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AHC Media

What should you worry about getting right for survey?

10 standards missed by more than a third of hospitals

Even the best hospitals are likely to get something wrong during a survey, and **Paul Ziaya**, MD, a surveyor in his tenth year with The Joint Commission, has an encyclopedic knowledge of the ones that are most likely to be a problem. When The Joint Commission released its top 10 list of problems cited during surveys, Ziaya rattled off the numbers related to the standards and the most common problems associated with them from memory with ease.

About half of all hospitals get dinged on the first seven on the list, and the last three are problems for between 35 and 40% of facilities, so they aren't insignificant issues. And the things that the hospitals get wrong that fall under each standard seem to be the same, too, Ziaya notes.

Critical access hospitals (CAH) have a slightly different list, but they share seven of the same elements. (*See page 75 for critical access hospital top 10 list.*)

For non-CAH facilities, Ziaya outlined each of the top 10 problem standards and the common issues related to them that he finds during surveys.

1. **52% of hospitals have issues with LS.02.01.20: "The hospital maintains the integrity of the means of egress."** This is usually related to hospitals having clutter impeding patients' ability to exit their rooms and the building, mostly because there is equipment in the halls that isn't something that is used every 30 minutes. Computer work stations that are left to charge, trash cans — they can be left for hours, Ziaya says. Crash carts or chemo carts can be left, but the other stuff? It has to be stored away.

2. **52% of hospitals have problems with RC.01.01.01: "The hospital maintains complete and accurate medical records for each individual patient."** Ziaya says the main issue here is timing — whether an order was acted on in a timely manner. Sometimes, it was, but if it wasn't logged, it is unknown. And if it wasn't written down, it might as well not have happened.

3. **48% have problems with LS.02.01.10: "Building and fire protection features are designed and maintained to minimize the effects**

of fire, smoke, and heat." The most common finding under that standard is holes found in the ceiling and firewalls that were drilled in order for cords to pass through, and then inadequately sealed up, he says. "Each of those penetrations has to be sealed with fire-rated material." If it isn't verified that the holes are filled with the right material — either by pictures or having a checklist filled out by having a walk through with the appropriate official, then you could be one of the hospitals that makes up the 48%, Ziaya says.

4. **47% of hospitals have issues with standard EC.02.05.01: "The hospital manages risks associated with its utility systems."** This is mostly related to ventilation systems, Ziaya says, especially where the environment has to go from cleanest to less clean — like from the operating theater out, or from sterile processing out. "Make sure you have proper air flow and monitoring. Surveyors will do a simple tissue test. They will take a tissue and where the door meets the floor, make sure a tissue floats in the proper direction. If it doesn't, we evaluate further. I teach this as a cheap technique to do on a recurring basis. Belts can break. Don't assume it's all running fine," he says.

5. **46% have problems with IC.02.02.01: "The hospital reduces the risk of infections associated with medical equipment, devices, and supplies."** This can be something critical related to cleaning and packaging, as well as issues like ensuring the proper cleaning agent is used. Storing of equipment is also an issue, he says, such as whether endoscopes and laryngoscope blades are stored so that you know they have not been contaminated post-sterilization. "You have to be sure they remain sterile once they are. This is one of those things that is potentially an immediate threat to patients," Ziaya says.

6. **45% of hospitals have problems with LS.02.01.30: "The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke."** This relates to the third standard cited above, he says. "Hazardous areas are constructed to protect other areas. Flammable storage areas are designed for that purpose, so use them for flammable stuff, not general storage. Don't use other rooms for flammable materials." Make sure that the doors close properly and that the gaps between and under doors meet requirements for the room. "If you have removed an automatic closure or a sweep from under a door, then you cause a breakdown in that fire prevention. The other thing that's important is that facility folks should have a program in place to regularly check these things. A door that closed right yesterday may not today. If you can educate the staff on units to be mindful

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of these things, it serves a couple of functions: It helps them to understand how important these items can be, so they don't remove the sweep or are more careful. And it can also magnify the number of eyes you have to see if a door is not closing properly. Then they can call facilities staff to repair it quickly and you aren't stuck doing a frenzied sweep and repair right before survey," he says.

7. 45% of hospitals have problems with EC.02.03.05: "The hospital maintains fire safety equipment and fire safety building features." Another fire-related standard, this relates to testing fire suppression and alarm systems, smoke detectors, and appropriate flow devices to make sure that the sprinklers will work. "A lot of this is about documentation," he says, again noting that if it wasn't documented, it didn't happen. "And you can't just say you checked the sprinklers or the smoke detectors. You have to document that you checked each and every device."

8. 39% fail to comply with EC.02.06.01: "The hospital establishes and maintains a safe, functional environment." This general standard is about issues such as whether interior spaces meet the needs of the patient population and issues of ventilation, temperature, and humidity. "It's very broad, and encompasses things that don't fit into other areas," he says. Think of issues that affect storage rooms, rather than ORs. You want to maintain appropriate temperature and humidity for what you store in them, which might differ from other areas of the hospital, he says.

9. 36% of hospitals are dinged on LS.02.01.35: "The hospital provides and maintains systems for extinguishing fires." The last of the fire-related standards on the list, this relates to fire suppression such as sprinklers, and also extinguishers in kitchen areas. It also includes an issue many hospitals fail to comply with: how far from the ceiling you can store things and how close to sprinkler heads you can store things. Store something too close to one and you impact the path of the spray, making it potentially useless in the event of a fire. There must be 18 inches between a sprinkler head and storage. You also can't have anything resting on the pipes that feed the sprinkler systems — not *anything*, he says. It can cause the pipes to kink and impede water flow.

10. 35% of hospitals have issues with MM.03.01.01. "The hospital safely stores medications." The biggest issue here is medication security and diversion prevention. The second most commonly scored item, he says, is properly labeling medication for expiration. "When multi-dose vials are opened and put in use, the original expiration is not valid," he says. "Then it's 28 days from when you opened it. There are some exceptions, but still, it has to

Top 10 Standards Issues for Critical Access Hospitals

Percent with problems	Standard Number	Standard Explanation
60%	EC.02.03.05	The critical access hospital maintains fire safety equipment and fire safety building features.
54%	EC.02.05.01	The critical access hospital manages risks associated with its utility systems.
49%	LS.02.01.20	The critical access hospital maintains the integrity of the means of egress.
47%	IC.02.02.01	The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies.
44%	LS.02.01.30	The critical access hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
42%	LS.02.01.10	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
38%	EC.02.02.01	The critical access hospital manages risks related to hazardous materials and waste.
35%	LS.02.01.35	The critical access hospital provides and maintains systems for extinguishing fires.
31%	EC.02.05.09	The critical access hospital inspects, tests, and maintains medical gas and vacuum systems.
30%	EC.02.05.07	The critical access hospital inspects, tests, and maintains emergency power systems.
30%	EC.02.06.01	The critical access establishes and maintains a safe, functional environment.

be redated. Once you open it, the clock ticks."

Why so much emphasis on fires? Ziaya is convinced you don't hear a lot about fires in hospitals because of the diligence related to the topic. "The focus on these aspects has been maintained," he says.

As for the overall list, Ziaya doesn't think it has changed a lot over time. "Life safety and environment issues are always prominent and require diligent documentation," he says. Infection control is also an issue, and he notes that RC 01.01.01 has been at the top of the list for several years.

"Often, the issues hospitals face relate to documentation," he concludes. "Organizations have to demonstrate that the right tests were done, or record the results of those tests. These things matter, particularly when taken together."

For more information on this topic, contact Paul Ziaya, MD, surveyor, Joint Commission, Oakbrook Terrace, IL. Email: PZiaya@jointcommission.org. ■

Can QI be too much of a good thing?

Interviews find many are burned out

Sociologists are professionally nosy, and **Ksenia Gorgenko**, PhD, a postdoctoral fellow at University of Pennsylvania in Philadelphia, and **Joanna Brooks**, PhD, MBioethics, a Robert Wood Johnson Scholar in Health Policy at Harvard, were happy to wander around hospitals asking doctors and other providers, as well as administrators and executives, about quality improvement (QI) efforts.

What they found was surprising: a lot of burnout. A feeling of QI overload. Worry that people expected too much too soon from folks who were already wearing too many hats to count. They wrote about their conversations in a *Health Affairs* blog (http://healthaffairs.org/blog/2014/03/07/the-dangers-of-quality-improvement-overload-insights-from-the-field/).

One of the stark examples of the kind of burned-out environment they saw relates to the surgical time-out, which just about everyone seems to think is a great idea. In reality, it has led many organizations to a quick, almost mechanical recitation of a speech before surgery that isn't as meaningful as its intent, according to the blog post. If the participants aren't "present" during the time-out, did the time-out really happen?

"We were working on a project and had all this data. And we wondered why some places were in overload and some weren't," says Gorgenko. Thus the interviews. And in light of the 150 interviews they've done at six hospitals, they have developed some insight into what works, and what potentially leads to burnout.

Brooks says there is great variation. One great determinant is whether the person has protected time available for QI projects. If they don't, they are much more likely to let a project lag, be unwilling to participate, or to participate in a less than full-hearted manner.

Frontline staff should always be part of projects, too, Gorbenko says, as long as they do have protected time. They are the people who have a vested interest in making things easier, better, and safer, so including them is a good way to ensure buy-in for new procedures.

Keeping staff informed of what you are working on and why is another way to help keep interest high and burnout low, Brooks says. "If they don't know what is happening on a particular project, they can hardly be expected to care. And if they aren't interested, then that might be a sign of overload."

Small projects with quick hits of success seem to be best at ensuring staff stay keen on QI, says Gorbenko. Huge projects with many moving parts that have a long wait time for a payoff? Those are harder to sustain interest, and it might be better to break them into smaller parts that have the potential for small successes, which she says is a better way of avoiding QI burnout among staff. "Small baby steps is better. When you try to say, 'Let's change it all right now!' people are overwhelmed. We can't make something perfect all at once."

Taking small bites out of the elephant rather than asking them to chow down all at once has the added bonus of making staff feel more cared for, which makes them do their job better, and thus makes patients safer, Gorbenko adds.

"One thing that motivated us to write the blog post was we found that hospitals are trying to do so much that they can't do anything effectively," Brooks says. "Trying to do hundreds of projects in one facility, no matter how big, is

undoubtedly overload." There is a lot pressure to participate in various QI initiatives and consortia, she says. "But we need to pause. We are getting to the point of too much."

She continues: "Hospitals are constantly changing. Technology is constantly changing. There is so much movement all at once, and staff is bombarded on all sides with requests for data and improvement and demands to meet benchmarks."

The best answer, Gorbenko thinks, is the one-bite-at-a-time method. But there are other ways to reduce burnout, too. Consider these suggestions.

1. Have a meeting, Brooks says. Go down to the floor or bring frontline staff to you and ask how things are going. Ask what their biggest frustrations are, where they think patients can be harmed. Without their voice, she says, "QI is challenging."

2. There is a lot of turnover in hospitals, Gorbenko says. What happens to Dr. Smith's pet QI project when she moves to Iowa? Figure out what isn't being done anymore, what's still running in a meaningful way, and what is sputtering along half-heartedly. Kill the dying ones, bury the dead ones, and put your effort into the projects that have interest and effort behind them, Gorbenko says.

3. Now that you have an inventory of your actual live projects, look at that list and compare it to the resources you have. Can you manage the list? Do you have people to run the projects with protected time? "It's better to do fewer projects that get done than try to do more that don't," Gorbenko notes.

4. Consider taking on projects that will improve staff morale. "We were surprised, but sometimes, little steps that improved the life of the worker were effective at improving patient care," says Brooks. "It helps to make them more engaged. It might not seem directly connected to patient safety, but it ensures buy-in from staff."

For more information on this topic, contact:

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Treat the patient or the data point?

Study examines 30-day mortality rate

There's a thing in science called the observation effect, where the very act of observing something changes the outcome. Is it possible that something similar is happening with cardiac patients? A study in *Health Services Research*[1] has found a bump in 30-day mortality rates at 30 days. There's no reason why explored in this paper — that research is yet to come, says **Bryan Maxwell**, MD, MPH, assistant professor at Johns Hopkins Medical Institutions in Baltimore and one of the study authors. But there are some hypotheses, including that physicians, knowing that there is a key benchmark related to 30-day mortality rates, change their care of the patient in order to get that patient to that key 30-day mark, and that patients who would otherwise be sent to hospice are more aggressively treated at great financial cost and with little benefit in terms of quality or length of life.

Maxwell and his colleagues closely analyzed a subtle pattern in the rate at which people die after surgery. "We have speculated about why, but we have only proven the pattern. Subsequent work will look further at the story of what's happening. But hypothetically, consider this scenario," he says. "A patient goes through a big surgery, with 10 hours in the OR, then the ICU for a few days, and a few days in the hospital — maybe a week or 10 days total. The riskiest time for most patients is right around the time of surgery. Other complications can arise later, but the risk is smaller."

For more complex patients, they might be in the ICU for weeks. That's the subgroup that is probably responsible for this 30-day mortality bump, Maxwell says. "Does the timing of death with them have something to do with those patients or with the decision making about their care?" For example, a patient doesn't die suddenly, but has a series of problems — dialysis, ventilator, nothing going in the right direction. At some point, Maxwell says, the doctor sits down with the family and says, "This isn't working, we can't fix all the problems and don't think there is a good chance of meaningful recovery." There are discussions about what

the patient would want in terms of life support and transitioning to hospice care. "But what is not always known is when are those decisions made? You might think it just happens with what clinically is happening. But what we found is it might be that there is some influence that's about all the pressure of benchmarks."

If the patient is at day 25, and one physician thinks things look grim, another might want to give it a few more days. It might be a front-of-mind thought about the 30-day benchmark, Maxwell says, or it might be back of mind. Either way, it's not malicious. "The reason they exist is to incent physicians to act a certain way, to improve quality, improve survival. But just like any process of measuring, people know what's being measured and what isn't," he says.

Teaching to the test?

He relates it to standardized tests: They exist to measure how well students learn, but what increasingly happens is that teachers teach to the tests.

Maxwell doesn't believe this is necessarily specific to heart surgeons. They picked cardiac surgery because postoperative mortality is more common, and it would be easier to see if a pattern existed there. "It's just easier to see when more of your patients are likely to die in that specialty."

He worried that heart surgeons would be upset, but they've largely been supportive. "My sense is that they want to do the right thing for patients, and what they largely feel about this study is they want better quality metrics and benchmarks, too."

He doesn't think we should just get rid of what we have. It's easy to measure 30-day mortality. Some groups and hospitals have started to tweak the measure by looking at in-hospital post-operative mortality regardless of when it occurs. But Maxwell also thinks that measuring things other than death is important: "If I was a family member or a patient wondering where to have heart surgery, I would want to know things like, how many patients return to a regular life versus go to a rehab facility. How long does it take to get back to normal activities? An expansion of what is being measured is called for."

He understands that the more complex and nuanced the metric, the more burdensome it is for those who collect and keep track of the data — and the harder for patients and the wider public to understand. "Risk-adjusted median length of stay is harder to understand than mortality. There is a trade-off. We have to provide what matters without creating too much of a burden on the organizations that provide care. I don't know how to balance that."

He thinks that as we get more efficient at collecting data on programs and patients, it may be easier to include information such as what he mentioned above, without having to put more resources into it. For now, Maxwell says he believes that QI managers should have some honest conversations with surgeons about what things matter in terms of outcomes other than mortality — such as how long it takes to recover and how fully patients recover.

"That's the kind of outcome information we should strive for, and how do we improve those data points is what's important. If you can, I'd collect and measure that."

For more information on this topic, contact Bryan Maxwell, MD, MPH, Assistant Professor, Johns Hopkins Medical Institutions, Baltimore, MD. Email: bmaxwel5@jhmi.edu.

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DVT in precipitous decline

NSQIP data leads to prevention program

Surgical patients have one less thing to worry about when they go into the hospital now: There is a much lower likelihood of deep vein thrombosis (DVT) in either legs or lungs for those who get preventive treatment based on appropriate risk assessment prior to surgery, and a quick return to walking after.

A study in the June issue of the *Journal of the American College of Surgeons*[1] indicates that the odds of a deadly clot steadily declined after the implementation of a multicomponent pre-

vention program in a hospital's department of surgery.

Researchers at Boston Medical Center reported that they lowered the frequency of DVT by 84% two years after the prevention efforts began, compared with the results two years before the program. Pulmonary emboli declined by 55% in the same period, according to study authors.

"We are encouraged by the success in reducing the frequency of these devastating events among our patients by implementing this prevention program," says co-investigator **David McAneny**, MD, FACS, vice chair of surgery at Boston Medical Center.

Prior to the study, Boston Medical Center had higher-than-expected rates of postoperative VTE compared with other hospitals when adjusted for severities of illness. Using the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) database, the surgeons were able to identify risk factors for DVT, including older age, obesity, smoking, confinement to bed, a personal or family history of DVT or pulmonary emboli, and a long surgical procedure.

Based on scientific evidence and national practice guidelines, the researchers developed a VTE prevention program that scored and totaled patients' individual risk factors. They then tested the program in all patients undergoing general surgery and vascular surgery procedures at their hospital.

Initially, there was an emphasis on early postoperative mobilization—getting patients up and walking three times a day, starting on the day of the operation when possible. The program later included these additional components, according to McAneny:

- Standardized risk assessment using five categories of VTE risk based on scores of 0 (lowest risk) to more than 8 (highest risk) (based on the Caprini grading system — Caprini JA, Arcelus JI, Hasty JH, et al. *Semin Thromb Hemost*. 1991: 17:304-312).
- Individualized, risk-based prophylaxis involving inflatable pressure boots and/or low doses of anticoagulation medications, commonly called blood thinners.
- Electronic physician orders that specified early mobilization, the requirement to score the patient's VTE risk, and the score-based appropriate preventive treatment along with the suggested duration of prophylaxis in the hospital and, for high-risk patients, continuing at home.
- Patient education to explain the importance of preventing blood clots.

Surgeons and their teams received mandatory electronic reminders regarding VTE prophylaxis before and after the operation and when the patient was discharged from the hospital. They could choose to opt out of the recommendation for preventive medication but needed to specify why. The researchers monitored the level of adherence to the automated recommendations.

Using the NSQIP database, the investigators tracked the occurrences of VTE in patients who underwent general surgery or vascular surgery procedures during the two calendar years before and then after implementing the electronic prevention program in February 2011.

Before the program was in place, the odds of a patient having a VTE after a general or vascular surgery procedure was 3.4 times greater than expected, when adjusted for patient risk, the authors reported. Two years after the program began, the risk of developing a VTE was less than one would expect, says McAneny. In that four-year period, the reported frequency of lung clots dropped from 1.1% of 1,569 patients to 0.5% of 1,323 patients. Meanwhile, the frequency of DVT declined from 1.9% of 1,569 patients to 0.3% of 1,323 patients.

In addition, he says surgeons' adherence to ordering the recommended prophylaxis was high. Compliance rates ranged from 100% for patients at low or moderate risk for a VTE to 77% for patients in the highest risk category. Even when patients at highest risk did not receive prevention in accordance with the recommended measures, the electronic records contained an explanation for not using blood thinners (drug allergy, active bleeding, risk of hemorrhage outweighing risk of VTE, etc.).

McAneny attributed the success of their prevention efforts to the combination of early ambulation and individualized risk assessment and prophylaxis.

He said their VTE prevention program may serve as a model for other medical centers.

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15 minutes to a safer hospital

Daily meeting makes difference at VCU

When the CEO of Virginia Commonwealth University's health system said he wanted to be "the safest health system in America," six years ago, he wasn't just talking. He spent money to help make the system into a high reliability organization, and made the mission "safety first, every day." It was leadership followed by everyone down the line.

One of the first things that came out of his mission to excel in safety was a daily check-in meeting that started in November 2008 with administrators and nursing alone, and eventually spread to include support staff and professional services.

According to **Shirley Gibson**, MSHA, RN, FACHE, associate vice president of nursing at VCU, there wasn't a whole lot of structure to the initial meetings, and people were slow to bring issues forward. Now, with every department participating, she is proactive in asking each about significant near misses, safety events, or other issues of concern. Each is asked for the daily census, there is a report of activity in the OR and ED, and how many cases are expected for the day. "We try to figure out what the tension will be in the organization that day," Gibson explains. For instance, there was a community bike race recently that led to some closed streets. Questions were asked about how patients and staff would get to work.

The meetings are conducted via conference call — although people will go in person to the room where Gibson sits for the meeting if they are on that floor. If an issue is raised, someone in the meeting will take responsibility for any follow-up needed. If an issue is of concern for multiple parties and requires extra time, Gibson explains that they will stay on the line after others leave the call to deal with it.

Initially, the calls took as long as an hour, but now they are rarely more than 15 minutes, even though there are up to 75 people on the line every morning and up to 25 departments reporting. Initially, the meetings were voluntary, not mandatory. What got people interested in coming was seeing how many longstanding problems were quickly being fixed due to the meetings. "It kind of snowballed from there," she says. "Once you went to one, you wanted to go back."

Currently, the organization is in the midst of a program called 52 Weeks of Safety. Each week features a different topic, and during the daily meeting, there is an update on the topic of the week. They have covered hand hygiene, falls, and pharmacy resources.

A typical call starts with an update on the safety topic for that week, followed by an unchanging introduction from Gibson: "Our vision is to be safest health system in America. Our goal is to have zero events of preventable harm to patients, staff and visitors."

She emphasizes that staff and visitors are included in the goal, something that can be left out of the equation when talking about safety. Then the departments report, although not everyone reports every day. "Even pastoral care will report if they have useful intelligence for us."

The results have been pretty spectacular: a 51% reduction of serious safety events since 2012. There was an initial increase when they first started, but that was expected as reporting increased. "The greatest thing is the situational awareness and accountability. It all comes out of things going in the right direction."

Safety a core value

A couple of things have changed over the course of the six years. They now have a run chart of serious safety events, so they can see a trend line. "We used to know when things happened, but there is a greater accountability now that we can see the numbers."

Safety is the core value of the organization, she says. "People take it seriously, and if there is a safety issue, it is transparent, it is recognized as a system issue, not a personal one. That helps make people more willing to report and that makes the whole system safer."

Any organization can do this, she says, noting that many hospitals have joined in on the calls over the years to see how VCU does what it does. They have then gone back to their own facilities to replicate it. "Some require everyone to go to a room and do a stand-up meeting — because standing up ensures it won't last to long."

She recommends doing a pilot test of what-

ever method you choose for safety meetings. Make sure you put in a good structure, too. Then start spreading the meeting out into the organization.

For more information on this topic, Contact Shirley Gibson, MSHA, RN, FACHE, Associate Vice President of Nursing, Virginia Commonwealth University, Richmond, VA. Email: sgibson@mcvh-vcu.edu. ■

CMS has new data on hospital utilization

Tools rolled out at Health Datapalooza

Hospitals and health systems might be interested in several of the initiatives announced by the Department of Health and Human Services (HHS) at its Health Datapalooza event this spring, which brought more than 2,000 entrepreneurs, health policy advocates, and health industry leaders together. Among the new data released and initiatives launched are:

• The Centers for Medicare & Medicaid Services (CMS) released the first of what it's calling an annual update to the Medicare hospital charge data, "or information comparing the average amount a hospital bills for services that may be provided in connection with a similar inpatient stay or outpatient visit," according to an HHS news release. The information is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/.

The new data provide the first update of the hospital inpatient and outpatient data that CMS released last spring. According to the news release, they include "information comparing the average charges for services that may be provided in connection with the 100 most common Medicare inpatient stays at more than 3,000 hospitals in all 50 states and Washington, D.C. Hospitals determine what they will charge for items and services provided to patients, and these 'charges' are the amount the hospital generally bills for those items or services."

The release adds, "With two years of data now available, researchers can begin to look at trends in hospital charges. For example, average charges for medical back problems increased by 9%, from $23,000 to $25,000, but the total number of discharges decreased by nearly 7,000 from 2011 to 2012."

Other data tools

CMS also released an array of other data products and tools designed to "increase transparency about Medicare payments," according to the release. These include inpatient and outpatient hospital charge data for 2012, and new interactive dashboards for the CMS Chronic Conditions Data Warehouse (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html) and geographic variation data (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_Dashboard.html).

The chronic conditions warehouse includes new information on chronic conditions among Medicare fee-for-service beneficiaries, including the following, according to the release:

• geographic data summarized to national, state, county, and hospital referral regions levels for the years 2008-2012;

• data for examining disparities among specific Medicare populations, such as beneficiaries with disabilities, dual-eligible beneficiaries, and race/ethnic groups;

• data on prevalence, utilization of select Medicare services, and Medicare spending;

• interactive dashboards that provide customizable information about Medicare beneficiaries with chronic conditions at state, county, and hospital referral regions levels for 2012;

• chartbooks and maps.

"These public data resources support the HHS Initiative on Multiple Chronic Conditions by providing researchers and policymakers a better understanding of the burden of chronic conditions among beneficiaries and the implications for our health care system," according to the release.

"The Geographic Variation Dashboards present Medicare fee-for-service per-capita spending at the state and county levels in interactive formats. CMS calculated the spending figures in these dashboards using standardized dollars that remove the effects of the geographic adjustments that Medicare makes for many of its payment rates. The dashboards include total standardized per capita spend-

ing, as well as standardized per capita spending by type of service. Users can select the indicator and year they want to display. Users can also compare data for a given state or county to the national average. All of the information presented in the dashboards is also available for download from the Geographic Variation Public Use File," according to the HHS release.

There is also a new tool designed to help estimate how many Medicare beneficiaries have certain health conditions or fit certain demographic profiles (https://www.ccwdata.org/web/guest/pricing/estimate-study-size). According to the release, it "can assist a variety of stakeholders interested in specific figures on Medicare enrollment. Researchers can also use this tool to estimate the size of their proposed research cohort and the cost of requesting CMS data to support their study." ■

AHRQ quality report shows improvement

Slow but steady

According to the Agency for Healthcare Research and Quality, we're getting better at delivering healthcare. The annual National Healthcare Quality Report for 2013 reports that 70% of the time, patients get the right care, and that hospitals in particular are doing better at making sure that happens. Care related to CMS-reported measures are also getting better. To be considered to be improving, the metrics have to improve more than 1% per year.

Domains of health care covered are effectiveness, safety, timeliness, patient-centeredness, care coordination, efficiency, and adequacy of health system infrastructure.

Within effectiveness, eight clinical conditions (cancer, cardiovascular disease, chronic kidney disease, diabetes, HIV and AIDS, mental health and substance abuse, musculoskeletal diseases, and respiratory diseases) and four cross-cutting services (maternal and child health, lifestyle modification, functional status preservation and rehabilitation, and supportive and palliative care) are discussed. Care delivered in doctor's offices, health centers, emergency rooms, hospitals, nursing homes, and home health and hospice settings is examined.

The report notes that quality is improving across some measures for all demographic groups, but not all measures, and not all demographic groups.

Among the hospital-specific measures that are improving:

- hospital patients with heart failure who were given complete written discharge instructions;
- hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations;
- postoperative physiologic and metabolic derangements per 1,000 elective surgery admissions, age 18+;
- hospital patients with heart attack who received percutaneous coronary intervention within 90 minutes of arrival;
- hospital patients age 50+ with pneumonia who received an influenza screening or vaccination.

Among those that are trending down: Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18.

Disparities in care

There are still significant disparities of care by race and ethnicity, with white people getting better care than Hispanics, African-Americans, Native Americans, and Asians, depending on the measure involved. For the two former, it was in 40% of quality measures, for the latter two, in a third and a quarter of them respectively. However, Asians receive better care than whites in about 30% of the measures.

Disparities are improving in some hospital-related areas:

- Among blacks compared to whites: Admissions for uncontrolled diabetes without complications per 100,000, age 18 and over.
- Among Asians compared with whites: Hospital patients age 65 and over with pneumonia who received a pneumococcal screening or vaccination and also adult hospital patients who sometimes or never had good communication with nurses in the hospital.

The complete report is available at http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/2013nhqr.pdf. ■

Hospital Report blog wins first-place award

AHC Media's **Hospital Report** blog won first place for Best Blog or Commentary at SIPA 2014: Strategies for Growth, the annual conference for specialized information publishers, held June 4-6 in Washington, DC.

Hospital Peer Review's executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute to the blog, which features commentary on a variety of issues relevant to hospital professionals, including quality improvement, patient safety and satisfaction, and regulatory issues. Joy Dickinson, executive editor of *Healthcare Risk Management*, and Leslie Hamlin, managing editor of *ED Management*, also contribute.

You can find **Hospital Report** on the Web at http://hospitalreport.blogs.ahcmedia.com/. ■

COMING IN FUTURE MONTHS

- Recent sentinel event data
- Are readmission rates getting better?
- How to work effectively with hospitalists
- CMS and the link between payment and safety
- The ICD-10 delay and what it means for you
- The role of nurses in patient safety

CNE QUESTIONS

1. How many standards do regular and critical access hospitals have in common on the top 10 lists of most commonly cited during Joint Commission survey?
   a. 1
   b. 4
   c. 7
   d. 3

2. To help reduce burnout from QI projects, Brooks and Gorbenko suggest which of these:
   a. interviewing administrators
   b. quitting QI consortia
   c. inventorying existing projects
   d. Increasing budgets

3. According to Bryan Maxwell, MD, MPH, assistant professor at Johns Hopkins Medical Institutions in Baltimore, what is the most dangerous time for heart surgery patients?
   a. During surgery
   b. 30 days post surgery
   c. Day 6
   d. immediately after surgery

4. The VCU safety check in meeting includes up to how many reporting departments?
   a. 25
   b. 20
   c. 75
   d. 60

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.

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. Scan the QR code below or 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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4. Complete and submit an evaluation form.
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Sincerely,

Lee Landenberger
Continuing Education & Editorial Director