

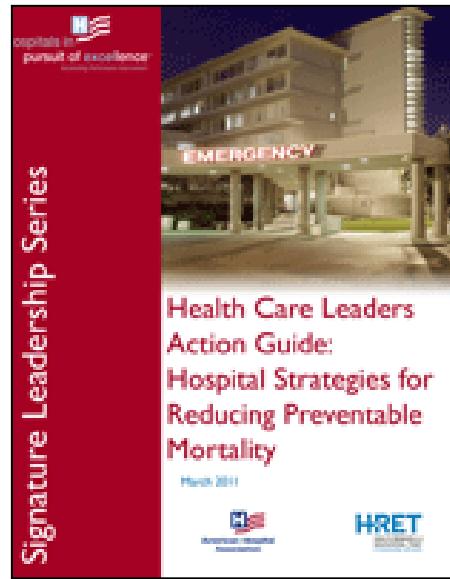
# Health Care Leader Action Guide: Hospital Strategies for Reducing Preventable Mortality

March 2011



TRANSFORMING HEALTH CARE THROUGH RESEARCH AND EDUCATION





*Health Care Leaders Action Guide: Hospital Strategies for Reducing Preventable Mortality.* Health Research & Educational Trust, Chicago, IL. February 2011. Accessed at [www.hpoe.org](http://www.hpoe.org).

# 2011-13 AHA Strategic Plan

- Strategic performance commitments that identify specific targets for hospital efforts to improve patient care:
  - reduce central line-associated bloodstream infections (CLABSI)
  - eliminate preventable readmissions
  - *eliminate preventable mortality*

# Why Is Focusing On Preventable Mortality Important?

- Much has been written about the numbers of patients that die unnecessarily in hospitals.
  - *To Err is Human: Building a Safer Health System* (IOM, 1999) - between 48,000 and 98,000 deaths from medical errors occur each year in U.S. hospitals
- While most hospital deaths are not due to failures in care delivery, many deaths are preventable and this presents an important opportunity for hospital leaders to address.

# Why Is Focusing On Preventable Mortality Important? (contd.)

- By collectively pursuing improvement strategies in a visible and measurable way, hospitals will be joining forces to advance a health care system that delivers the right care, to the right patient, in the right place.
- Hospital mortality also an issue that easily resonates with the public
- Demonstrable improvement in this area will go a long way towards maintaining and strengthening public confidence in our nation's hospitals.

# Where Should Hospital and Health System Leaders Begin?

- Start by looking at your data
  - Understand how your hospital compares to the national average mortality rate for each condition.
  - Explore other proxy measures to monitor mortality on a more timely basis.
  - Be aware that Hospital Compare includes mortality rates for Medicare patients only and other proxy measures of mortality may include all patients.
- Set a specific, visible, and measurable goal with timelines for reducing mortality.
  - Make this a strategic priority for your organization and be persistent about communicating the goal and your progress organization-wide.

# Where Should Hospital and Health System Leaders Begin? (contd.)

- Decide where to focus your hospital's improvement efforts.
  - Begin with the obvious, e.g., *Hospital Compare* care process measures for heart attack, heart failure, and pneumonia? Are there opportunities for improvement?
- Consider cross-cutting concerns.
  - Numerous examples of interventions involving healthcare-associated infections, delays in responding to patients with deteriorating conditions, poor communication, surgical complications, and medication and medical errors

# Where Should Hospital and Health System Leaders Begin? (contd.)

- Align your quality improvement activities and create a visual map.
  - Can help to give leaders and staff a sense of priority and awareness of how many of the activities they are working on fit into the organization's strategic goals.
- Establish an organized process for reviewing mortality.
  - Structured process for monthly mortality case review, including structured review forms, interdisciplinary committees, and identification of systemic opportunities for improvement.
  - Nursing departments also reviewing mortality as a way to identify system issues in care and improve nursing practice.

# Where Should Hospital and Health System Leaders Begin? (contd.)

- Integrate these improvement efforts into your hospital's quality improvement program and develop an action plan for implementing these strategies.
  - Establish improvement teams with caregivers affected by the improvement process and provide visible executive leadership support
- Be accountable.
  - Put this on the agenda of board and senior leadership meetings and actively review progress.

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