**Q: 1**. "The gold standard for defining quality measurement remains Donabedian's three-element model of structure, process, and outcome" (Varkey, p. 30).

Although this model of quality measurement may apply to all kinds of clinical care facilities, you will focus on hospitals for this assignment so that you can make use of data on the CMS's "Hospital Compare" Web site. Using this Web site, you will examine quality information for a particular hospital, and conduct some basic benchmarking analysis.

To prepare for this Application:

* Visit the Hospital Compare Web site: <http://www.medicare.gov/hospitalcompare/?AspxAutoDetectCookieSupport=1>
	1. Click on the links at the top titled “About Hospital Compare”  and “About the Data” and review them briefly.
* On the top left there is another tap titled "About Hospital Compare Data" that Shows information on Process of Care Measures, Outcome of Care Measures, and Outpatient Imaging Efficiency Measures.
* As you consider this information, bring to mind the six dimensions of quality: Safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Search...through step 3.
* For the purposes of this assignment, go back to the 1st page and select a hospital by either entering the zip code for the hospital or the name of the hospital. When you've done that and clicked on Show Hospitals, you should have hospitals that you can compare. Follow the directions to review Patient Survey Results (HCAHPS survey results), Timely and Effective Care or Readmissions, Complications and Deaths.
* Consider which organizations are most appropriate to compare for benchmarking purposes. Use the Hospital Compare website and compare your primary hospital's data with data from another hospital – either one in the same area or one across the country, as you think appropriate.
* After comparing the data, assess which measures you think are of the greatest concern and in need of improvement in your primary/original hospital. What is your rationale for this assessment? Select two or three measures to focus on for this assignment. Consider which dimensions of quality they relate to (safety, effectiveness, patient-centeredness, timeliness, efficiency, and/or equity).
* Review this week's Learning Resources, new the hospital's Web site, and consider what other steps you would take to get a clearer picture of these quality issues.

**The Assignment**

Write a 1- to 2-page paper that addresses the following:

* Identify the primary hospital you have selected.
* Identify the measures you have chosen to focus on (those that are most in need of improvement or that otherwise warrant attention). Compare and contrast the characteristics of structure, process, and outcome measures, and explain which category or categories your chosen measure relates to. Also, indicate the dimensions of quality with which these measures are associated.
* Briefly summarize the data, including your benchmarking analysis.
* Analyze the benefits and challenges of externally reported measures for health care providers and for patients. Also, explain why benchmarking can be useful for identifying areas for improvement.

**Q: 2**. As noted in the Institute of Medicine report, *To Err is Human*, “It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet the challenges ahead” (Institute of Medicine, 1999, p. 15).

What are the most common—or most significant—risks to patient safety? How do these risks vary in different health care settings or with disparate groups of patients? What can be done to address these risks? You will explore these questions and more in this Application Assignment.

To prepare for this Application:

* Begin by brainstorming types of health care organizations and groups of patients (e.g., geriatric patients requiring chronic care, pediatric patients admitted for acute care). Identify a particular type of setting and/or patient population to help you pinpoint your focus for the following step.
* Review the National Patient Safety Goals, the CDC's NHSN Web site, and the information on patient safety concerns presented in the other Learning Resources. Select a specific patient safety risk (e.g., patient falls, medication reconciliation) to focus on for this assignment.
* Analyze the systems errors and/or human factors errors that should be considered with regard to this safety risk.
* Reflect on related insights that could be gained from high-reliability organizations. What approaches do these organizations use that might be applicable within a health care organization?
* Consider the strategies and tools (e.g., Six Sigma, Lean) that could be used to assess and reduce this particular risk.
* Evaluate the potential benefits of patient and family involvement and steps that could be taken to ensure that they are included in this endeavor.

**Note**: To complete this Application Assignment, you will need to use the Learning Resources assigned in both (4) *and* (5).

**The Assignment**  Write a 4- to 5-page paper that addresses the following:

* Briefly summarize the patient safety risk you have selected, and provide a rationale for why it deserves particular attention.
* Analyze the influence of systems errors and human factors errors with regard to this risk.
* Discuss related insights that could be gained from high-reliability organizations and how they might be applied within a health care organization.
* Propose strategies and tools for assessing and reducing risk related to this safety issue.
* Describe how patients and patients’ families can be involved in addressing this issue.

**(4 ) Resources: Readings**

* Course Text: *Medical Quality Management: Theory and Practice*
	1. Chapter 3, "Patient Safety"  This chapter addresses common causes of errors and introduces tools that can help shed light on why specific errors have occurred. It also examines the characteristics of high-reliability organizations, which have a strong focus on safety.
* Course Text: *Foundations in Patient Safety for Health Professionals*
	1. Chapter 3, "Safety Improvement Is in Professional Practice"  In this chapter, patient safety is examined as a professional practice issue. In addition, interdisciplinary collaboration is addressed as a key concept for the prevention of safety errors.
	2. Chapter 7, "Why Things Go Wrong"  This chapter provides a brief introduction to the science of errors, including the distinction between systems errors and human factors errors.
	3. Chapter 9, "Safe Patient Care Systems"  This chapter describes the characteristics and practices of systems that promote patient safety.
* Article: Wu, A. W., Lipzhutz, A. K. M., & Pronovost, P. J. (2008). Effectiveness and efficiency in root cause analysis. *JAMA, 299*(6), 685–687. Retrieved from the Walden Library databases.  This article poses questions for consideration regarding the use of Root Cause Analysis (RCA) in health care.
* Article: Hitchings, K., Davies-Hathen, N., Capuano, T., Morgan, G., & Bendekovits, R. (2008). Peer case review sharpens event analysis. *Journal of Nursing Care Quality, 23*(4), 296–304. Retrieved from the Walden Library databases.  This article examines the use of peer case review to identify and analyze issues related to nursing care of a specific patient. As you read the article, compare this approach to the descriptions of Root Cause Analysis presented in the other Learning Resources.
* Web Article: The Joint Commission. (2010). *National patient safety goals*. Retrieved from <http://www.jointcommission.org/standards_information/npsgs.aspx>  Review the National Patient Safety Goals for the Application Assignment.
* Web Site: CDC's National Healthcare Safety Network (NHSN)
* <http://www.cdc.gov/nhsn/>
* NHSN utilizes information technology to coordinate safety data from a variety of health care organizations. Read through the information presented on this Web site to become familiar with this system.

**Optional Resources**

* Book: Reason, J. (1990). *Human error*. New York, NY: Cambridge University Press.
* Book: The Joint Commission. (2009). *Root Cause Analysis in Health Care: Tools and Techniques* (4th ed.). Oakbrook Terrace, IL: Author.
* Brochure: American Hospital Association. (2003). *The patient care partnership: Understanding expectations, rights, and responsibilities*. Washington, DC: Author. Retrieved from <http://www.aha.org/content/00-10/pcp_english_030730.pdf>

Article: Pronovost, P. J., Rosenstein, B. J., Paine, L., Miller, M. R., et al. (2008). Paying the piper: Investing in infrastructure for patient safety. *Joint Commission Journal on Quality and Patient Safety, 23 or 34*(6), 342–348.

**(5) Resource: Readings**

* Article: Gawande, A. A., et al. (2009, January). A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine, 360*(5), 491–499. Retrieved from the Walden Library databases.  This article discusses the implementation of checklists to reduce surgical complications at participating hospitals around the world through the World Health Organization's Safe Surgery Saves Lives program.
* Article: Laurance, J. (2009, August). Peter Pronovost: Champion of checklists in critical care. *The Lancet, 374*(9688), 443. Retrieved from the Walden Library databases.  This article addresses Dr. Peter Pronovost's efforts to promote the use of checklists for patient safety.
* Article: Bosk, C. L., Dixon-Woods, M., Goeschel, C. A., and Pronovost, P. J. (2009, August). Reality check for checklists. *The Lancet, 374*(9688), 444–445. Retrieved from the Walden Library databases.
* This article examines how and why checklists may improve patient outcomes, noting aspects of the intervention that have often been overlooked.
* Article: Grol, R. (2001). Improving the quality of medical care: Building bridges among professional pride, payer profit, and patient satisfaction. *Journal of the American Medical Association,* 286(20), 2578–2 585. Retrieved from the Walden Library databases.  In this article, the author discusses various approaches for improving quality.
* Web Article: World Health Organization. (2009). *Safe surgery saves lives*. Retrieved from <http://www.who.int/patientsafety/safesurgery/en/>  The World Health Organization's Safe Surgery Saves Lives campaign is the subject of some of this week's articles. This campaign illustrates global efforts to improve health care quality.

**Web Sites**

* Web Resources: The Joint Commission. (2009). *Speak Up Initiatives*. Retrieved from <http://www.jointcommission.org/speakup.aspx>  There are a number of brochures related to patient safety at this Web site, including one on patients' rights. You may download and read those that are of interest to you.

**Note**: In addition to completing this week's required reading, you will also need to review the information on quality-related tools (e.g., Lean, Six Sigma) that was assigned in previous weeks of the course.

**Optional Resources**

* Web Site: Centre for Evidence Based Medicine
* <http://www.cebm.net/>
* This center promotes the use of evidence-based medicine and provides support and resources to health care professionals to help maintain the standards of medicine.

Article: Guyatt, G., Cairns J., Churchill D., et al. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *Journal of the American Medical Association, 268,* 2420–2425.

**Q: 3**. Health information technology can be a powerful tool for improving the quality of health care delivery. Yet, the transition to implementation can be expensive and challenging, and it can sometimes be difficult to demonstrate the return on investment.

To prepare for this Application:

* Identify a specific challenge related to quality and safety. (This may be the same challenge you selected for this week's Discussion or a different one.)
* Investigate how health information technology could be used to address this challenge. Review the information presented in this week's Learning Resources, and conduct additional research of your own using the Walden library and credible Web sites. Then, narrow your focus to one type of technology that would be highly beneficial for addressing this challenge.
* Consider the potential outcomes associated with implementing this technology.
	1. What stakeholder concerns might arise?
	2. How would it potentially decrease (or would it possibly increase) systems errors and/or errors related to human factors?
	3. How could the return on investment be determined?

**The Assignment**

 Write a 1- to 2-page paper that addresses the following:

* Identify a specific challenge related to quality and safety.
* Explain how health information technology could be used to address this challenge. (Make your response as specific as possible.)
* Evaluate possible outcomes of the implementation of this technology.