NEWS RELEASE

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New Study Analyzes Eight Minority-Serving Hospitals’ Efforts to Reduce Readmissions

Featured in October 2014 Issue of The Joint Commission Journal on Quality and Patient Safety


Hospitals that serve minority patients typically have higher readmission rates. As a result, these hospitals often receive higher penalties under the federal readmissions policy, known as the Hospital Readmissions Reduction Program, which requires the Centers for Medicare & Medicaid Services to reduce payments to hospitals with excess readmissions. In their study, the authors analyzed how eight minority-serving hospitals, reflecting a range of geographies and sizes, were responding to the federal readmissions policy and the specific challenges that they face in attempting to reduce readmissions. Semi-structured interviews with the hospitals’ leaders and frontline personnel focused on knowledge of readmission rates and prioritization of readmission reduction, strategies and barriers to reduce readmissions, and opinions about the federal readmissions policy.

Findings showed that each of the hospitals had only a general awareness of their performance on readmission metrics but placed a high priority on reducing readmissions, largely because of the federal readmissions policy. The hospitals also
followed a similar progression in strategies to reduce readmissions—moving from working on the discharge process to creating customized approaches to transitional care to, finally, focusing on building more community support and resources. In addition, the authors identified barriers to reducing readmission rates, including scarce resources, a variety of patient needs, limited ability to influence care in the community and a misalignment of financial incentives.

The remaining articles from the October 2014 issue are:

**Methods, Tools and Strategies**

**E-Autopsy: Using Structured Hybrid Manual/Electronic Mortality Reviews to Identify Quality Improvement Opportunities**

*Kerry C. Litman, M.D.; Helen Lau, RN, M.H.R.O.D.; Michael H. Kanter, M.D.; Jason P. Jones, Ph.D.*

Low levels of harm among a random or sequential sample of mortality reviews may not yield actionable improvement opportunities. To increase the efficiency of the process, Kaiser Permanente Southern California developed a condition-specific, hybrid electronic/manual chart review, which can be applied to a wide variety of patient conditions and settings.

**Information Technology**

**Meaningful Use Status and Participation in Health Information Exchange Among New York State Hospitals: A Longitudinal Assessment**

*Erika L. Abramson, M.D., M.S.; Michael Silver; Rainu Kaushal, M.D., M.P.H.; with the HITEC Investigators*

New York State is a leader in state-based initiatives promoting health information technology. In a follow-up survey conducted from November 2012 through February 2013 to evaluate progress since 2009, 129 (52 percent) of 207 hospitals in the state responded (62 percent response rate). Of those, 126 (97 percent) hospitals had implemented or begun implementing an electronic health record—a 410 percent increase in three years. Nearly three-quarters had already attested to Stage 1 meaningful use for Medicare and Medicaid, but only 10.7 percent anticipated it would be easy to achieve Stage 2 meaningful use.

**Diagnostic Error**
A Qualitative Analysis of Physician Perspectives on Missed and Delayed Outpatient Diagnosis: The Focus on System-Related Factors

Urmimala Sarkar, M.D., M.P.H.; Brett Simchowitz, M.D.; Doug Bonacum, M.B.A.; William Strull, M.D.; Andrea Lopez, B.S.; Leahora Rotteau, M.A.; Kaveh G. Shojania, M.D.

An integrated health system conducted six physician focus groups in 2004 and 2005. Multiple barriers to timely and accurate diagnosis, including organizational culture, information availability and communication factors, were identified. Concerns about health system structure and physicians’ interactions with one another and with patients far outweighed those regarding the cognitive factors that might affect the diagnostic process.

Medication Safety

Medication Safety in the Operating Room: A Survey of Preparation Methods and Drug Concentration Consistencies in Children’s Hospitals in the United States

Robert E. Shaw, B.S.; Ronald S. Litman, D.O.

In 2010, the Anesthesia Patient Safety Foundation initiated an effort to reduce medication errors in the operating room (OR) environment. This effort included the recommendation that the hospital pharmacy supply premixed solutions. However, a telephone questionnaire survey revealed that at all 34 children’s hospitals, at least one anesthetic drug was prepared by the anesthesia provider in the OR. Several different anesthetic medications were supplied in different concentrations both between institutions and often within the same institution.

Tool Tutorial

The Safe Day Call: Reducing Silos in Health Care Through Frontline Risk Assessment

Cynthia Paterson, RN, M.S.A., Ph.D.; Kristen Miller, M.S.P.H., Dr.P.H.; Mark Benden, M.S., Ph.D.; Eva Shipp, M.S., Ph.D.; Adam Pickens, M.P.H., Ph.D.; Monica Wendel, M.A., M.P.H., Dr.P.H.; Peter Pronovost, M.D., Ph.D., FCCM

The Veterans Affairs Ann Arbor Healthcare System holds a daily Safe Day Call—a 15-minute conference call to review adverse events and close calls and discuss other patient safety concerns. As a result of the call, more specific patient safety issues have been addressed and patient safety announcements (which are disseminated on the next Safe Day Call and discussed at patient safety committees) have been prompted.
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