Report from the National Quality Forum: Third Quarterly Synthesis of Action In Support of the Partnership for Patients

July 31, 2014

Introduction

In 2011, the U.S. Department of Health and Human Services (HHS) launched the Partnership for Patients initiative in support of the National Quality Strategy priority and goals focused on patient safety. This initiative has emphasized collective action from both public and private sectors of healthcare to focus on two critical goals: reducing hospital-acquired conditions (HAC) by 40 percent and reducing preventable hospital readmissions by 20 percent.

Drawing on the 2014 quarterly meeting series, action team meetings, and other patient safety activities, NQF is producing a series of four quarterly reports that describe actionable, high-impact efforts in the field that are catalyzing and accelerating change. This report features three illustrative case studies from organizations that demonstrate exceptional results through collaboration and innovative thinking. This report is the third in a series of four, and focuses on activities occurring from May 2014 – July 2014.

Quarterly Meetings in Support of the Partnership for Patients

Both Partnership for Patients goals are multifaceted, complex and require strategic, ongoing collaboration and aligned actions throughout the healthcare industry. To reach these ambitious goals, HHS requested that the National Quality Forum (NQF) convene a series of quarterly meetings in 2014 to facilitate shared discussions about strategies for achieving the Partnership for Patients goals. The intent of these meetings is to foster shared commitment and renew or invigorate high-leverage activities on the part of participants to achieve the goals. The third quarterly meeting, "Leveraging Accreditation and Certification Standards to Ensure Safe Care," took place on July 14, 2014. Approximately 30 participants representing accreditation organizations, certification boards, patients, and other healthcare organization came together to identify and spread best practices for improving patient safety through their organizational practices.

This meeting featured several health systems in action to improve quality and patient safety. Deborah Nadzam, Project Director, Joint Commission Resources opened the conversation by focusing on achieving improvements across the board. She gave an overview of the **Joint Commission Resources' Hospital Engagement Network's** (JCR HEN) efforts in improving patient safety through best practices in nursing care, patient and family engagement, healthcare disparities and vulnerable populations, measurement and improvement, and individual targeted adverse events. To date, the JCR HEN has seen impressive results, such as an 83 percent reduction in early elective delivery, and a 73 percent reduction in ventilator associated pneumonia. To achieve success, they focus on activating both the clinicians and patients' voices, using real data and consistent messaging across the board. Ms. Nadzam concluded with an overview of the Missed Nursing Care Model, which highlights the relationship between missed nursing care (when best practices or required care is not provided appropriately) and adverse events. This model also demonstrates the importance of having a system in place that supports best practices in nursing care.

Marco Villagrana, Director of Federal Relations at the Joint Commission provided an overview of **The Joint Commission**'s mission and the tools they use to drive healthcare quality improvement. He emphasized the Joint Commission's role in supporting organizations with its readiness to deploy tools and expertise to accelerate improvement. They provide this support by establishing accreditation standards and national patient safety goals, conducting surveys, and creating educational, sentinel event alerts and programs.

David Price, Director, **American Board of Medical Specialties** (ABMS), gave an overview of the ABMS Multi-specialty Maintenance of Certification (MOC) Portfolio Program (MSPP), a program through which specialty boards offer credit for quality improvement activities sponsored by approved institutions. This program offers many advantages to both physicians and sponsoring institutions, such as alignment of MOC with organizational priorities and efficiencies in the MOC process. Through this program, over 3300 physicians have received MOC credit through more than 500 quality improvement projects at 32 participating organizations.

The Mayo Clinic also has a longstanding institutional commitment to patient safety that recognizes the value of MOC for quality improvement. Catherine Roberts, Associate Dean, Mayo School of Health Sciences, presented a brief overview of the **Mayo Clinic's MOC program**, which strives to make MOC relevant to current practice and a key driver of quality improvement. From 2009 – 2013, the Mayo Clinic's successful MOC program yielded several positive outcomes, such as improved communication and teamwork, improved patient experience and access, decreased hospital acquired infection rates from *Clostridium difficile* by 85 percent, reduced in-hospital mortality rates from acute myocardial infarction by 25 percent, and reduced patient falls and decubitus ulcers by 50 percent.

Engaging Patients and Families for Safer Care

In *Safety is Personal: Partnering with Patients and Families for Safer Care*[1], a report released this year by the National Patient Safety Foundation's Lucian Leape Institute, the following desirable outcomes are identified as resulting from engaged patients and families: participation in diagnosis; shared decisionmaking; following the treatment plan; another pair of eyes; the experience of partnership; improved satisfaction with outcomes; and the relationship between patient experience and a culture of safety. Below are examples of organizations partnering with patients and families in one or more of these capacities to improve the safety of its care.

Shared Decisionmaking

The **Carolinas HealthCare System** has been using a patient-centered, shared decisionmaking toolkit for asthma management, with the goal of increased medication adherence and decreased readmissions. The toolkit helps to educate the patient about his or her condition and medication options (e.g., cost and side effects), and to prioritize what management aspects the patient has control over – such as how to use the medication and what different options are offered by the provider. The shared decisionmaking process helps the patient and provider decide on a final treatment plan, which incorporates the patient's health goals. Carolinas HealthCare System is piloting the toolkit for inpatient use, which would involve the patient walking through the steps of the toolkit on the day of discharge. The toolkit has already resulted in a reduction in emergency department and inpatient visits.

Improved Communication between Providers and Patients

At the **University of Minnesota Medical Center**, patient experience staff have been doing one-on-one coaching with physicians about how to talk with patients and their families. After the first session of coaching is completed, the physicians put new lessons learned into practice. After a month, physicians are shadowed on their rounds by trained staff and provided with a score. After another month, they receive the same so that they can follow their own progress and determine how to improve. The program has been extremely well received and both the patient experience staff and physicians are enjoying the partnership and learning experience. Most importantly, patients are reaping the benefits of meaningful communication with their care provider.

Engaging Patients in Care Transitions

Five sites of care, **including Griffin Hospital, Longmont United Hospital, Longmont United Transitional Care Unit, Bethel Health Care, and Bishop Wicke Health Center** have collaborated with **Planetree**, a not-for-profit organization that partners with healthcare settings to transform healthcare culture, to heighten patient activation and confidence in their care transitions, and to improve communication and care coordination across healthcare stakeholders and settings. Each site of care has implemented a Care Partner program in which processes were developed and resources were utilized to identify patients' chosen caregivers and support their engagement in care in tangible and measurable ways. Additionally, each site of care facilitated patients' use of the "How's Your Health" personal health survey whereby a personal health plan was developed based on patient-generated information, and patients could choose to share the personal health plan with their care team, their Care Partners, and their primary care providers.

Integrating the Patient Voice into the Healthcare System

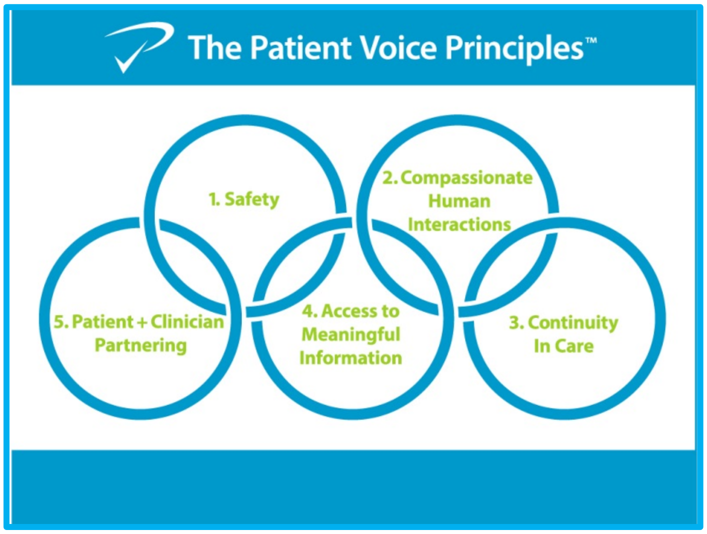
A large number of health systems are working on integrating the patient voice and perspective into their work. **Hennepin County Medical Center** is an example of a health provider walking its talk when it comes to making the patient voice more clearly heard. It has just completed a year's worth of work introducing patients into all of its interviewing panels for C-suite executives, including Vice President of Human Resources, Chief Executive Officer, and several chief physician positions. It acknowledges that this has shaken things up, but it believes for the better. At **Good Samaritan Hospital**, there is work to re-implement something called "patient orders", in which a patient is able to write out the things they need while in the hospital's care, to help alleviate physical pain or to comfort emotionally, such as asking volunteers to visit and check on them if they don't have family or friends. At **Beth Israel Deaconness**, social work staff in the patient and family engagement office is developing a support system for patients and families who want to share their story, understanding that the act of sharing a personal story can take an emotional and psychological toll. As part of this effort, Beth Israel staff helps patients and families condense their story, decide which parts they feel safe sharing, and prepare them for a provider audience. **HealthInsight**, a non-profit, community-based organization dedicated to improving health and healthcare in three western states has just worked with **Patient and Family Centered Care Partners** in California to help them form a Patient and Family Advisory Council to inform the work of their quality improvement organization, which oversees the entire population of Utah.

NQF Patient and Family Engagement Action Team

NQF's Patient and Family Engagement Action Team has been working to integrate the patient voice into the healthcare system through three strategies of its action pathway. The first strategy, to create tools for dialogue, is being achieved through the development of elements essential for a *Patient Passport*, a communications tool to assist patients in having meaningful and effective communication with providers at the point of care, particularly in the hospital setting. The prototype of this tool contains categories such as critical health information, personal goals, and personal history; what the patient needs most at the point at which they enter the system; discharge planning; and advance directives. Unique to this tool is its ability to allow the patient to initiate and guide conversations. Team members are utilizing their networks and partnerships to promote the passport design and components, and are developing a framework of recommendations for the implementation of tools like the passport, which identifies keys to success (e.g., engaging frontline staff early in the process), challenges to plan for (e.g., not having a champion for the passport), and potential impact (e.g., fewer hospital stays and days, improved patient engagement and activation). The action team is committed to continuing to spread patient and family engagement through these mechanisms.

Quarterly Spotlight: Sharing the Wisdom of Patients

The recently launched Patient Voice Institute (PVI) is providing a first-of-its-kind training and matchmaking for providers looking for a patient voice. The goals of this advocacy organization include finding and telling patient stories and activating patients to participate within health systems to improve care. PVI strives to make patient and consumer engagement in healthcare a valuable asset by amplifying the patient voice in ways that are consistent and true, creating connections across patient advocacy groups and with healthcare organizations, and mentoring patients who want to share their story. As part of its story compilation, PVI promotes shared “Patient Voice Principles” that distill stories and themes into the following overarching categories: Safety, Compassionate Human Interactions, Continuity in Care, Access to Meaningful Information, and Patient and Clinician Partnering. For each of these principles, PVI provides specific examples of how these principles can be put into practice. For example, Safety specifies “treatment that is appropriate, with disclosure of risk and discussion of less-invasive alternatives”, as just one example. Compassionate Human Interactions specifies “24-hour visitation, directed by the patient”, and “providing comfort through words, actions, and human touch for patients who are in physical pain.”



Reducing Preventable Readmissions

Family Caregiver Role in Reducing Readmissions

Reflecting the growing recognition of the critical role family caregivers play in reducing avoidable hospital readmissions, **Project RED (Re-Engineered Discharge)**, a foundational intervention that helps hospitals implement safe and effective discharges, has been expanded to include new guidance for professionals on how to work with family caregivers. The new chapter in the Project RED toolkit was developed jointly by the research group at **Boston Medical Center/Boston University School of Medicine** and staff from the **United Hospital Fund**. Project RED's new tool identifies five steps: identifying the family caregiver, assessing the family caregiver's needs, integrating the family caregiver's needs into the after-hospital care plan, sharing family caregiver information with the next setting of care, and providing telephone reinforcement of the discharge plan.

"Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge," is one of seven chapters in the Project RED toolkit and the first addition to the toolkit since its launch in 2007. Project RED—shown in a randomized controlled trial to reduce hospital utilization by 30 percent—is used by hospitals throughout the United States to minimize human and system errors in the discharge process. "United Hospital Fund's work with hospitals and with family caregivers has demonstrated repeatedly that thoughtful inclusion of the family caregiver as part of the care team can help improve the patient experience, especially during transitions in care, such as a discharge from the hospital," said Carol Levine, Director of the Families and Health Care Project at United Hospital Fund and an author of the new professional tool. "We are thrilled that hospitals using this toolkit will now have a systematic approach to including family caregivers and to make sure they have the necessary information and training to support their family member after discharge from a hospital."

Medication Reconciliation at Discharge

Studies have shown that as many as 40-45 percent of patients discharged to home have at least one medication discrepancy or error. Medication reconciliation is the comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as to observe compliance and adherence patterns.

Sharp Coronado Hospital created a "Planetree Patient-Centered Care Team for Improving Discharge Planning" which agreed to focus on the discharge medication list and the accuracy of medication reconciliation. The team developed a goal to improve the accuracy and completeness of medications on the discharge list from 25 percent to 100 percent, with correct dose, route, frequency, and duration.

The process for improvement began with a two week audit of the completeness of patients' discharge medication lists during May-June 2013. Opportunities were identified at a 25 percent completion rate, and education was provided to physicians and nurse practitioners during June 2013. A re-audit during one week in August of that year showed an improvement that moved the needle to a 66 percent completion rate. The topic was added to a stand up meeting on September 11th. Cerner updated Sharp Coronado's system in August and October, which increased the notes flow and efficiency of electronic information. The hospital created a plan for its pharmacists to review targeted populations, and a re-audit in October showed additional improvement that had moved the needle to a 72 percent completion rate. Sharp Coronado Hospital plans to continue ongoing physician and staff education, and to continue the process redesign of the pharmacist review of medications as well as re-auditing on a periodic basis in the hopes of reducing readmissions as well as adverse drug events.

NQF Readmissions Action Team

To complement the Partnership for Patients goal of reducing hospital readmissions and the many efforts focused on improving care transitions from the hospital setting, **NQF's Readmissions Action Team** is leveraging patient, provider, and community partnerships to identify and address the needs of vulnerable patients, particularly focusing on their psychosocial needs. These strategies include working together to enhance systems improvement, collaboration, and patient and family engagement. Action team members have been working on developing a starter clearinghouse of tools and resources to identify and assess individuals with psychosocial needs, but are recognizing that few resources exist in the public domain. The **Carolinas Center for Medical Excellence**, the **American Case Management Association**, and the **American Nurses Association** are promoting a roadmap that presents the rationale for addressing readmissions as well as elements of a business case for collaborating and partnering with community organizations to achieve results. Action team member **Patient Advocacy of Connecticut** is conducting patient and family workshops in the community to share resources and the full action team is supporting the goal of increasing patient and family representation on hospital boards and advisory councils. Many organizations have contacted **Mt. Sinai's Preventable Admissions Care Team (PACT)** program to learn more about its approach to integrating psychosocial risk assessment after learning about it on an earlier action team webinar.

Quarterly Spotlight:
Engaging Providers across the Continuum of Care

The Reducing Avoidable Readmissions Effectively (RARE) Campaign is a large-scale healthcare change initiative that is engaging hospitals and care providers across the continuum in Minnesota to prevent avoidable 30-day readmissions. The campaign has resulted in the avoidance of at least 6,000 readmissions, helping people to sleep in their own beds instead of the hospital, and saving millions of dollars in healthcare expenses.

The 82 hospitals participating in the RARE campaign account for more than 85 percent of the annual statewide hospital readmissions. Participating hospitals receive intensive support, including technical assistance and best practice tools to aid in redesigning their care processes to achieve readmission reduction. Support for hospitals was provided on a one-on-one basis by a RARE resource consultant, as well as through the campaign website and a monthly newsletter. Hospitals had the opportunity to participate in any of three learning collaboratives – Care Transitions Intervention, Project RED (ReEngineered Discharge), or SAFE Transitions of Care. The operating and supporting partners of the RARE Campaign offered monthly webinars for sharing of best practices, and hosted Action Learning Days and celebratory events. Potentially preventable readmissions (PPRs) were tracked over time, and a ratio of actual-to-expected PPRs (A/E PPRs) was calculated for each hospital and reported quarterly.

Contributing factors to the success of the campaign include peer-to-peer networking, collaboration between hospitals facing similar issues, statewide resources, and supports for system improvements. These have led to improved discharge planning, better management of care transitions and medications, engaged patients and families, and lower readmission rates. The RARE Campaign was awarded the John M. Eisenberg Patient Safety and Quality Award presented annually by The Joint Commission and the National Quality Forum.

Reducing Harm and Inappropriate Care

Preventing Pressure Ulcers

CALNOC (the **Collaborative Alliance for Nursing Outcomes**), is the leading provider of actionable information and research on nursing sensitive quality indicators. Since 2009, **Virginia Mason Medical Center** has participated in the quarterly CALNOC Pressure Ulcer Prevalence study to drive process improvement and benchmark against other CALNOC organizations.

Virginia Mason employs a strategy of decentralized pressure ulcer prevention ownership through local data collection and outcome discussion. The standardized prevention bundle is evidence-based and simply designed to allow integration into nursing workflow s and documentation, but depends heavily on frontline leadership. Early analysis of specific population defects helped the guiding team target initial improvements, and the inception of the SKIN Champion role was instrumental and unique to the process. A SKIN Champions unit consists of an RN and Nursing Assistant; their function is to perform weekly local prevalence inspection with a focus on bedside mentoring, handoffs, discussions at daily huddles and coaching of staff on best practices. Local improvements are guided by observations and comparison with established practice standards. Although prevalence data was collected and shared across the organization, the primary goal of SKIN Champs is the translation of pressure ulcer assessment and prevention knowledge to frontline nursing care. As a result of its participation in CALNOC, Pressure ulcer prevalence at Virginia Mason has dropped from an annual defect rate of five percent in 2007 to one percent in 2013 with fourth quarter results reaching zero.

Reducing HACs and Inappropriate Use

The **American Society for Radiation Oncology**, as part of its Target Safely Initiative, has focused on reducing adverse healthcare-associated conditions and harm from inappropriate use or unnecessary care through the development of a Radiation Oncology Incident Learning System (RO-ILS), an enhanced patient safety organization. ASTRO developed the RO-ILS after recognizing the need for a common framework within radiation oncology for medical error reporting at the national level. The system is designed to collect information on errors and near misses and to track and monitor these events. Information collected from this system facilitates root-cause analyses while promoting the ability to trend events that may inform medical alerts and benchmarking reports for participants or other safety-focused communications to the radiation oncology community. This approach is representative of the “Preventing Harm Across the Board” initiative that focuses on developing infrastructure supports for harm prevention and builds components for safety culture and teamwork into the healthcare organization. In particular, one aspect of Preventing Harm Across the Board is its emphasis on reviewing and sharing data for improvement opportunities. To maximize its learnings, ASTRO has collaborated with key specialty stakeholders, executed an education and awareness campaign regarding the importance of incident learning, and launched a nationally coordinated outreach to enhance provider buy-in. ASTRO has partnered with **Clarity PSO**, one of the earliest PSOs to be certified by the **Agency for Healthcare Research and Quality (AHRQ)**, to help them develop best practices. They have also collaborated with the **American Association of Physicists in Medicine (AAPM)** for intellectual support with system design, program implementation and program evaluation.

Preventing Infections in Medically Complex Children

The **Standardized Care to Improve Outcomes in Pediatric End Stage Renal Disease ESRD (SCOPE)** Collaborative is a project operated through the **Children’s Hospital Association’s Quality Transformation**

Network (QTN). Like the Association's other QTN projects, SCOPE employs rigorous quality improvement methodologies to increase implementation of best care practices. 60 percent of pediatric dialysis patients are on hemodialysis (HD); HD catheter related bacteremia is a major cause of patient morbidity and mortality. SCOPE began as an effort of the pediatric nephrology community, with guidance from the **American Board of Pediatrics** and the **American Society of Pediatric Nephrology**, to develop a quality transformation project aimed at improving the care provided to pediatric ESRD patients. To achieve this aim, the pediatric nephrology community partnered with the Children's Hospital Association's QTN, and built upon the collaborative network of pediatric dialysis units participating in the North American Pediatric Renal and Trials Collaborative (NAPRTCS), to further develop and implement SCOPE, which launched in June 2011. SCOPE currently has 30 sites participating in two initiatives: peritoneal dialysis and hemodialysis.

The SCOPE program has achieved significant outcomes in its first year. Compliance with best practice bundles has improved from 8 to 60 percent; the rate of peritonitis has been reduced by 21.4 percent; 64 infections and 40 hospitalizations are estimated to have been prevented with a projected cost savings of $865,000.

Quarterly Spotlight: Keeping Mothers and Babies Safe

Despite the significant progress made in recent years to reduce early elective deliveries (EED)—an estimated 73 percent decrease to a rate of 4.6 percent2, –NQF's Maternity Action Team (MAT) acknowledged that some areas in the country are still finding it difficult to achieve results. As a result, the action team agreed that a concerted effort was needed to help those still struggling, and began development of a resource to help. *Reducing Early Elective Deliveries: Playbook for the Homestretch* ("Playbook") is intended to provide guidance and specific strategies to help those still struggling to reduce their EED rates. It is geared toward those who are practicing and delivering maternity care, with an emphasis on hospitals and hospital systems facing a variety of barriers and challenges in their quality improvement (QI) efforts. The Playbook reflects a range of potential solutions that have been successfully applied in various situations and settings across the country.

The Playbook presents the current landscape for eliminating EEDs, challenges and barriers to EED reduction efforts as well as strategies for overcoming them, specific measurement guidance related to The Joint Commission's PC-01 measure, and educational tools, resources, and exemplars to support EED reduction efforts. It will be available in August 2014 and officially released via a public webinar on August 18, 2014.

Future NQF Activities in Support of the Partnership for Patients

NQF will host three public webinars in August—one per action team--which will offer an opportunity to engage the public in this important work to further action. The last quarterly meeting of the 2014 Patient Safety Meeting Series will occur on September 25th and will focus on driving system change through person-centered care, with an emphasis on vulnerable populations. This work will culminate in a fourth quarterly impact report to be completed by October 15. Materials for all past and future events are available on NQF's website.

Endnotes

[1] The National Patient Safety Foundation’s Lucian Leape Institute. Report of the Roundtable on Consumer Engagement in Patient Safety. Boston. 2014

[2] Dramatic decline in dangerous early elective deliveries; The Leapfrog Groups cautions against babies being born too soon, hits national target. The Leapfrog Group, March 2014. Available at http://www.leapfroggroup.org/policy_leadership/leapfrog_news/5164214.