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ORIGINAL ARTICLES

Hospital Readmissions

175 Unending Complexity in the Readmission Program
H.R. Burstin

The study on how the use of peer groups in the Centers for Medicare & Medicaid Services (CSM) Hospital Readmissions Reduction Program (HRRP) introduces differing performance standards for hospitals raises important concerns. Given its complexity, the HRRP should be closely monitored for potential unintended consequences.

177 Will Hospital Peer Grouping by Patient Socioeconomic Status Fix the Medicare Hospital Readmission Reduction Program or Create New Problems?
R.L. Fuller, J.S. Hughes, N.I. Goldfield, R.F. Averill

Analyses of the potential effects of a peer grouping system for hospitals in the context of the HRRP show a strong relationship between volume and readmissions that is independent of socioeconomic-status peer groups. The findings support existing literature that high volume is related to lower readmissions for surgery, but the relationship between volume and readmissions for medical conditions is much more mixed. In addition, hospital size has an independent effect on readmission rates that goes one way for surgical readmissions and the other way for medical readmissions. More analysis is required before implementing hospital peer groups.

Patient and Family Engagement

186 How Patient Partners Influence Quality Improvement Efforts
J. Greene, D. Farley, C. Amy, K. Hutcheson

Patients are increasingly viewed as key stakeholders in improving quality, yet there is little evidence of their impact. Focus groups and in-depth interviews were conducted with patient partners and staff in quality improvement teams (QITs) at WellSpan Health and Aligning Forces for Quality—South Central Pennsylvania to identify the mechanisms through which patients help improve care. The findings indicate that patient partners influenced QI through three mechanisms: the “symbolism” of being part of the team, providing feedback (for example, new policies), and making suggestions, such as regarding clinical care processes. Integrating patient partners into ambulatory care QITs was a largely positive experience for patient partners, QIT leaders, and administrators.

Teamwork and Communication

196 Optimizing Hospitalist-Patient Communication: An Observation Study of Medical Encounter Quality
J. Apker, M. Baker, S. Shank, K. Hatten, S. VanSweden

Increasing emphasis has been placed on patient-centered communication, yet specific behaviors and strategies need to be better defined. Researchers observed and timed 206 medical encounters between 36 hospitalists and adult patients. On the adapted Kalamazoo Essential Elements of Communication Checklist (KEECC), hospitalists scored highest on the Builds a Relationship, Shares Information, and Gathers Information dimensions —and lowest on Understands the Patient Perspective and Reaches Agreement. Findings also included a positive relationship between overall KEECC score and length of time spent interacting with patients, an observed effectiveness-efficiency tradeoff time period of 9-14 minutes, and the identification of specific hospitalist communication techniques that may contribute to better-quality medical encounters.

Methods, Tools, and Strategies

204 A Collaborative for Implementation of an Evidence-Based Clinical Pathway for Enhanced Recovery in Colon and Rectal Surgery in an Affiliated Network of Healthcare Organizations

In 2015 the Mayo Clinic Care Network (MCCN) created a collaborative to diffuse the clinical practice redesign in colon and rectal surgery at the Mayo Clinic (Rochester, Minnesota) to eight MCCN members. The members’ multidisciplinary team participated in both a didactic learning session and follow-up remote sessions regarding Mayo Clinic’s enhanced recovery pathway for colon and rectal surgery. Length of study decreased by an average of 34% across the eight sites. The teams learned from Mayo Clinic initially but went on to learn from one another and teach Mayo Clinic new ideas through their own experiences.
**Adverse Effects**

212 The Hidden Cost of Regulation: The Administrative Cost of Reporting Serious Reportable Events

B.B. Blanchfield, B. Acharya, E. Mort

Twenty-seven states and the District of Columbia require reporting of Serious Reportable Events (SREs). At one academic medical center during fiscal year 2013, the administrative cost to process 44 SREs was estimated at $353,291, representing an average cost of $8,029 per SRE. The benefits of public reporting should be collectively reviewed to ensure that the incremental costs continue to improve patient safety and that trade-offs are acknowledged.

**TOOL TUTORIAL**

219 Using the Patient Safety Huddle as a Tool for High Reliability

S.D. Brass, G. Olney, R. Glimp, A. Lemaire, M. Kingston

A community hospital developed a Patient Safety Huddle, which is used to improve communication across departments, troubleshoot operational problems, focus on safety and quality metrics, and reporting unusual occurrences, to help it progress toward high reliability.

**IMPROVEMENT BRIEF**

227 Improving Satisfaction with Pediatric Pain Management by Inviting the Conversation


Pediatric pain control is challenging, given the inability to elicit reliable histories, particularly in younger patients. At an academic pediatric hospital, the question, “Pain management is very important to us. Has your child’s pain been well controlled?” was added to nurse manager rounds. Patients receiving the intervention reported higher satisfaction with pain management (in response to the Press Ganey survey question, “How well was your child’s pain controlled?”) than those who did not (p < 0.0001). Hospitals seeking to improve satisfaction with pain management should encourage health care providers to reliably discuss pain control with pediatric patients.

233 INFORMATION FOR AUTHORS