a discharge plan, and hospitals aren't required to create them. But in some cases, it is suggested. For example, Pendleton says, patients using outpatient observation services might benefit from an abbreviated discharge plan.

So far, Pendleton and Gustafson haven't had a lot of calls from clients concerned about the new CoPs. But both note that the detail in the requirements is substantial, and some organizations will have to think carefully about how to implement them. "There may also be challenges with the implementation of the patient wish component," says Pendleton.

There's good reason to move forward, though: Recent research has shown that assessing the risk of patients as part of discharge planning can help reduce unplanned 30-day readmissions[1]. Given CMS' focus on that metric, it seems worth it to give your discharge planning the once over, too.

For more information on this story, contact Jessica Gustafson or Abby Pendleton, The Health Law Partners, Detroit, MI. Telephone: (248) 996-8510.

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Medicare opens doors to more data

Organizations to use info for public reports

If payer claims data creates a more robust picture of the cost and quality of care provided, then more data is better. But until recently, organizations that want to make use of data were doing without anything much from the Centers for Medicare & Medicaid Services. Seven organizations have received word from CMS that they're getting their hands on data this spring from Medicare outpatient and pharmacy claims.

Data junkies aren't usually irrationally exuberant, but the people at Oregon Health Care Quality Corporation (Q Corp) are extremely happy to have wider access to Medicare claims data, says **Katrina Kahl**, MPH, director of communications for the organization.

"Having data from another part of the continuum is really important," she says. "Hospitals increasingly need to know what is happening in primary care."

Q Corp has had some Medicare Advantage data available, as well as Medicaid and private insurer data. But Kahl says that with care coordination so vital and a huge emphasis on preventing readmissions, getting some patient-level detail on what is happening on the outpatient front can only assist hospitals that are trying to get a glimpse at something more than their little patch of real estate.

The data should be with the organization in the summer, when it will be added to an existing claims database. It will be part of the regular twice-yearly reporting season for 20 primary care data points. Kahl is not sure if the data will be ready for the November data release for providers, which is delivered through a secure portal. But by the April release, the additional data will be part of the reports. The state report and consumer report, which come out in the new year, will also include the additional data.

Kahl says that Q Corp has applied for a grant that would allow for some cost of care reporting outside of its regular reporting cycles, too. "We could use the new data in other ways that we haven't thought of or identified yet, too," she adds.

For the time being, this data can allow users to see who is getting preventive care, who is showing up in the emergency department, and who is getting regular health screenings. That kind of information will be vital in the future when hospitals and other health care organizations try to parse out exactly who is at risk of readmissions or other adverse events and who isn't.

"Having this Medicare fee-for-service data will give us another snapshot of what is happening," she says. "We have a lot of initiatives in our state for data and metrics. Having access to more data, complete data, in a timely way to see how you as a provider or hospitals are doing is important."

For more information on this story contact Katrina Kahl, MPH, Director of Communications, Oregon Health Care Quality Corporation, Portland, OR. Telephone: (503) 972-0865. ■

Measuring the next big thing

"Second wave" emphasizes value, not volume

If healthcare of the past was about how much you do, then healthcare of the future is about making sure you do it well and for a good price. A report from the American Hospital Associations' (AHA) Hospitals in Pursuit of Excellence platform looks at this "second wave" and how we'll be measuring its successes — and failures — down the road.

"Metrics for the Second Curve of Health Care" lists four "imperatives":

- aligning hospitals, physicians and other clinical providers across the continuum of care;
- utilizing evidence-based practices to improve quality and patient safety;
- improving efficiency through productivity and financial management;
- developing integrated information systems.

Each item on that must-do list includes a list of metrics. For instance, with regard to aligning hospitals, physicians and others across the continuum of care, there are measures such as distribution of shared bonuses and the percentage of physicians in leadership positions. For using evidence-based practices, metrics include

effective measurement and management of care transitions.

The report — available at http://www.hpoe.org/resources/hpoehretaha-guides/1357 — expands on each imperative and its recommended metrics. It outlines what it is that would put a hospital at the beginning of the curve, transitioning, or well into the second curve. There is a link in the report for an associated self-assessment tool, too.

For quality managers, the report is a useful tool, says **Heather Jorna**, MHSA, vice president of health care innovation at the AHA's Health Research and Educational Trust in Chicago. "We are all on this quality journey to improve care for our patients," she says. "Patient safety professionals and hospitals are eager to understand next steps. This report provides a framework and guidance for those on the front lines to assess their work and think about how they can do even more."

The things listed in the report and self-assessment aren't things you should feel bad about not having done or mastered yet: These are the focus of what's coming down the pipeline and which hospitals and health systems will have to focus on to be successful in the future, says Jorna.

You may look through the report and find you are already doing some of what is in there. Jorna notes, though, that others may find some new ideas and strategies, new ways of thinking that might complement what you are already doing. This isn't the only thing you need to get ready for the future of healthcare, she adds: It is one more tool in your box. In the end, healthcare is all local anyway, and what works in one community might not work in another.

"Healthcare is rapidly changing, and the Affordable Care Act has introduced some uncertainty into our work," Jorna says. "We know we have to improve quality and doing this will not come about with a 'one size fits all' approach."

This is a follow-up report to one that outlined 10 must-do strategies that would be critical for hospitals in what she calls a "transformational" period. The four noted above have the highest priority. Of those, the one related to utilizing evidence-based practices to improve quality and patient safety is perhaps the most appropriate one to emphasize for quality managers.

"I think broadly you have to look at measuring and creating organized processes, strategies that address the shift toward value-based care delivery, and ultimately addressing value, integration, the ability to meet patient expectations and clinician engagement on all levels."

The self-assessment linked to the report is a way to get more specific for your own needs, she says. "We know all hospitals are different and their approach to improving care will reflect that. The assessment will give hospitals a chance to think through some specifics. By taking the self-assessment they can better understand where they are currently."

She hopes that quality managers aren't the only ones who find use in the report: Hospital leadership can make use of it, too. "It will help hospital leaders determine their current position and progress along the continuum toward meeting the second curve metrics, including all of those related to patient safety and quality."

For more information on this topic, contact Heather Jorna, MHSA, Vice President, Health Care Innovation, Health Research & Educational Trust, American Hospital Association, Chicago, IL. Telephone: (877) 243-0027. ■

Shorter hours for interns can increase handoff risk

Johns Hopkins researchers say they have uncovered an unintended consequence of the move in recent years to reduce the legendarily long and onerous work hours of interns. Shorter work hours can increase the risks of patient handoff, they say.

Limiting the number of continuous hours worked by medical trainees also failed to increase the amount of sleep each intern received per week, but it dramatically increased the number of potentially dangerous handoffs of patients from one trainee to another, the research from Johns Hopkins suggests. The reductions in work hours also decreased training time, the researchers found. *(The study is available online at http://bit.ly/16dCzFB.)*

In 2011, stricter national regulations, reducing the continuous-duty hours of first-year resident physicians from 30 to 16, were put in place with the theory that limiting trainees'

work hours would lead them to sleep more and that less fatigue would translate to fewer serious medical errors. But lead researcher **Sanjay V. Desai**, MD, an assistant professor of medicine at the Johns Hopkins University School of Medicine and director of the internal medicine residency program at The Johns Hopkins Hospital in Baltimore, MD, says data from his work do not support that idea. Instead, he says, his research suggests that unintended consequences of the new rules could be making patients less safe and compromising resident training.

"The consequences of these sweeping regulations are potentially very serious," Desai says. "Despite the best of intentions, the reduced work hours are handcuffing training programs, and benefits to patient safety and trainee well-being have not been systematically demonstrated."

He says the 16-hour limit was put in place without evidence of whether it would improve patient safety and outcomes. "We need a rigorous study," Desai says. "We need data to inform this critical issue."

Desai and his colleagues compared three work schedules in the months leading up to the 2011 change. For three months, groups of medical interns were assigned randomly to a 2003-compliant model of being on call every fourth night, with a 30-hour duty limit, or to one of two 2011-compliant models. The latter included being on call every fifth night but working only 16 hours straight, or a night float schedule, which essentially had interns working a regular week on the night shift not exceeding 16 hours.

Although interns on the 16-hour limit schedule did sleep an average of three hours longer during the 48 hours encompassing their on-call period than those working 30-hour shifts, there was no difference in the amount of sleep they received across a week. "During each call period, the interns had 14 extra hours out of the hospital, but they only used three of those hours for sleeping," Desai says. "We don't know if that's enough of a physiologically meaningful increase in sleep to improve patient safety."

In the study, the researchers found, the minimal number of patient handoffs between interns increased from three for those working 30 hours to as high as nine for those working 16-hour shifts. When handoffs increase, there is less continuity of care and more room for medication and other treatment and communication errors, past research has shown.

Meanwhile, the minimal number of interns caring for a given patient during a three-day stay increased from three to as high as five. Whether, or in what way, that number affects patient care or patient satisfaction is another unknown, Desai says. ■

AHRQ report: Health disparities continue

No one expects the wrongs of millennia to be righted overnight, but it seems as if not a lot has changed every year when the Agency for Healthcare Research and Quality (AHRQ) releases its annual report on healthcare disparities. If you are poor or a racial or ethnic minority, you are still less likely to have appropriate access to the healthcare you need when you need it.

The good news? Quality is improving, even as access gets worse and disparities stagnate.

Over all, the report — using data from 2002-2009 — shows that we get the right treatment just 70% of the time, and a quarter of us say we face some barrier to getting care, whether financial or otherwise.

There are some bright spots: Surgical patients get the right care and antibiotics, and hospital patients get their pneumonia and flu screenings and shots when appropriate.

Patients with chronic illnesses like diabetes need to get better care. If you were 40 or older with diabetes, you had a less than one-in-four chance of getting all four of the recommended services for your condition — at least two blood tests, an eye exam, a foot exam, and a flu shot. It was even worse if you were African-American or Hispanic and had diabetes.

Those two minorities received worse care on about 40% of the quality measures, and African-Americans had worse access to care on a third of the measures. Hispanics fared worse still, with worse access to care on 70% of the measures.

The report includes new measures related to hospital acquired conditions, as well as mea-

sures related to prenatal care, colorectal cancer screening, and patient safety culture in the hospital.

The full report is available at http://www.ahrq.gov/research/findings/nhqrdr/index.html. ■

MRSA down in ICUs

A study on 74,000 patients in 74 US intensive care units found that using antibacterial soaps and ointment on all intensive care patients can reduce infection with methicillin-resistant *Staphylococcus aureus*.

The patients either received routine care, the germ-killing soap and ointment to all patients, or giving the soap and ointment treatment just to patients who tested positive for MRSA.

Treating everyone worked significantly better, preventing one MRSA infection for every 54 patients. Given the high-risk population in most ICUs, the strategy makes sense, the authors note. ■

Hospital Report wins award

On June 6, **Hospital Report**, AHC Media's free blog (http://hospitalreport.blogs.ahcmedia.com/) was named "best blog or commentary" second place by the Specialized Information Publishers Association at ceremony held in Washington, DC.

Be sure to check out Hospital Report for further analysis and discussion of topics important to hospital professionals. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute blog posts. ■

COMING IN FUTURE MONTHS

- More on CMS Conditions of Participation
- Accreditation field reports
- IPPS updates
- The standards that trip hospitals up most

CNE QUESTIONS

1. Peter Pronovost says that Johns Hopkins collects how many performance measures?
   a. 300
   b. 200
   c. 190
   d. 280

2. Patient experience with physicians and nurses accounted for how much of patient experience according to a new survey?
   a. 15%
   b. 19%
   c. 34%
   d. 12%

3. New CoPs for discharge planning require an evaluation within how much time?
   a. 24 hours
   b. 48 hours
   c. no time period mandated
   d. daily until discharge.

4. CMS is releasing what kind of data to seven organizations this summer?
   a. Medicare Advantage
   b. Inpatient Medicaid
   c. Pharmacy and outpatient
   d. Dental and pharmacy

CNE OBJECTIVES

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

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- 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.
- 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.

IHI blogs offer learning, entertainment

Looking for some inspirational reading that can actually help you do a better job? The Institute for Healthcare Improvement (IHI) has launched eight Improvement blogs designed to "capture fresh ideas and new thinking from the frontlines of patient care and population health."

The blogs include one written by IHI president and CEO Maureen Bisognano, one devoted to issues of lower- and middle-income countries, and one for students and members of the IHI Open School.

Of interest to quality professions are the Reducing Readmissions blog written by IHI vice president Pat Rutherford, which looks at practical strategies to reduce unplanned returns to the hospital; the Safety First blog, which deals with both patient safety issues as well as dealing with issues like physician burnout and drug shortages; and the Innovation@IHI blog that looks at a new set of improvements every 90 days, using rapid testing and scalable solutions. ■

CNE INSTRUCTIONS

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
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 successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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Dear *Hospital Peer Review* Subscriber:

This issue of your newsletter marks the start of a new continuing education semester.

Hospital Peer Review, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options. Our intent is the same as yours — the best possible patient care.

Here are the steps for earning credit for this activity:

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
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 successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

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On behalf of AHC Media, we thank you for your trust.

Sincerely,

Lee Landenberger
Continuing Education Director
AHC Media