

Are Core Measures Helping or Hurting Health Outcomes?

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INTRODUCTION

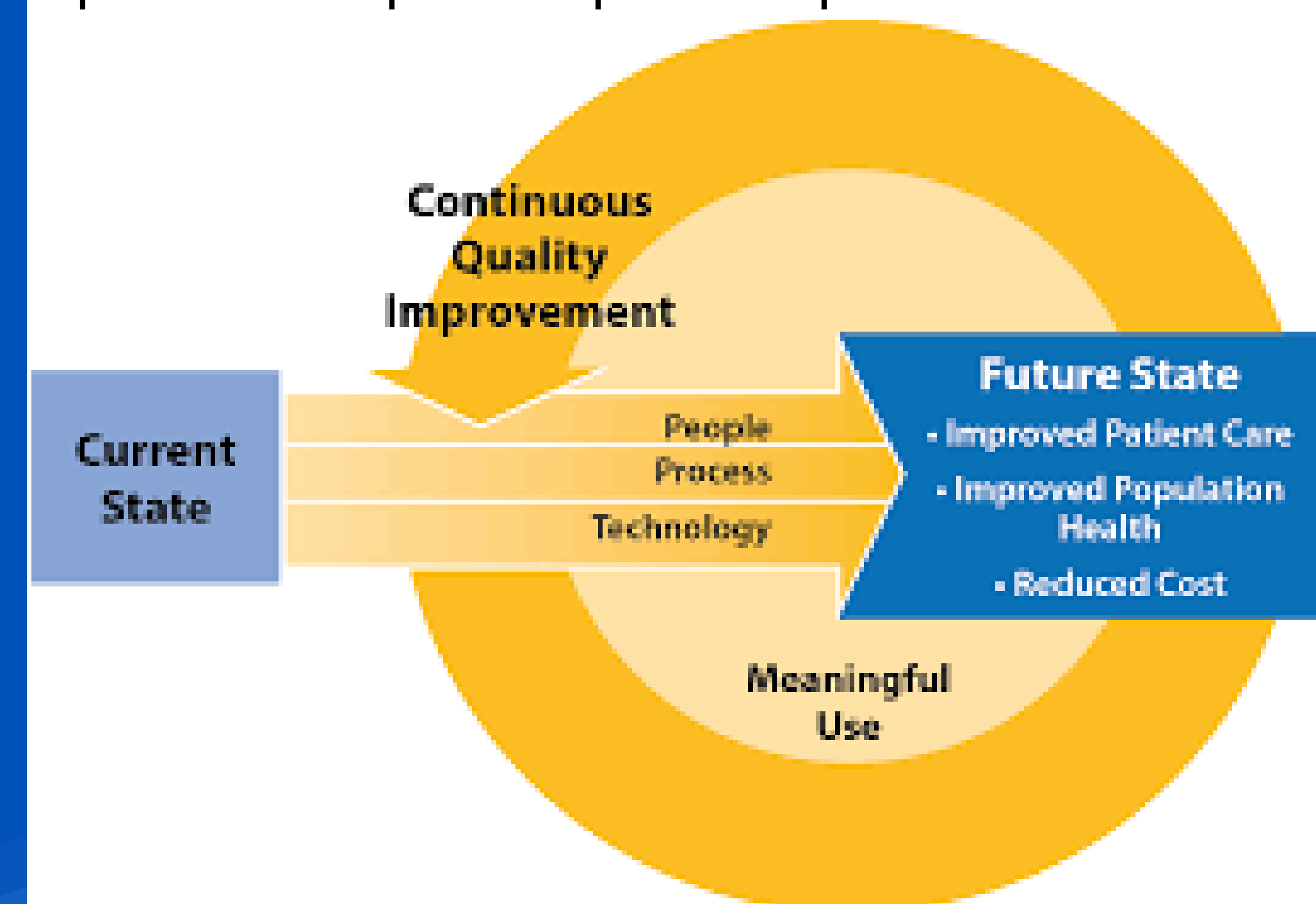
In order to provide the best healthcare possible, accurate information on the quality of health care from consumers, employers, physicians, clinicians, and policy makers is imperative and could be achieved through core measures. Core measures in health care according to CMS (2020) are as followed: Aim to identify high-value, high-impact, evidence-based measures that promote better patient outcomes, and provide useful information for improvement of decision making and payment. Align measures across public and private payers to achieve congruence in the measures being used for quality improvement, transparency, and payment purposes. Reduce the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and quality measure reporting requirements across payers. The core measure processes are proven standards of care that reduce complications and lead to better patient outcomes. The higher the percentage of compliance means the hospital is following the best steps to care for a patient's particular condition (Core measures, 2021). Therefore, with core measures in place every patient admitted with the same diagnosis, such as CHF or pneumonia, can expect to receive the same baseline quality care measures that were established through evidence of medical research to improve patient health outcomes.

SIGNIFICANCE

- In the interest of promoting high-quality, patient centered care and accountability, the Centers for Medicare & Medicaid Services (CMS) and hospital Quality Alliance (HQA) began publicly reporting 30-day mortality measures for acute myocardial infarction (AMI) and heart failure (HF) in June 2007 and for Pneumonia (PN) in June 2008 (CMS, 2020)
- Hospital RSMRs for pneumonia declined by 0.7 % between June 2014 and June 2016 (CMS, 2020)
- Hospital RSMRs for AMI and heart failure both rose by 0.2% between June 2014 and June 2015, and then declined by 0.8, and 0.5 %, respectively by June 2016. (CMS, 2020).

POSITION STATEMENT

Core measures in healthcare can be beneficial for health outcomes if they are implemented and monitored properly on a regular basis, as well as incorporated into discharge teaching for patient compliance post hospitalization.



SUPPORT FOR POSITION

Core measures and safety goals level of evidence and impact on patient outcomes, according to (Masica et al., 2009) are as followed:

Myocardial Infarction (MI):

- PTCA within 90 minutes – 20% mortality reduction compared with thrombolytics
- Timely thrombolytics- 18% reduction compared with no treatment
- Aspirin- 25% reduction in stroke, MI, or death
- Smoking cessation- 40% mortality reduction
- Beta- blockers- 18% mortality reduction

Heart failure (HF):

- Beta blockers- 33% mortality reduction
- ACE inhibitors/ ARBs- 20% mortality reduction
- Discharge education- 10% mortality reduction, 25% reduction in readmission rates

Community-acquired pneumonia:

- Timely antibiotics- 15% mortality reduction
- Blood cultures- 40% of cases of severe pneumonia antibiotic selection adjusted based on blood culture results
- Smoking cessation- 50% reduction in individual's risk of developing pneumonia
- Flu vaccination- 50% reduction in pneumonia, hospitalization, or death.

IMPLICATIONS FOR PRACTICE

It is important for nurses to implicate the core measures of health care to have a positive influence on health outcomes such as mortality rates, readmission rates for the patients, or hospital acquired infections. Nurses are the ones to make sure that the patient receives their medications on the correct schedule, practice proper aseptic technique with wound care, urinary catheterization, IV placement, etc.

The following findings are supported from *Linking Joint Commission inpatient core measures and National Patient Safety Goals with evidence* (Masica et al., 2009):

- Myocardial infarction management: Beta-blockers can reduce the risk of death 13%-23% in patients without contraindications and should be given upon hospital arrival and prescribed at discharge. Aspirin reduces the risk of a serious vascular event (stroke, recurrent MI, or cardiovascular death) by 20%-30% and should be given upon hospital arrival as well as prescribed at discharge with proper medication education from the nurse. Enhance patient's knowledge of smoking by educating them that smokers who quit after MI lower their risk of death by up to 40% compared to those who do not quit
- Heart failure management: Smoking cessation improves heart failure patients' self reported quality of life and should be discussed with the patient. Discharge instructions with specific information about diet, daily weight measurements, medication use, and detailed follow-up planning reduce the risk of rehospitalization by up to 25% and risk of mortality by up to 10%
- Pneumonia management: Antibiotics that are administered within 4 hours of a patient's arrival to the hospital lowers risk of mortality by 15%. Blood cultures should be performed before administering the first dose of antibiotic; microbiology testing often leads to a change in antibiotic therapy up to 40% in patients with severe pneumonia. Smoking cessation should be provided at discharge since smokers are 2 to 3 times more likely to get pneumonia than non-smokers

CONCLUSION

Core measures are helping further advance the improvement of healthcare not only in the quality of care that patients receive, but also the outcomes in which they are provided. By having core measures in place for medical conditions such as AMI, HF, and Pneumonia, nurses and hospital staff can efficiently provide baseline healthcare to patients knowing these interventions have been proven through extensive research to work. In conclusion, patients can make the best decision regarding their health knowing staff are equipped and comply with core measures.



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