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AHC Media

Health IT harm now a target for investigation

When the cure causes harm

A decade or so ago, it was a common belief that if only everyone had electronic records, we could make healthcare cheaper and better. While that may be true in theory, health information technology (HIT) also includes risks — not just the kind that involve a lapse in HIPAA, but the kind that can cause physical harm to a patient. As healthcare becomes more advanced technologically, those risks multiply to include potential harm from devices that malfunction, improperly programmed machines, and operator error.

The federal government released a plan in July to come to grips with some of the risks. (The entire plan is available at http://www.healthit.gov/sites/default/files/safety_plan_master.pdf.) Among the stated goals of the HIT Patient Safety Action and Surveillance Plan are to make it easier for clinicians and hospitals to report risks and adverse events related to HIT. To facilitate this, the Agency for Healthcare Research and Quality (AHRQ) is updating its common formats to facilitate the reporting of information to patient safety organizations (PSOs). The Centers for Medicare & Medicaid Services (CMS) will also encourage the use of the common formats in hospital reporting programs and will develop training programs for its surveyors on the topic.

The plan requires that the federal Office of the National Coordinator for Health Information Technology (ONC) propose standards and certification criteria to make it easier to generate reports from data stored in electronic health records (EHRs), and that AHRQ and the ONC develop tools to help providers figure out what is an event or risk, how to describe it, and how to report it.

Stakeholders will work with patient safety organizations, providers, and IT developers on ways to improve reporting, as well as how to mitigate risk, and will move quickly to include post-market surveillance for safety issues for certified EHR technology. Another goal is to support research, development of best practices and tools to help reduce risk, and then to disseminate those practices and tools.

One of the key parts of the plan is to investigate the kinds of harm that are happening or are at risk of happening, and their frequency. The Joint Commission will be working with 10 organizations, including five ambulatory

care organizations. Two have already been identified through previous reports of sentinel events related to HIT.

The others will come from good old-fashioned reaching out to hospitals and ambulatory facilities, says **Ron Wyatt,** MD, the medical director at The Joint Commission's division of healthcare improvement. Some hospitals have actually called the organization to ask about participating, he adds, so it doesn't look as if it will have a problem finding people willing to talk about the safety problems they've had related to HIT.

"It is a challenge for many to talk to us about events — whether they are related to IT or not. But there are many organizations and systems that are beginning to understand the value of reporting and learning from safety events, including sentinel events," he says.

A database query found "hundreds" of potential events that will provide a solid start to the endeavor, says Wyatt. "We will let them know this is not about accreditation, but about process improvement, quality and safety. We have been trying for some time to get them to see us not as a regulator, but as an organization that will collaborate with them on patient safety and quality improvement. And that is paying off. They know that this is not something that will lead to punitive action. We aren't interested in where you aren't in compliance with a standard, but where there was an event and how to build a more resilient system so that it doesn't happen again. Then we want to share that learning with others."

That sharing is key: Organizations always want to know how others have dealt with the problems uncovered in the root-cause analyses of sentinel events.

As for the process, it won't differ at all from the existing sentinel event investigation process. The information is confidential, data are de-identified, and conversations take place in a sound-proof room. There may be additional issues that arise in the initial phase that could require tweaking the process for tech-related events, Wyatt says.

The entire process will be completed within the next nine months, he says.

Jumping on the bandwagon now

While the national plan related to HIT safety is likely to result in more emphasis in the future on keeping track of HIT-related harm, there's no need to wait to figure out where your risks lie, says **Linda Kloss**, president of Chicago-based Kloss Strategic Advisors. She says that many hospitals are putting in monitoring programs to determine whether, how, and how often patients are harmed by HIT.

While many have been flying blind in their efforts until now, this month the ONC will be

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issuing some tools that will help organizations understand the risks and potential fixes based on expert opinions and research.

"That will be a good place to start, because there is enough literature, and study, and expert opinion to know where many of the points of vulnerability are," she says. "When you know those, you can begin to get some focus on where to start."

One of the areas that members of the ONC advisory board on HIT safety issues noted as potentially risky is any time there is a software update of technology, Kloss notes. While organizations are very rigorous in their testing of any new technology before it goes into production, most are not as rigorous in how they test updates before beginning to use them.

Other areas of interest that may result in an on-line tool from the ONC include problems with user interface, Kloss says, such as when a clinician doesn't have all the information he or she needs, and doesn't know how to get to the screen that contains it. Workflow issues, interfaces between systems, and even things as simple as the problem of duplicate records are all hazards that could potentially cause harm to a patient if not addressed.

Solutions in the works

"We need to know the places where we have to be extra careful and extremely aware," says **Dean Sittig,** PhD, who has been working to come up with ways to define HIT events, and then to create systems that will make those events less common. He sits with Kloss on the ONC expert panel and was the lead investigator for the SAFER initiative[1] on EHR resilience that is the basis for the tools being released later this month on the ONC website.

The SAFER project came up with nine areas of concern:

- computerized provider order entry and e-prescribing;
- clinical decision support;
- test result reporting;
- communication between providers;
- patient identification;
- EHR downtime events;
- EHR customization and configuration;
- system-system interface data transfer;
- health IT safety-related human skills.

The best place to start is to look at your adverse events and figure out if there was a technological element to it, he says. It might not be obvious. Take patient registration: If you have two people with the same name, you might end up giving one the wrong medication. But what if you have two patients with the same name and the same address, but different middle initials? Likely, one of those was a typo. But if you don't have the complete record of a patient's experience — if some of it is in the John L. Smith file and some is in the John Q. Smith file — the physician may not have all the information he or she needs on tests done in the past, drugs that didn't work, or comorbidities. All of those issues could change the way a physician treats the patient.

Indeed, Sittig says the first, easiest thing a hospital can do to reduce potential harm is to look at how many people have the same first and last name and same date of birth in your system. In some databases, as many as 20% of patients have duplicate records.

The importance of doing this now is critical: We can't use technology to monitor and improve safety until we know that technology is, itself, safe, Sittig says. "That's where we want to get, but most people don't trust computers enough to let them be in charge of safety."

"Don't look at this as some externally imposed project," Kloss says. "It is something to do, but the consequences of not addressing the issues are potentially as extraordinarily adverse for patients as the potential benefits that same technology can provide. Besides," she notes, "it's not going to get any simpler."

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Hospitals turn around readmissions woes

From losing money to bonuses in one year

Two years ago University Hospitals' Richmond Heights (OH) facility and Banner Heart Hospital in Mesa, AZ, were both dinged by the Centers for Medicare & Medicaid Services (CMS) for having too many unplanned readmissions. But just a year later, both hospitals have earned bonuses based on their reduced rates.

The leadership team at Richmond Medical Center knew that they had a readmissions problem before CMS started cutting payments for hospitals that didn't meet certain standards related to it. "We noticed before then that our readmission rates were higher than they needed to be," says **Laurie Delgado**, president of the system. "It's possible that had we not started work on the issue when we did, the penalty may have been greater."

The organization wanted to see what the patients who bounced back had in common, she says. "We have a number of patients who are the chronic, repeat readmissions folks. We needed to get our arms around that group and figure out a new way of managing them." Because the penalties relate to acute myocardial infarction, pneumonia, and congestive heart failure (CHF), those were the initial kinds of patients that were the focus. However, they decided to really concentrate on heart failure patients.

Delgado says they drilled down to look at any patient who had CHF as a reason for readmission, or who had heart failure and was readmitted for some other stated reason. "We wanted to see whether they went home, home with home care, or to a nursing facility. If it was the latter, then we wanted to see which facilities had the most readmissions so we could better improve by partnering with them."

The hospital is relatively small — 50 beds were involved in the effort, of the 101 for the Richmond/Bedford combined facilities. That may have made it easier to dissect the data from the readmissions. They put together a team that included the chief medical officer, the chief nursing officer, nurse managers, unit care coordinators, emergency room staff, the quality manager, the lead hospitalist, a cardiologist, a pulmonologist, and several internal medicine residents. There is also a "sub-team" that meets a week before that committee meets to do a chart and data review, says Delgado, so that more time is spent in discussion than in searching for meaningful data.

While looking at the data is the crux of the committee's work, the committee also looked at what initiatives were already in place related to readmissions, which had been effective, and whether they could be applied to this specific patient group, she says.

The result of the work the committee did in 2011 and 2012 was the implementation of several initiatives that required some financial outlay on the part of the hospital, all with the hopes that the money could be recouped by reducing readmissions.

For instance, while there is a requirement for a patient to be home-bound to receive home care, the committee felt that some patients who are not home-bound are still at high risk. "We started to send a home care nurse for a free visit to help re-educate patients and go over their medications in a less stressful environment than the hospital," she says. They also make sure that the patient has a follow-up appointment with his or her primary care physician and a means of getting there. One of the key ways this helps is to ensure that patients are taking their medications. Many go home with prescriptions only to find they aren't covered by their insurance or that they can't get to the pharmacy. The home nurse helps with that.

The committee also looked at the skilled nursing facilities where there were the greatest number of admissions and readmissions. Now, when a patient returns to such a facility, a geriatric nurse specialist visits within a day or two to review the care plan with the nursing team at the facility.

"The thing that probably helped the most was getting a clear understanding of our patients," Delgado notes. "When we first started looking at reasons, we needed to get a grip on what was the barrier for them that led them back." They developed a tool to collect data identifying the reason for admission, what the plan of care was the last time they were in the hospital, whether they complied with medication regimens, and any other problems they had. That led to the creation of the next discharge plan, with an eye to preventing any of

those issues from happening again.

"It also helped the committee to understand the barriers that patients had — access to medication, for example," she says. "We have ways of assisting with those problems, like pharmaceutical company programs or alternative medications."

They still look at the data, and are pleased with the results. Some patients don't want a home care nurse to come in, even though it's free, but by and large, Delgado says the plan changes have been exceptionally well received and have paid off.

Not that they are finished: This month, they are starting a project with the internal medicine residency manager for a transition clinic for patients who might not be able to get into their doctor's office within a week — a risk factor they identified in their initial data mining. It's free, open three days a week, and staffed by residents who can help with education. A dietitian is available if needed, and all information from those visits is transferred to the primary care physician in time for the eventual office appointment. Concerns are bounced to the cardiologist, as well as the primary care physician. They may implement a voucher system to help the patients get to the transition clinic.

Medicare figures are slow in coming, so they didn't see a big drop for a while. But they know that they reversed a systemwide CMS financial hit of $128,000 inside a year. And it was great to watch the trend chart move downward, she says. Now they're looking to do something similar with chronic obstructive pulmonary disease "because we know that getting to a pulmonologist within a week after discharge helps prevent readmissions."

She says that one of the biggest lessons she learned is that it's OK to try a lot of things at once to evince change. Not all may work, but something will.

A system view, rather than patient view

At Banner Heart Hospital in Mesa, AZ, the journey to lower readmissions started four years ago, with participation in the Heart Failure Accreditation Colloquium (colloquiumhealth.com). The hospital was one of the first to participate and was required to hit various milestones on the path to accreditation, says chief medical officer **Mark Starling**, MD.

The process included a site visit that required hard thinking about why providers and the facility did the things they do. "It was very provocative stuff," he says. "And we found out that what we were doing just didn't serve the patients. We thought we were, but we weren't."

Starting in 2010, they began a process that mapped the patient experience in the system from the time patients are referred to the hospital. "We wanted to know what decisions they had to make, and whether that impacted the quality of their care," Starling notes.

They learned that pretty much everything flows to the ED, which has only two choices: to admit the patient or not admit the patient. They decided to add another option: A dieresis clinic that could help keep the patients out of the hospital.

Looking further at the system flow to the inpatient portion of the patient journey, they found a system that didn't engage the patient or put him or her at the center of care. They needed to get patients involved with their care, so technicians trained patients who were able to weigh themselves every day. Getting them to understand why this was important, putting the onus on them to monitor their weight, and knowing what to do if it went in the wrong direction would help them after discharge to better manage their own care. Similarly, able patients were given a card with all their medications, time of dosage, dosage, and route of administration. They go to the nurse station to retrieve their medications, where they are quizzed on the purpose of the prescriptions they take. Again, this is great training for when the patient leaves. "And the patient gets up and walking, which is also good," he says.

Starling says they also trained select nurses as experts to be a resource to new nurses and also to develop patient education. This education is kept consistent throughout the continuum of care, ensuring patients get the same information with the same language whether they are in the ED, an inpatient unit, or at a Banner clinic. Meanwhile, patients were assessed on admission by social work, case management, and the bedside nurse, as well as the clinician. Then the group would do interdisciplinary rounds to share the information on what the patient needed.

This was the third arm, Starling says: getting them ready for discharge from the start. "Before, we were just kicking them to the curb like we

were discharging them from the army, with no idea of what happens outside our realm." So they built a transition model that included making an appointment for them to see a clinical pharmacist while they are in the hospital, ensuring they have a timely appointment with a cardiologist post-discharge, and making sure they get into post-discharge heart failure rehabilitation. It's not covered by Medicare, so for patients who can't pay, the hospital picks up the tab.

Putting the patient at the center

Further along the continuum, the hospital reduced the number of skilled nursing facilities they work with to three. "To participate with us, they have to be ready to track data, use our teaching tools, and implement our plan," he says. The nursing homes also helped identify three stellar home health agencies. "One thing we did was ask them what they needed from us," says Starling. "They told us that they needed help with cardiac diets. So they came to us and watched our people prepare and plate meals for the patients, and they continue to act as a resource for the nursing homes' dietary staffs." The nursing home and home care staff are also invited to participate in nursing education provided to the hospital nurses.

Starling says they "turned the care continuum upside down and put the patient at the center." The readmission rates went from 28% to 15% between mid-2011 and the summer of 2013. They keep an eye on data monthly, and any readmission is investigated in detail by a clinical nurse specialist and case manager.

"We are building a model that could work with any chronic illness — post-operative heart patients, chronic kidney disease, COPD — they can all work with this. You just change the particulars. You end up with better quality, better patient functionality, and it costs us less. We are the most efficient building in Banner."

They are sharing the program, and it has been deployed for heart failure patients in other hospitals in the system. "It's just known as 'the Program,'" he says.

He says being bold was a key to success. "Sometimes the best slate is the one that's wiped clean. You have to realize that the care of the patient is more than just the three and a half days a patient is here with us. There were people struggling; we were not helping them. Looking at our system showed us where the gaps were. It doesn't take a genius to know that if your only choice is to discharge a patient from the ED or admit him to the hospital, a lot will be admitted even if that's not the level of care they need."

Starling thinks it's imperative to know exactly what happens when a patient enters your system, and it's worth the money to pay for an expert to help you do it. "I know what happens to a patient every hour. I know who touches them. Frankly, I was surprised when I did this that anyone ever got out."

Spending $60 for two lessons on self care for patients, or a couple hundred dollars for eight two-hour rehab sessions is a no-brainer compared to spending $6,000 for every readmission, Starling says. "There is less depression, better functionality, and they manage their care. Not all patients need this, but many do. And they aren't coming back."

The hospital is so confident of its program that it has applied to CMS for bundled payments. "We figure we can get down with our innovations to 10% readmissions. I think when we're bundled fully, we'll have money left over. Give me a hunk of money for 90 days care and I'll make $4,000 on each patient every year. And we'll do it for heart attacks, for post-op heart patients, for everyone."

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How to set priorities for your QI year

So much to do, so little time

To call quality improvement a "resource-intensive enterprise" like **Patricia Reid Ponte**, RN, DNSc., the senior vice president for patient care services and chief nurse at Dana Farber Cancer Institute in Boston, is really just a fancy way of saying it costs money, and that means making very careful choices about where to focus those resources.

But given the reality of competing initiatives, increasing data collection requirements, and being able to show you're doing better every year, how can you do anything as structured as choosing a project to champion?

There may be a lot of requirements for reporting that leave little choice in picking programs, but Ponte says there is always some room for choosing areas of focus, and to do that effectively, you need to create a prioritized list. "You do have to monitor and improve what CMS and the Joint Commission ask, and what payers put into your contracts," she says. "Beyond that, you have to see where you have an intersection of high volume and high risk. It might be an issue in medication administration in oncology because you had sentinel events there last year. Perhaps you have a lot of volume in your OR, so that might mean looking at ways to improve care for surgical patients is a better idea."

Where to start

Start by looking at the areas of practice where you have the most patients — either based on procedure, disease process, bed days, or costs, says Ponte. Those high-volume cases are also the places where you will see the most risk, simply because you do hip replacements more often than you face a situation with a new mom bleeding out during delivery.

Next, figure out if you have any small patient groups that are the focus of a lot of dollars or undergo extremely high-risk procedures. Also figure out if there are any areas — large or small volume — where you have had a higher than expected number of adverse events or near misses.

All of this information should be readily available through data, or by asking members of your patient care assessment committee. The latter can be particularly helpful in pointing out areas that aren't evident by looking at data.

For example, Ponte says that a year ago her facility determined it had to improve its patient access process. Patients and families were complaining they couldn't get an appointment when they wanted. "We knew we could lose market share, so for us, that was an important process to improve."

When Massachusetts General Hospital set up the Lawrence Center for Quality and Safety in 2007, it got a suggestion from the malpractice provider to become a data hub for the entire institution, says **Elizabeth Mort**, MD, MPH, the senior vice president for quality and safety and the chief quality officer at the hospital. "They said we should reach out to all corners of the institution, to anyone and everyone that has any data of any kind, which could impact what we do. That's really just about everyone."

Having access to those vast amounts of data helps Mort and her team prioritize projects for the year. They make sure that each project involves at least one of the six pillars from the Institute of Medicine — that care is: Safe, Timely, Effective, Efficient, Patient Centered, and Equitable. She says that most institutions aren't great at including equity, so she always makes sure there is some quality improvement goal related to that.

"I know innovation has to be a piece of it, too," she says. "It's an obligation because the healthcare world looks to us for innovation."

By making sure that her projects stem from data and address one of those six pillars, Mort says she can find an island of calm in her busy quality department. "It makes me feel comfortable knowing that I haven't forgotten any important area," she says.

A process and a spreadsheet

The mechanism for creating an annual to-do list is pretty basic, she says. "You just need a process and a spreadsheet." The Mass Gen process was described in a recent article published in the journal *Academic Medicine*[1]. It involves gathering data, internally and externally, and then classifying it. Those managing the priority designation process determine what the most pressing quality issues are and bring their conclusions to an internal review team, which then chooses the top quality goals for the year. Each goal is given an "owner." They choose appropriate metrics and send regular updates to senior hospital leadership.

The spreadsheet? Well, it helps keep your desk neat and keep track of goals that are of interest, but not imperative right now. "This pays off because there are always urgent things that have to take precedence," Mort says. They often have a longer-term trajectory, but require regular work on them. There are other things that are more aspirational — like reducing healthcare disparity. "We have a commitment

to doing this, and we create an annual report on the subject that usually relates to the latest literature on disparity — right now, pain management in the ED is a big issue.

"It's not as urgent as looking at medication errors, but if every year you identify a couple of these kinds of issues to investigate, they won't get lost among the other urgent priorities."

One way she can get the resources she needs for the things that are not required, but still of interest and important, is to make sure that on all the quality requirements, results are not just good enough, but exceptional. "I think that for smaller hospitals, it might be harder to get the basic quality and safety work done and do what we manage here," Mort says. "But you should still figure out what you would like to do beyond that. If you get more money, or through philanthropy or a grant, then you will be clear about what to do with it. But I get that other facilities may be just thrilled at getting the ever-increasing requirements done."

You might have more opportunity, too, as value-based purchasing expands: It will help you quantify the value of the quality department and argue more effectively for increased resources, Mort says. "And often community hospitals have an edge over us in that they don't have to have buy-in from 500 people."

Mort says she's working on tracking tools and dashboards to try out that could help organizations better plan their annual quality calendars. She expects those to be published sometime in 2015.

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Are you on top of patient experience?

Most hospitals have yet to make it a priority

Have you heard of a CXO? It's the latest addition to the C-suite: the patient experience officer. It wouldn't be unusual if you didn't, since only about a fifth of hospitals in a recent survey said they had a CXO or other individual solely in charge of measuring and improving patient experience.

The survey, conducted by the Beryl Institute with an assist from Catalyst Healthcare Research, marks the second time the organization has taken an in-depth look at patient experience. It includes data from more than 670 organizations, spread over every state and the District of Columbia. More than 1,000 individuals responded.

Key findings include:

• Just over half of hospitals have a formal mandate to improve patient experience. That's down from almost 60% in the 2011 survey.

• More than 80% have a formal structure in place to address patient experience, up from 70% two years ago.

• Noise remains the biggest problem hospitals are tackling. Better pain management and improved discharge communications round out the top three on the PX radar.

• Priorities for action didn't change over the two years, although the order shifted — reducing noise, hourly rounding, pain management, improving discharge, and improving communication.

• A quarter of hospitals use a committee to oversee patient experience, down from 40% in 2011, and 22% have a CXO or other patient experience leader in charge. Troubling to the study authors is that in 28% of organizations no single person is responsible for patient experience. The worry is that if it is everyone's responsibility, it becomes no one's responsibility.

• The biggest drivers for success are the same this year as in 2011: support from the top and support from clinical leadership. Having a formalized process review and internal communication about patient experience also help. While in 2011 staff orientation was listed, in 2013 it was replaced by having a formal patient experience structure.

• Roadblocks include having leaders who are pulled in many directions, with no one focusing on PX with exclusivity or near exclusivity. Second on the list was having other organizational priorities.

• Methods for improving patient experience include using follow-up phone calls, creating service recovery programs, using performance scorecards, and reviewing processes. While laudable, these are still viewed as reactive. However, the study notes that there are more real-time data collection efforts afoot, such as bedside surveys, patient and family focus groups, and having patient and family advisory committees.

• Measurement focuses on using internal and national surveys, like HCAHPS, as well as doing post-discharge phone surveys, as well as information from advisory committees and focus groups. Organizations that don't have a definition of patient experience — about half of the survey respondents — have a harder time with measurement.

The entire report can be seen at http://c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/BenchMarkingPaper_2013.pdf ■

Quality strategy update shows sluggish start

Additional data coming soon

Two years ago, the federal government put in place a mechanism for determining quality goals and strategies for the healthcare system. The National Quality Strategy came up with three aims — better care, healthier communities, and affordable care. Those aims, divided into six priorities, have had a year to percolate through healthcare, and in August, the Agency for Healthcare Research and Quality (AHRQ) released its second annual report with the first set of data included. The results aren't glowing — although some of the data that could show improvement won't be ready until later this fall or early in 2014. *(See table on page 118 with list of baseline measures, current measures, and aspirational goals.)*

Here's how the six priorities did over the last year:

Priority 1: Reduce Harm. Measures included hospital-acquired conditions (HAC) and 30-day readmission rates. HACs declined from 145 per 1,000 admissions to 142. Readmissions data was static. That may change when new numbers are released by the Centers for Medicare & Medicaid Services (CMS), which showed a decline in such rates last year, from 19% to 18%. Other payers, health systems, and cooperatives are also noting reductions in all-payer, all-cause readmissions that might not be reflected in this year's report. It highlights the Texas-based VHA cooperative of 192 hospitals, which saw a 17.6% reduction in readmissions over a one-year period. The organization cites its "Practice Blueprints," which outline strategies for readmission reduction.

The success with HACs may also be understated this year, as individual hospitals are noting remarkable reductions in ventilator-associated pneumonia, central line-associated bloodstream infections, catheter-associated urinary tract infections, and surgical-site infections.

Priority 2: Patient and Family Engagement. There are no data available on measures related to this priority yet, but the report called out some of the more notable efforts by hospitals to improve engagement and experience. Mount Sinai Hospital in New York City worked to reduce disorienting noise in the ED for its older patients by opening a quieter geriatric ED. Trained volunteers walk around with reading glasses, hearing aids, and magazines. They will sit and talk with the patients to help them get their bearings. Also noted was Kaiser Permanente in Southern California, which piloted shared decision-making at three of its facilities. Patients considering hip or knee replacement surgery to deal with joints damaged by osteoarthritis participated in a video program to help them figure out their treatment goals and the various options. Patients overwhelmingly like the process, and there was a 50% reduction in elective hip replacement surgeries as a result. The program is expanding to other areas.

Priority 3: Effective Communication. This priority has two measures — care coordination for pediatric patients who need it, and a three-item checklist of patient discharge questions. The latter won't have data until later this fall. The former? The baseline of 69% fell to 66%. The goal is in the other direction, 90%. Still, there were bright spots noted by the report, including a patient-centered medical home in Alaska that received a level three designation from the National Committee for Quality Assurance, the highest level it gives. The medical home's work has led to a 5% reduc-

National Quality Strategy Update — 2013

Source: AHRQ

National Quality Strategy Priority	Measure Focus	Measure Name/Description	Baseline Rate	Most Recent rate	Aspirational target
Making Care Safer	Hospital-Acquired Conditions	Incidence of measurable hospital-acquired conditions	145 HACs per 1,000 admissions	142 HACs per 1,000 admissions in 2011	Reduce preventable HACs by 40% by the end of 2014
	Hospital Readmissions	All-payer 30-day readmission rate	14.4%, based on 32.9 million admissions	14.4%, based on 32.7 million admissions in 2011	Reduce all readmissions by 20% by the end of 2014
Person- and Family-Centered Care	Timely Care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	14.1%	Update available in Fall 2013	Reduce to <10% by 2017
	Decisionmaking	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	15.9%	Update available in Fall 2013	Reduce to <10% by 2017
Effective Communication and Care Coordination	Patient-Centered Medical Home	Percentage of children needing care coordination who receive effective care coordination	69%	66.1%	Increase to 90% by 2017
	3-item Care Transition Measure	• During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health • When I left the hospital, I clearly understood the purpose for taking each of my medications	45%	Update available in Fall 2013	Increase to 50% by 2017
Prevention and Treatment of Leading Causes of Mortality	Aspirin Use	Outpatient visits at which adults with cardiovascular disease are prescribed/maintained on aspirin	47%	53%	Increase to 65% by 2017
	Blood Pressure Control	Adults with hypertension who have adequately controlled blood pressure	46%	53%	Increase to 65% by 2017
	Cholesterol Management	Adults with high cholesterol who have adequate control	33%	32%	Increase to 65% by 2017
	Smoking Cessation	Outpatient visits at which current tobacco users received tobacco cessation counseling or cessation medications	23%	22%	Increase to 65% by 2017
Health and Well-Being of Communities	Depression	Percentage of adults who reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months	68.2%	68.1% for 2011	Increase to 78.2% by 2020
	Obesity	Proportion of adults who are obese	35.7%	Update available in 2014	Reduce to 30.5% by 2020
Making Quality Care More Affordable	Out-of-Pocket Expenses	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10 percent of income	18.5%	Update available in Fall 2013	See footnote 1
	Health Spending per Capita	Annual all payer health-care spending per person	$8,402	$8,680 per person in 2011	See footnote 1

1 See the HHS Budget in Brief for a discussion of investments and proposals to reduce health care spending. U.S. Department of Health and Human Services. Fiscal Year 2014: Budget in Brief. April 2013. http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

tion in ED visits by a patient population that is primarily Alaskan native, poor, and often without appropriate access to care. It also reduced hospital admissions by more than half, specialty care visits by nearly two thirds, and visits to the doctor by 20%.

Priority 4: Effective Treatment for Leading Causes of Mortality — Cardiovascular Disease. This is probably the brightest spot in the report. Smoking cessation and cholesterol management need to improve — the declines in those are not considered statistically significant, but the goal is to increase them. Aspirin use and blood pressure control are on the right track, though. The report notes that efforts like the Million Hearts Initiative, as well as other efforts by individual hospitals, non-profit organizations, government entities, and private companies should pay off.

Priority 5: Improving Community Health. While obesity rate data won't be out until next year, there have been some stories indicating that the increase in it — particularly in children — appears to have leveled off. Depression patients reporting treatment, the other measure for this focus, is currently stagnant. Because coverage for mental health is mandated by the Affordable Care Act, the study anticipates this will show improvement over time.

Priority 6: Making Quality Healthcare More Affordable and Accessible. Out-of-pocket expense data should be available later this year. The baseline rate is 18.5%, and there is thus far no target

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Hospital Peer Review's* executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- ■ Strategies for measuring near misses
- ■ Quality in end-of-life care
- ■ Accreditation field reports
- ■ What the new IPPS means to you

CNE QUESTIONS

1. Which of these is NOT one of the nine risk areas for health IT, according to the SAFER project?
   a. e-prescribing
   b. test results
   c. patient engagement
   d. system down-times

2. Banner Heart Hospital's current readmission rate is:
   a. 10%
   b. 15%
   c. 20%
   d. 23%

3. Which of these is often the forgotten pillar of quality healthcare, according to Elizabeth Mort?
   a. safety
   b. timeliness
   c. equitable
   d. efficient

4. Which percentage of survey respondents report a single person in charge of patient experience according to a Beryl Institute study?
   a. 22
   b. 26
   c. 32
   d. 34

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.

figure set. Nor is there one for all-payer health care spending per person, which was up from the baseline of $8402 to $8680. Growth has slowed in the health sector — it's had a 3.9% growth rate for three years running. For Medicare, health spending per capita grew by just 0.4% in FY2012, and it fell for Medicaid by 0.9% in FY2011. But what a family pays for insurance premiums is growing faster — 4.5% in 2012. There are organizations that are making a difference, though. In the Washington, DC area, CareFirst BlueCross BlueShield established a medical home program for more than a million of its members. It links physician payments to the quality of care, and last spring, it reported that it saved $98 million in its second year — up from $38 million the first year. While reducing costs, doctors providing the highest quality of care got increased reimbursement. The question remains, though, how this will impact what the public pays for insurance.

The entire report is available at http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm ■

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. ■