Monday, October 12, 2015

NEW CMS QAPI STANDARDS AND REVISED QAPI WORKSHEET

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Speaker

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- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, No emails)

Objectives

- Review the CMS worksheet on QAPI.
- Explain why the Board is ultimately responsible for the QAPI program.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

You Don't Want One of These

The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Manual updated more frequently now
  - Tag number 0001 through 1164 and PI starts at tag 263
  - Questions to CMS at hospitalscg@cms.hhs.gov
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **Survey Procedures** [2]
  - Hospitals should check this website once a month for changes

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

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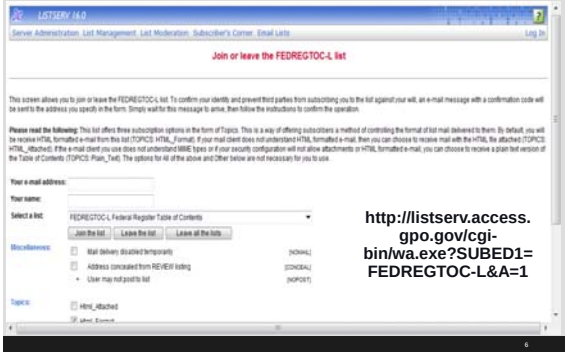
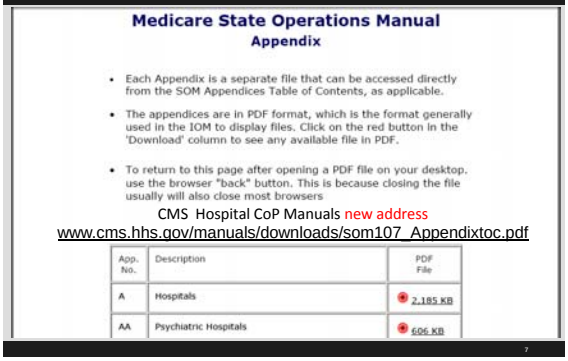


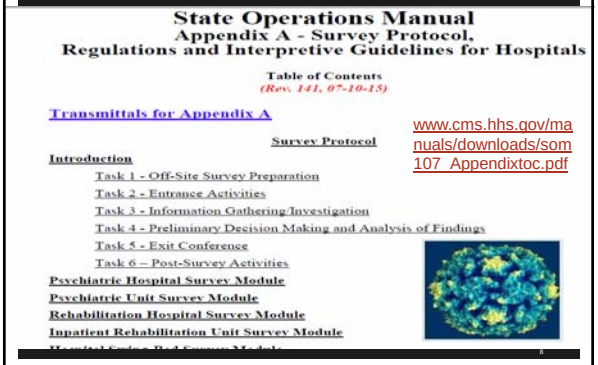
http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1

Location of CMS Hospital CoP Manuals



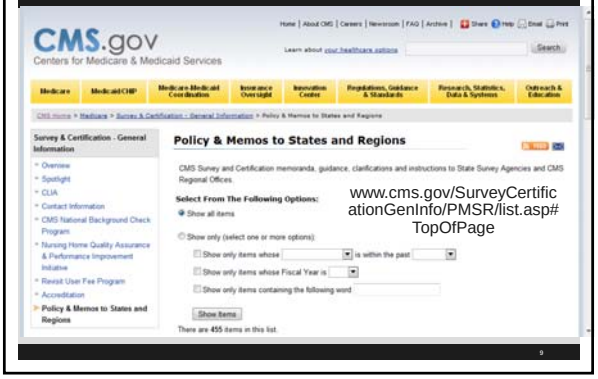
CMS Hospital CoP Manuals new address
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

CoP Manual Also Called SOM



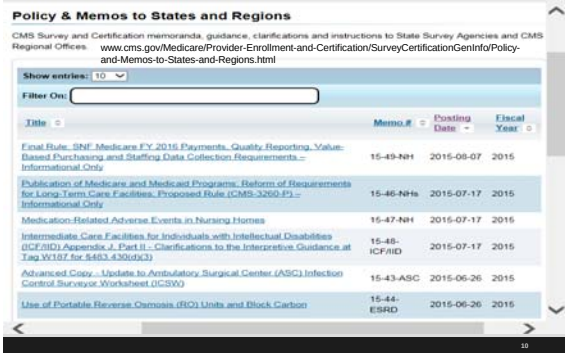
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

CMS Survey and Certification Website



www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Policy & Memo to States



Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov

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Number of Deficiencies for QAPI

- CMS deficiency reports show many deficiencies in QAPI
- CMS is updating quarterly
- PI standards were rewritten March 21, 2014 and many changed tag numbers
- Reports lists the name and address of all hospitals receiving deficiencies
- Can read the deficiencies for each one to get an idea of what surveyors are hitting hard

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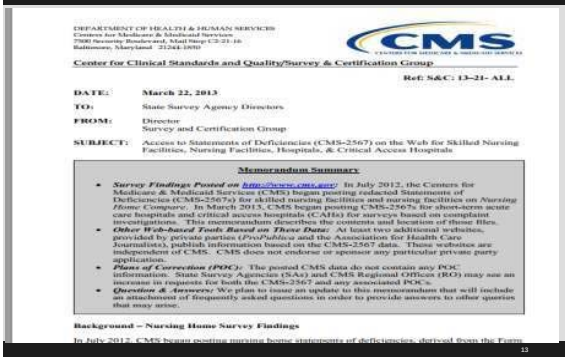
Access to Hospital Complaint Data



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Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-21- ALL

DATE: March 22, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

Memorandum Summary

- ***Survey Findings Posted on http://www.cms.gov/:*** In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

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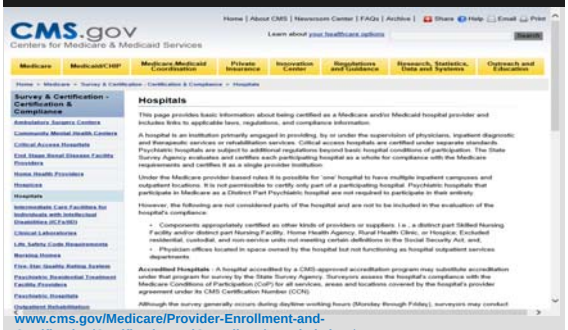
Updated Deficiency Data Reports



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Home > Medicare > Survey & Certification - Certification & Compliance > Hospitals

Survey & Certification - Certification & Compliance

- Ambulatory Surgery Centers
- Community Mental Health Centers
- Critical Access Hospitals
- End Stage Renal Disease Facility Providers
- Home Health Providers
- Hospices
- Hospitals
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
- Clinical Laboratories
- Life Safety Code Requirements
- Nursing Homes
- Five-Star Quality Rating System
- Psychiatric Residential Treatment Facility Providers
- Psychiatric Hospitals
- Outpatient Rehabilitation

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. I.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act, and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

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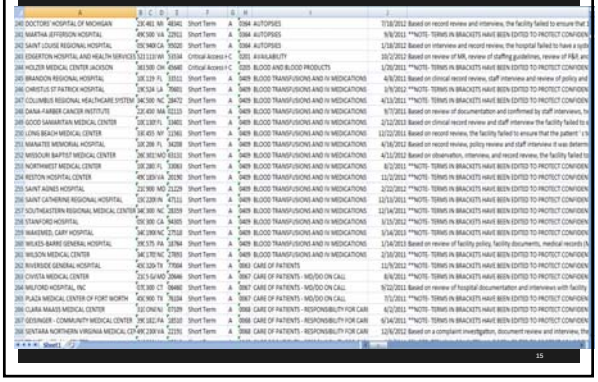
Can Count the Deficiencies by Tag Number



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Deficiency Data

Tag	Section	April 15, 2015
263	QAPI	100
270	Provision of Services	21
271 & 272	Patient Care Policies	30
273	Data Collection and Analysis	176
274/275	Policy Emergency Services	7

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Deficiency Data

Tag	Section	April 15, 2015
276	Policies Drug Management	20
277	Policies Med Errors & ADR	4
278	Policies Infection Control	21
279	Policies Nutrition	8
280	Patient Care Policies	8

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Deficiency Data

Tag	Section	April 15, 2015
280	Patient Care Policies	8
281-282	Patient Services	11
283	QI Activities	160
284	Patient Services	1
286	Patient Safety	224 Total **799**

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Hospital CoPs for QAPI

- CMS issued new hospital COPs memo for QA and Performance Improvement (QAPI)
- CMS issues Memo March 15, 2013 on AHRQ Common Formats
  - Hospitals are required to track adverse events for PI
- Starts with tag number 0263
- Short section because the hospital compare program is not part of the CMS CoP
  - Hospital compare is the indicators that must be sent to CMS to receive full reimbursement rates

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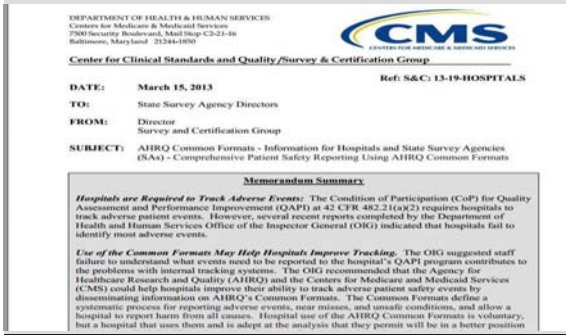
Report Adverse Events to PI



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Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 13-19-HOSPITALS

DATE: March 15, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

Memorandum Summary

Hospitals are Required to Track Adverse Events: The Condition of Participation (CoP) for Quality Assessment and Performance Improvement (QAPI) at 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events. However, several recent reports completed by the Department of Health and Human Services Office of the Inspector General (OIG) indicated that hospitals fail to identify most adverse events.

Use of the Common Formats May Help Hospitals Improve Tracking. The OIG suggested staff failure to understand what events need to be reported to the hospital's QAPI program contributes to the problems with internal tracking systems. The OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) could help hospitals improve their ability to track adverse patient safety events by disseminating information on AHRQ's Common Formats. The Common Formats define a systematic process for reporting adverse events, near misses, and unsafe conditions, and allow a hospital to report harm from all causes. Hospital use of the AHRQ Common Formats is voluntary, but a hospital that uses them and is adept at the analysis that they permit will be in a better position

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Adverse Event Reporting

- Hospitals are required to track AE (adverse events)
- Several reports show that nurses and others were not reporting adverse events and not getting into the PI system
- OIG recommends using the AHRQ common formats to help with the tracking
- States could help hospitals improve the reporting process
- Encouraged all surveyors to develop an understanding of this tool

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Adverse Event Reporting

- IOM (National Academy of Medicine) report discussed the need for comprehensive patient safety reporting to address the alarming high incidence of AE occurring in hospitals (Pg. 2)
- OIG report November, 2010 “AE in Hospitals: National Incidence Among Medicare Beneficiaries” encouraged internal reporting of all AE, whether preventable or not
- OIG issues report in January 2012 “Hospital Incident Reporting Systems Do Not Capture Most Patient Harm”
  - 86% of AE are never reported to the PI program
  - 44% are considered preventable

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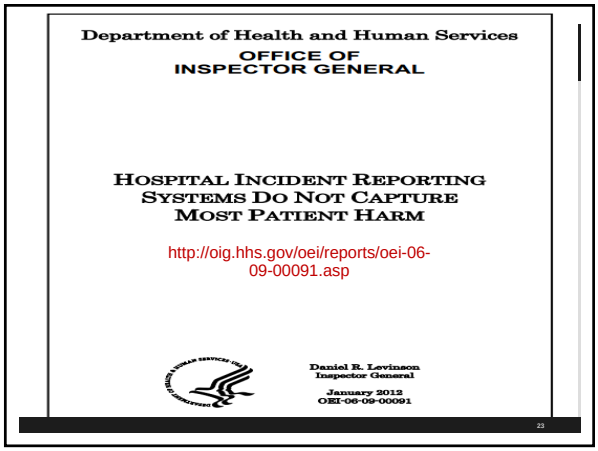

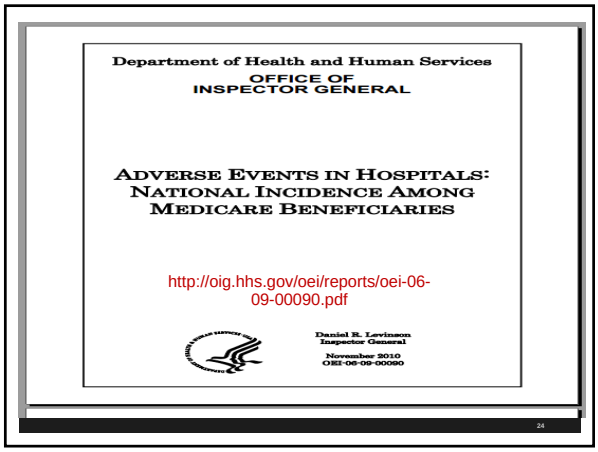

Adverse Event Reporting

- CMS PI section requires hospital to track AEs and analyze the causes and implement actions to prevent in the future
- Need to include near misses
- The internal hospital reporting system represents a foundational capability to determine if the hospital can maintain compliance with the CoPs
- The AHRQ Common Formats are evidenced based
- Common Formats allow for identification and reporting of any AE even if rare and includes NQF 29 never events such as falls and medication errors

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Events That Should be Reported

Event Category[7]	Examples of event occurrences
Event was an expected outcome or side effect	Thrush
Event caused little harm and/or harm was ameliorated	Hypoglycemia treated with orange juice (glucose)
Event was not on the hospital mandatory reporting list	Patient given wrong medication, but no harm; Reporting of Stage 2 pressure ulcers is not mandated in some states.
Event occurs frequently in hospitals	Medication given late; falls
Event symptoms became apparent after discharge	VTE diagnosed 10 days after discharge; Surgical Site infection 3 weeks after pacemaker implant.
Event occurred in a patient with a history of similar events	Falls, Stage 1 or 2 pressure ulcers
Events not caused by a perceptible error	Postoperative illeus (severe, lasting more than six days) Constipation after narcotics Adverse reaction (rash) to a medication the patient was not known to be allergic to

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9 Modules in the Common Formats

1. Blood or Blood Product
2. Device or Medical/Surgical Supply, including Health Information Technology (HIT)
3. Fall
4. Healthcare-associated Infection
5. Medication or Other Substance
6. Perinatal
7. Pressure Ulcer
8. Surgery or Anesthesia
9. Venous Thromboembolism
10. Other (allows collection of information on all other types of events)

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Hospital Common Formats

The Conditions of Participation (CoPs)

- The manual is known as the conditions of participation or the CoPs for short
- The CoP sections are called tag numbers and go from 1 to 1164
- When interpretive guidelines (IG) are final they are printed in a transmittal and then placed in the manual
- All the sections contain a tag number so it is easy to go back and look up that section if you want to read more about it

Transmittals

www.cms.gov/Transmittals/01_overview.asp

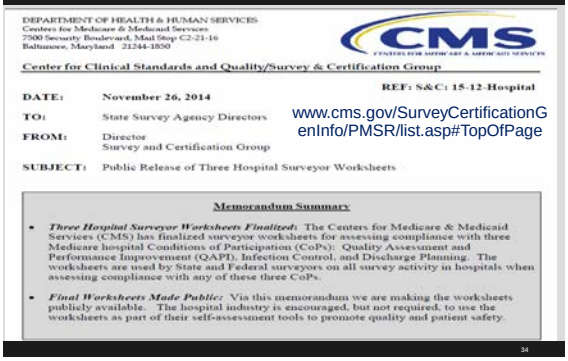
CMS Worksheets

Infection Control, Discharge Planning and QAPI

CMS Hospital Worksheets History

- October 14, 2011 CMS issues a 137 page memo in the survey and certification section and it was pilot tested in hospitals in 11 states
- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, infection control, and QAPI (performance improvement)
  - May 18, 2012 CMS published a second revised edition and pilot tested each of the 3 in every state over summer 2012
  - November 9, 2012 CMS issued the third revised worksheet
  - Final ones issued November 26, 2014

Final 3 Worksheets QAPI



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Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Public Release of Three Hospital Surveyor Worksheets

Memorandum Summary

- ***Three Hospital Surveyor Worksheets Finalized:*** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.
- ***Final Worksheets Made Public:*** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

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www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Hospital Worksheets

- Hospitals should be familiar with the three worksheets and QAPI one is 15 pages
- Will use whenever a validation survey or certification survey is done at a hospital by CMS
- CMS says worksheets are used by State and federal surveyors on all survey activity in assessing compliance with any of the three CoPs
- Hospitals are encouraged by CMS to use the worksheet as part of their self assessment tools which can help promote quality and patient safety

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CMS Hospital Worksheets

- And of course completing the forms helps the hospital to comply with those three CoPs
- Citation instructions are provided on each of the worksheets
- The surveyors will follow standard procedures when non-compliance is identified in hospitals
- This includes documentation on the Form CMS 2567
- Not used in CAH but good tool for CAH to use
- Questions to: **hospitalscg@cms.hhs.gov**

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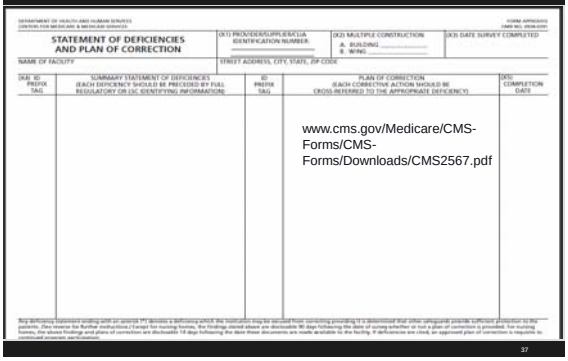
Form 2567 Statement of Deficiency/POC


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS2567.pdf

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CMS Hospital Worksheets

- Some of the questions asked might not be apparent from a reading of the CoPs
- So the worksheets are a good communication device
- It helps to clearly communicate to hospitals what is going to be asked in these 3 important areas
- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment
- Hospitals should consider attaching the documentation and P&P to the worksheet

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CMS Hospital Worksheets

- This would impress the surveyor when they came to the hospital
- The worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited who are suppose to have a CMS survey every three or so years
  - The Joint Commission (TJC), American Osteopathic Association (AOA) Healthcare Facility Accreditation Program, CIHQ, (Center for Improvement in Healthcare Quality) or DNV Healthcare are the 4 AOs with deemed status
- It would also be used for hospitals undergoing a validation survey by CMS

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CMS Hospital QAPI Worksheet

- First two pages included identification information
- Name of the state survey agency which in most states is the department of health under contract by CMS
  - In Kentucky it is the OIG or Office of Inspector General
- It will ask for the name and address of the hospital, CCN number (certification number), number of surveyors, date of survey, number of surveyors, time spent on performing the PSI surveys, is hospital accredited and if so date of last survey

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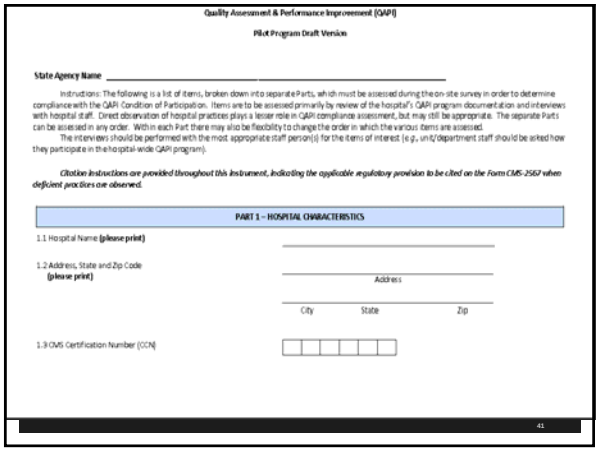

Quality Assessment & Performance Improvement (QAPI)

Pilot Program Draft Version

State Agency Name _____

Instructions: The following is a list of items, broken down into separate Parts, which must be assessed during the on-site survey in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital's QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate. The separate Parts can be assessed in any order. Within each Part there may also be flexibility to change the order in which the various items are assessed.

The interviews should be performed with the most appropriate staff person(s) for the items of interest (e.g., unit/department staff should be asked how they participate in the hospital-wide QAPI program).

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on the Form CMS-2567 when deficient practices are observed.

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name **(please print)** _____

1.2 Address, State and Zip Code **(please print)** _____ Address

_____ City State Zip

1.3 CMS Certification Number (CCN) ☐☐☐☐☐☐

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CMS QAPI Hospital Worksheet

- CMS uses the term “tracers” for the first time
- The first worksheet is on QAPI which stands for Quality Assessment Performance Improvement
  - CMS previously called it Quality Assurance Performance Improvement and changed June 7, 2013
- The worksheet is a document that the surveyor will sit down with the hospital and fill out
- The first column includes the elements to be assessed and there are boxes to fill in

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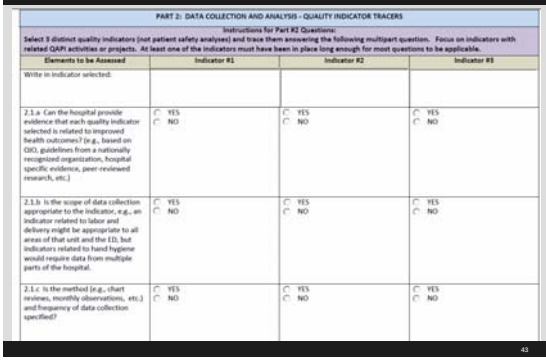
Quality Indicator Tracers



PART 2: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS

Instructions for Part #2 Questions:

Select 3 distinct quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
Write in indicator selected:			
2.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on CBO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.b Is the scope of data collection appropriate to the indicator, e.g., an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would require data from multiple parts of the hospital.	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
2.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

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QAPI Tracer Data Collection & Analysis

- This section is 15 pages long
- First select three quality indicators related to PI activities or projects
  - An example might be the timing of medications and PI data to show medication was given on time and number of medication errors or missed or omitted doses
  - Number of catheter associated UTIs
- Write the quality indicator at the top and answer the following questions for each one

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QAPI Tracer Data Collection & Analysis

- Hospitals collect all kind of data
- TJC requires data to be collected in a number of areas
  - Data on medication management (ADR, medication errors), FMEA, patient flow, staff compliance with employee health screening requirements, patient satisfaction, pediatric asthma, ED measures, infection control surveillance data
  - Data on R&S use, patient perception of care, organ donation, blood transfusion reactions, ORYX data, medical record deficiency data, staffing, data on how patient communication needs are met, race and ethnicity etc

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QAPI Tracer Data Collection & Analysis

- CMS has hospital compare with data on number of MI patients who get thrombolytics timely or pneumonia patients who get their antibiotics timely
- Measure patient experience or patient satisfaction data
- Measure some or all of the AHRQ patient safety indicators
- National Quality Forum includes lists of quality indicators that are evidence based that hospital may measure

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QAPI Tracer Data Collection & Analysis

- Can you show evidence that each quality indicator is related to improved health outcomes? (Tag 273)
  - Based on QIO, national guidelines, evidence based studies, peer reviewed etc.
- Is the scope of data collection appropriate to the indicator (273)
  - Hand hygiene would require data from multiple parts of the hospital
  - ED or L&D might be specific to date from that area such as the average LOS in the ED or the number of elective C-sections performed with premature infants

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PI Tracer Data Collection & Analysis

- Is the method and frequency of data collection specified? (Tag 273)
  - Such as chart reviews or monthly observations
  - Is the data collected in the manner specified and it is done as often as specified such as will do 30 charts per month for ED documentation criteria
- If unit staff play a role in data collection then is the data collection consistent with the specifications (273)
  - Example OR staff complete a data collection tool with number of cases time out is taken and documented, H&P and consent on chart before surgery, etc.

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PI Tracer Data Collection & Analysis

- Are data collected aggregated in accordance with hospital methodology specified for this indicators
  - Is the data analyzed? (Tag 273)
- If indicator is type that measures rate are the rates calculated for points in time and compared to benchmark data set out by national organizations when available? (273)
  - Pneumonia patients should get their first dose of antibiotics within 6 hours or MI patients thrombolytics in 30 minutes or PCI within 90 minutes

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PI Tracer Data Collection & Analysis

- Is data broken down into subsets that allow for comparison among hospital units (Tag 273)
  - Such as hand hygiene or the fall rate
- If data identified area that needs improvement then is there evidence the issue was addressed (283)
  - Such as an infant abduction risk, high fall rate, high medication error rate, injury from restraints
  - Are the interventions evaluated for success?
    - If successful did hospital monitor to ensure success was sustained
  - If not, what did the hospital do?

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QAPI Tracer Data Collection & Analysis

- Does PI focus on high risk, high volume, or problem prone areas? (Tag 283)
  - Orthopedic hospital does lots of Orthopedic projects or hospital that does CABG do QAPI on these?
- Can hospital prove it conducts distinct PI projects?
  - Should be reflected in the PI minutes (297)
  - Every department should participate in PI process
- Is number of projects proportional to the scope and complexity of the hospital's service and operations
  - Larger hospital expected to do more projects

51

QAPI Tracer Data Collection & Analysis

- If NICU is there QAPI related to that area such as the percentage of babies who do not survive the first 28 days of life (297)
  - Or quality measures for low birth weight babies including HAI, intraventricular hemorrhage, hearing loss, retinopathy, or chronic lung disease
- If the hospital has an open heart surgery unit
  - Part of SCIP or surgical care improvement project such as antibiotics within one hour of incision, antibiotics discontinued within 24 to 48 hours, appropriate hair removal (razors are out and clippers are in), normothermia, perioperative beta blocker, DVT prophylaxis, and control post-op glucose

52

PI Tracer Data Collection & Analysis

- Can hospital show evidence of why each project was selected? (297)
  - Unless QIO project or IT project such as CPOE
- CMS then has a section on patient safety that discusses adverse events (AE) and medical error
- This part is to evaluate the hospital's leadership expectation for patient safety
- Is there staff training or communications related to expectation for patient safety to all staff?
- Is there a P&P on non-punitive approach to staff reporting medical errors which includes near misses?

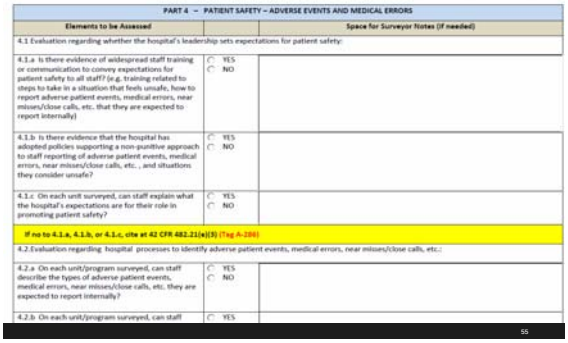
53

QAPI Patient Safety AE and Medical Errors

- Can staff on each unit explain hospital's expectation for their role in promoting patient safety? (286)
- Is there widespread staff training related to expectation for patient safety?
- Training related to what steps to take in situation that feels unsafe
- Is there a systematic process to identify medical errors which include near misses and AEs?
- On every unit, can the staff describe what is a medical error or near miss?

54

Patient Safety LD, AE and Medical Error



PART 4 – PATIENT SAFETY – ADVERSE EVENTS AND MEDICAL ERRORS		
Elements to be Assessed		Space for Surveyor Notes (if needed)
4.1 Evaluation regarding whether the hospital's leadership sets expectations for patient safety:		
4.1.a Is there evidence of widespread staff training or communication to convey expectations for patient safety to all staff? (e.g. training related to steps to take in a situation that feels unsafe, how to report adverse patient events, medical errors, near misses/close calls, etc. that they are expected to report internally)	○ YES ○ NO	
4.1.b Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of adverse patient events, medical errors, near misses/close calls, etc. , and situations they consider unsafe?	○ YES ○ NO	
4.1.c On each unit surveyed, can staff explain what the hospital's expectations are for their role in promoting patient safety?	○ YES ○ NO	
If no to 4.1.a, 4.1.b, or 4.1.c, cite at 42 CFR 482.21(a)(3) (Tag A-286)		
4.2 Evaluation regarding hospital processes to identify adverse patient events, medical errors, near misses/close calls, etc.:		
4.2.a On each unit/program surveyed, can staff describe the types of adverse patient events, medical errors, near misses/close calls, etc. they are expected to report internally?	○ YES ○ NO	
4.2.b On each unit/program surveyed, can staff	○ YES	

55

QAPI Patient Safety AE and Medical Errors

- Can they explain how to report? (286)
  - How do they report?
    - Phone report, incident report, communicate to supervisor etc.
  - Who do they report it to?
    - Manager, risk manager, physician, pharmacist etc.
- Does the staff know what needs to be reported internally?
  - ADEs, medical errors, near misses and unsafe situations
- Does hospital employ other methods to find medical errors such as trigger tools, chart reviews, review of claims, patient grievances, interview patients etc.

56

QAPI Patient Safety AE and Medical Errors

- Can hospital provide evidence of medical errors and AEs identified through staff reports? (286)
- Is there a PI program with the infection preventionist (IP) to track avoidable HAI?
  - IC section requires this and starts at tag 747
- Are problems identified by the IP addressed through QAPI activities? (756 or 286)
- Does the PI program track medication errors and ADE and drug incompatibilities
  - Tag 508 requires this

57

QAPI Patient Safety AE and Medical Errors

- Is there a process to report blood transfusion reaction and determine if due to medical error? (286 and 410)
  - Must be reviewed to identify if an medical error
- Did the survey team have prior knowledge of any serious AE that the hospital failed to identify? (286)
  - Were any identified by the surveyors?
- Has a RCA (systematic analysis) or QAPI review been done on all serious preventable AEs? (286)
  - Sample all serious preventable events identified in the past 12 months

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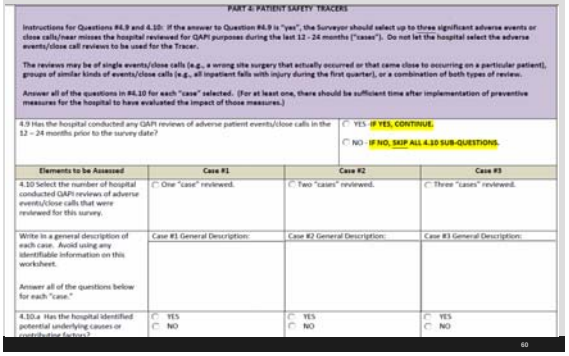
PI Causal Analysis Tracers Part 5

- The next question discuss the causal analysis tracers (RCAs) or patient safety tracers
  - Causal analysis searches for the cause and effect or causes of the particular event or adverse outcome
  - More commonly referred to as a RCA or root cause analysis
  - CMS calls it QAPI reviews
- The surveyor (not the hospital) will select three causal analysis done for single event or near miss during the last 12 to 24 months (286)
- Were underlying causes identified?

59

Causal Analysis Tracers



PART A: PATIENT SAFETY TRACERS

Instructions for Questions #4.9 and 4.10: If the answer to Question #4.9 is "yes", the Surveyor should select up to three significant adverse events or close calls/near misses the hospital reviewed for QAPI purposes during the last 12 - 24 months ("cases"). Do not let the hospital select the adverse events/close call reviews to be used for the Tracer.

The reviews may be of single events/close calls (e.g., a wrong site surgery that actually occurred or that came close to occurring on a particular patient), groups of similar kinds of events/close calls (e.g., all inpatient falls with injury during the first quarter), or a combination of both types of review.

Answer all of the questions in #4.10 for each "case" selected. (For at least one, there should be sufficient time after implementation of preventive measures for the hospital to have evaluated the impact of those measures.)

4.9 Has the hospital conducted any QAPI reviews of adverse patient events/close calls in the 12 – 24 months prior to the survey date?
- YES - IF YES, CONTINUE.
- NO - IF NO, SKIP ALL 4.10 SUB-QUESTIONS.

Elements to be Assessed	Case #1	Case #2	Case #3
4.10 Select the number of hospital conducted QAPI reviews of adverse events/close calls that were reviewed for this survey.	One "case" reviewed.	Two "cases" reviewed.	Three "cases" reviewed.
Write in a general description of each case. Avoid using any identifiable information on this worksheet. Answer all of the questions below for each "case."	Case #1 General Description:	Case #2 General Description:	Case #3 General Description:
4.10.a Has the hospital identified potential underlying causes or contributing factors?	YES NO	YES NO	YES NO

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QAPI Patient Safety Tracers

- Was preventive actions developed based on the RCA? (286)
- TJC has a matrix which contains elements that must be included in a reviewable sentinel event
  - Removed from July 1, 2015 P&P but still good tool to use
- Did the hospital identify any other departments utilizing similar processes that are at a similar risk? (286)
  - Alarm fatigue issue in ED, CCU, ICU, and telemetry
- Were preventive actions implemented in at least one area of the hospital? (286)

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QAPI Patient Safety Tracers

- Has the hospital evaluated the impact of the preventable actions including tracking a reoccurrences or near misses? (286)
- If the goals were not met did the hospital go back to the drawing board?
  - New patient fall tool used in the ED but staff did not have a culture of safety and not implementing actions
- Has the hospital implemented the preventable actions found to be effective unless there is a documented reason for not doing so? (286)

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TJC Framework for Conducting RCA

www.jointcommission.org/sentinel_event.aspx

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TJC Sentinel Event Policy

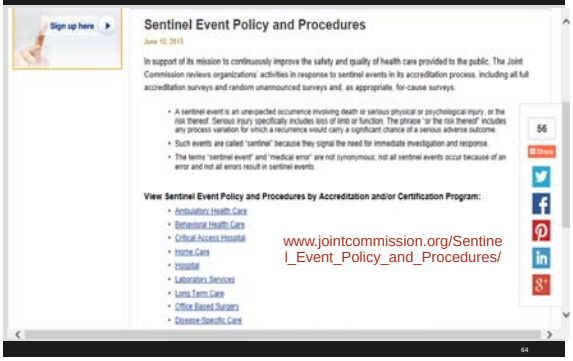


Table 3. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

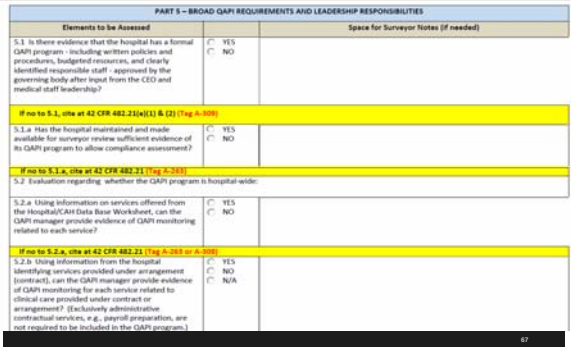
	TYPES OF SENTINEL EVENTS												
Areas of Potential Root Causes	Suicide (24-Hour Care)	Medication Error	Procedural Complication	Wrong Site Surgery	Treatment Delay	Restraint Death	Elopement Death	Assault/Rape/Homicide	Transfusion Death	Patient Abduction	Unanticipated Death of Full-Term Infant	Unintended Retention of Foreign Body	Fall Related
Behavioral assessment process[11]	X					X	X	X					
Physical assessment process[55]	X	X	X	X	X	X	X				X		X
Individual identification process		X		X					X				
Individual observation procedures	X				X	X	X	X	X		X		X
Care planning process	X		X			X	X				X		X
Continuum of care	X	X			X	X							X
Staffing levels	X	X	X	X	X	X	X	X	X	X		X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X	X	X	X

continued on next page

Broad PI Requirements & Leadership

- Part 5 addresses broad QAPI requirements and leadership responsibilities (309)
- Does the hospital have a formal PI program?
  - Most hospitals have a PI plan that discusses the PI program
  - Is there a written P&P on the PI program?
  - Is there budgeted resources so staff can attend education programs and data can be collected?
  - Is there responsible staff to do PI
  - Is the PI program approved by MS, CEO, and the board?

Broad PI Requirements and Leadership



PART 5 – BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

Elements to be Assessed		Space for Surveyor Notes (if needed)
5.1 Is there evidence that the hospital has a formal QAPI program - including written policies and procedures, budgeted resources, and clearly identified responsible staff - approved by the governing body after input from the CEO and medical staff leadership?	○ YES ○ NO	
If no to 5.1, cite at 42 CFR 482.21(e)(1) & (2) (Tag A-309)		
5.1.a Has the hospital maintained and made available for surveyor review sufficient evidence of its QAPI program to allow compliance assessment?	○ YES ○ NO	
If no to 5.1.a, cite at 42 CFR 482.21 (Tag A-263)		
5.2 Evaluation regarding whether the QAPI program is hospital-wide:		
5.2.a Using information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?	○ YES ○ NO	
If no to 5.2.a, cite at 42 CFR 482.21 (Tag A-263 or A-308)		
5.2.b Using information from the hospital identifying services provided under arrangement (contract), can the QAPI manager provide evidence of QAPI monitoring for each service related to clinical care provided under contract or arrangement? (Exclusively administrative contractual services, e.g., payroll preparation, are not required to be included in the QAPI program.)	○ YES ○ NO ○ N/A	

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Broad PI Requirements and Leadership

- Has the hospital maintained and made available to the surveyor sufficient evidence of its QAPI program to allow compliance assessment? (263)
- Is the QAPI hospital-wide?
- Can the QAPI manager provide evidence of QAPI monitoring related to each service? (263 or 308)
  - Surveyor to use information in the data base worksheet to determine what services are offered by the hospital
  - Every department should be involved in the QAPI process
- Is there evidence of PI review for contracted services for clinical care? (83, 263, or 308)

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Broad PI Requirements and Leadership

- Is there evidence that the board, CEO, MS leadership and senior leaders, including the CNO, have a role in PI planning and implementation? (309)
- Is there evidence of PI review in the board minutes? (273)
- Does the board approve the PI program quality indicators and how often the data is collected?
  - Determine how many projects for next year?
  - Does board hold CEO accountable for effectiveness of PI program? (309 and 57)
- CMS Board section starts at tag 38

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Resource Allocation

- Is there evidence of funding and personnel dedicated to the QAPI program? (315)
- If condition level deficiencies, is there evidence that the lack of resources contributed to this? (315)
- Did the hospital at any time refuse to provide the requested material claiming it was protected by the Patient Safety Work Product under the federal PSO law?
  - This is for information only and no citation risk

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CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS) 2015

What PPS Hospitals Need to Know About the QAPI Section

CMS CoP PI Section Starts at Tag 263

A-0263
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

A-0273
(Rev. 105, Issued: 03-21-14, Effective: 03-21-14, Implementation: 03-21-14)

Data Collection & Analysis

§§482.21(a), 482.21(b)(1), 482.21(b)(2)(i), & 482.21(b)(3)

§482.21(a) Standard: Program Scope

(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes....

(2) The hospital must measure, analyze, and track quality indicators...and other aspects of performance that assess processes of care, hospital service and operations.

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Changes to the Tag Numbers

- Old Tag Numbers:
  - 263, 264, 265, 266, 267, 273, 274, 275, 276, 277, 283, 285, 286, 287, 288, 289, 290, 291, 297, 298, 299, 300, 301, 302, 303, 309, 310, 311, 312, 313, 314, 315, 316, and 317
  - 34 tag numbers and 7 pages
- New Tag Numbers after March 21, 2014:
  - 263, 273, 283, 286, 297, 308, 309 and 315
  - 8 tag numbers and 7 completely rewritten and 4 pages
  - 34 tags to 8 standards

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Hospital CoPs for PI 263

- QAPI stands for quality assessment and performance improvement
  - Use to stand for Quality Assurance and Performance Improvement (QAPI) but changed June 7, 2013 to Quality Assessment
  - Referred to in short as PI
- In each section, such as nursing and pharmacy, CMS states every department has a role in QAPI
- Also CMS Compare is an important and has information about the hospital's quality of care

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Hospital Compare Measures

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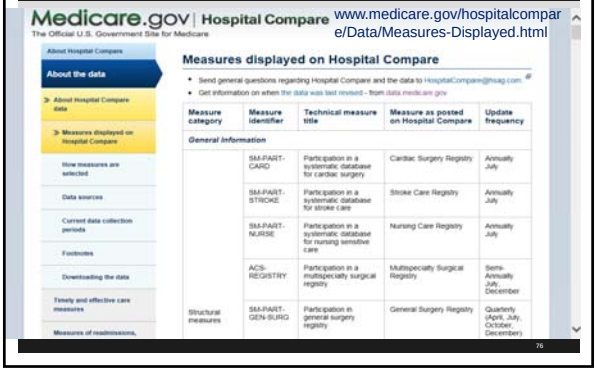
Measures Displayed on Hospital Compare

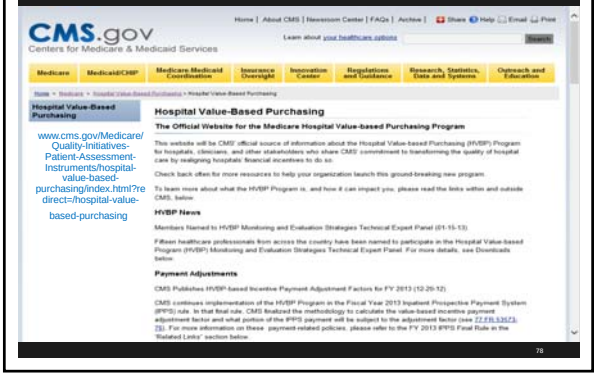


www.medicare.gov/hospitalcompare/Data/Measures-Displayed.html

Hospital Compare Measures

- Patient experience, use of medical imaging
- Timely and effective care; time to transfer for acute coronary intervention, time to EKG, MI got thrombolytics within 30 minutes, ASA on arrival, PCI within 90 minutes, etc
- Heart failure, pneumonia, SCIP measures including timely removal of foley within 1 or 2 PODs,
- ED throughput, children's asthma care, preventive care with immunizations for flu, stroke, blood clot prevention, readmission rates, surgical complications, HAIs,

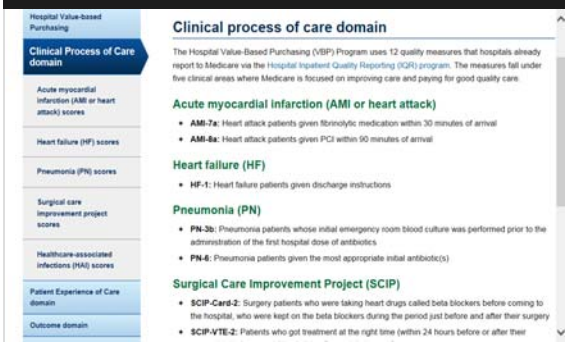
CMS VBP Website

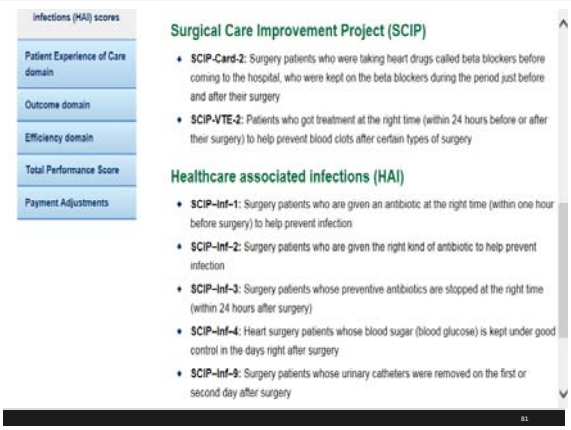


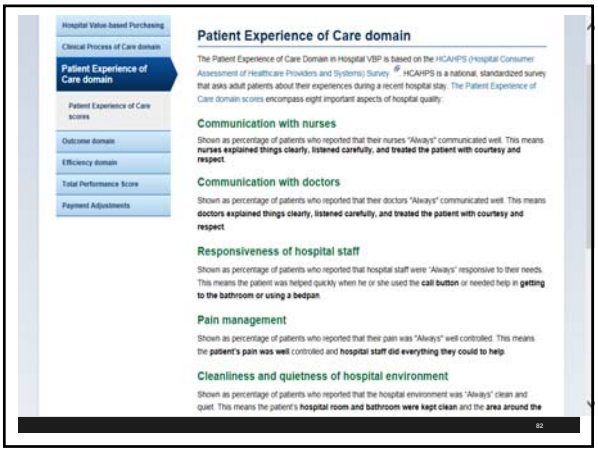
www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing

Hospital Value Based Purchasing

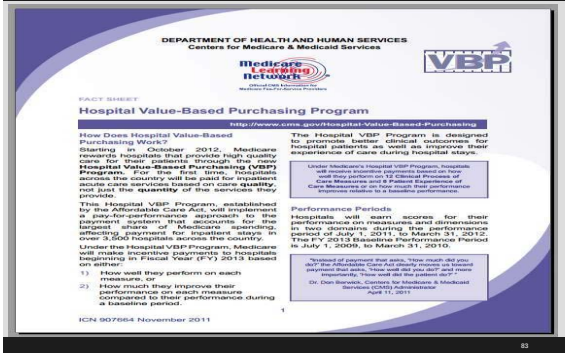
Clinical Process of Care Domain







VBP Fact Sheet


DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

FACT SHEET

Hospital Value-Based Purchasing Program

http://www.cms.gov/Hospital-Value-Based-Purchasing

How Does Hospital Value-Based Purchasing Work?

Starting in October 2012, Medicare rewards hospitals that provide high quality care for their patients with the new Hospital Value-Based Purchasing (VBP) Program. For the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

The Hospital VBP Program, established by the Affordable Care Act, will implement a pay-for-performance approach to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country.

Under the Hospital VBP Program, Medicare will make incentive payments to hospitals starting in Fiscal Year (FY) 2013 based on either:

1) How well they perform on each measure, or
2) How much they improve their performance on each measure compared to their performance during a baseline period.

The Hospital VBP Program is designed to promote better clinical outcomes for patients and to improve patients' experience of care during hospital stays.

Under Medicare's Hospital VBP Program, hospitals will receive incentive payments based on how well they perform on 12 Clinical Process of Care Measures and 8 Patient Experience of Care Measures or on how much their performance improves relative to a baseline performance.

Performance Periods

Hospitals will earn scores for their performance on measures and dimensions in two domains during the performance period of July 1, 2011, to March 31, 2012. The FY 2013 Baseline Performance Period is July 1, 2009, to March 31, 2010.

"Instead of payment that asks, "How much did you do?" the Affordable Care Act directly moves us toward payment that asks, "How well did you do?" and more importantly, "How well did the patient do?"

Dr. Don Berwick, Centers for Medicare & Medicaid Services (CMS) Administrator
April 11, 2011

ICN 907664 November 2011

1

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Hospital CoPs for QAPI 263

- Standard: Must have PI program that is ongoing, data driven, and effective
- Board must make sure that PI program reflects the complexity of the hospital's organization and services
- Must involve all departments including contracted services
- Focus on indicators to improve health outcomes

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Hospital CoPs for PI

- Includes all departments even if contracted services
- Must focus on indicators related to improve health outcomes
  - How do you improve outcomes in the patient with hyponatremia, sepsis, or delirium?
  - How to improve outcomes in the diabetic patient admitted with hyperosmolar syndrome?
- Must focus on the prevention and reduction of medical errors
  - What do you do to prevent medical errors such as medication errors which is the most common type?

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Program Scope 273

- Standard: PI program needs to be ongoing and show measurable improvements to improve health outcomes
- Must measure, analyze and track the quality indicators
- Must track other areas of performance that assess processes of care, hospital service and operations
- MI patients get their thrombolytics timely which helps to dissolve the clot to increase blood though the coronary artery which increases their survival

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Ongoing Program

- Hospitals has improved patient flow and admitted patients now get to their bed in four hours or less
- Patients get their antibiotics timely in the OR now
- Patients with pneumonia now get their antibiotics within the six hour window
- Use of the sepsis bundle has improved survival rate

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Track Quality Indicators

- The hospital must measure, analyze, and track quality indicators which would include adverse events
- Want to focus on aspects and processes that related to the health and safety of patient care services
- Look at what could result in a sentinel event if not properly managed
  - TJC has a sentinel event policy and lists reviewable SE

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TJC Revised Sentinel Event Policy

Sentinel Events (SE)

www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

I. Sentinel Events

In support of its mission to continuously improve the safety and quality of health care provided to the public, The Joint Commission in its accreditation process reviews hospitals' activities in response to sentinel events. The accreditation process includes all full accreditation surveys and, as appropriate, for-cause surveys, and random validation surveys specific to Evidence of Standards Compliance (ESC).

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events are called "sentinel" because they signal the need for immediate investigation and response.
- The terms "sentinel event" and "error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

II. Goals of the Sentinel Event Policy

The policy has four goals:

1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To focus the attention of a hospital that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organizational culture), and on changing the hospital's culture, systems, and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention
4. To maintain the confidence of the public and accredited hospitals in the accreditation process

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Reviewable Sentinel Events

- The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition[3][‖]

  or
- The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):
  - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
  - Unanticipated death of a full-term infant
  - Abduction of any patient receiving care, treatment, and services
  - Discharge of an infant to the wrong family
  - Sexual abuse/assault (including rape)[4]
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)

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Table 1. Examples of Sentinel Events That Are Reviewable Under The Joint Commission's Sentinel Event Policy

Note: *This list may not apply to all settings.*

Examples include the following:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient's body, on the wrong site on the patient's body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery

Program Scope 273

- So what is the scope of activities of your PI program?
  - Is the scope your PI program to include an overall assessment of the efficacy of the PI activities with a focus on continually improving the care provided at your hospital?
  - Does it look at indicators for both process and outcome?
  - Are the indicators objective, measurable, and based on current knowledge and experience?

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STK		STROKE
	STK-1	Venous Thromboembolism (VTE) Prophylaxis
	STK-2	Discharged on Antithrombotic Therapy
	STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter
	STK-4	Thrombolytic Therapy
	STK-5	Antithrombotic Therapy by End of Hospital Day 2
	STK-6	Discharged on Statin Medication
	STK-8	Stroke Education
	STK-10	Assessed for Rehabilitation
VTE		VENOUS THROMBOEMBOLISM
	VTE-1	Venous Thromboembolism Prophylaxis
	VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis
	VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
	VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
	VTE-5	Venous Thromboembolism Discharge Instructions
	VTE-6	Incidence of Potentially-Preventable Venous Thromboembolism

OUTPATIENT Core Measure GROUP	INDICATORS	
SCIP		SURGICAL CARE IMPROVEMENT PROJECT
	OP-6	Timing of Antibiotic Prophylaxis (Prophylactic ABX initiated within 1 Hr. prior to Surgical Incision)
	OP-7	Antibiotic Selection
ED		ED -THROUGHPUT
	OP-18	Median time from ED arrival to ED departure for discharged ED patients
	OP-19	Transition record with specified elements received by discharged patients

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What is the Scope of Your PI Program?

- Medication therapy/medication use
  - Includes medication reconciliation
  - Includes the use of dangerous abbreviations
- Threats to patient safety
  - Such as falls, patient identification, trauma
- Infection control system, including healthcare associated infections (HAI)
- Utilization Management System
- Patient experience or patient satisfaction

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What is the Scope of Your PI Program?

- Discrepant pathology reports
- Unanticipated deaths, adverse and/or sentinel events
- Adverse event/near miss
- Physical Environment Management Systems
- Operative and invasive procedures
  - Including wrong site/wrong patient/wrong procedure surgery
- Anesthesia/moderate sedation, Complaints
- Blood and blood components, blood incompatibility
- Restraint use/seclusion use and injury

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What is the Scope of Your PI Program?

- Effectiveness of pain management system
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of four hours
- ED throughput with median time from ED arrival to ED departure for discharged patients
- ED door to door diagnostic evaluation by QMP
- Patients who are AMA or LWBS
- Median time to pain management for long bone fractures

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What is the Scope of Your PI Program?

- Timing of antibiotics within 1 hours of surgical incision and antibiotic selection
- Other adverse events, CaUTI, SSI, air embolism
- Critical and/or pertinent processes, both clinical and supportive
- Medical record delinquency
- Other aspects of performance that assess process of care, hospital service and operation
- Contract reviews, immunizations, SCIP, Hospital based inpatient psych services, VTE, stroke, etc.

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Data Collection and Analysis 273

- Program Data: The PI program must incorporate quality data
- This must include patient care data and other relevant data
- For example, information submitted to or received from the hospital's QIO
  - Hospital works with QIO on quality project to reduce falls, readmissions, and to reduce SSI, CaUTI, CDI and CLABSI

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10th Scope of Work with QIO

- Abbreviations
  - Central line bloodstream infections (CLABSI)
  - –Catheter-associated urinary tract infections (CAUTI)
  - –Clostridium difficile infections (CDI)
  - –Surgical site infections (SSI)

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Data Collection and Analysis 273

- The hospital must use data collected to monitor the effectiveness and safety of services and quality of care
  - Data shows that hospital reduced their fall rate by 25% after new initiatives were implemented
  - Hospital reduced their CaUTI rate by 40%
- The frequency and detail of data must be specified by the board
  - Some data may be collected quarterly while some may be collected monthly

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What's in Your PI Plan?

General Hospital PI Plan

POLICY: ORGANIZATIONAL PERFORMANCE IMPROVEMENT PLAN	POLICY NUMBER: 111.104
ORIGINATING DEPT: PERFORMANCE IMPROVEMENT APPLIES TO DEPTS: ALL	Original: March 1996 Reviewed: 05/1999 Reviewed: 05/2000 Reviewed: 02/2002 Revised: 05/2004 Revised: 04/2005 Revised: 09/2006 Revised: 02/2007 Revised: 01/15/2010 Revised: 08/05/2010 Revised: 06/11/2011 Revised: 08/20/2011 Revised: 09/23/2011 Revised: 01/16/2012 Revised: 08/27/2012

PURPOSE

The purpose of the Organizational Performance Improvement Plan at General Hospital is to ensure that the Board of Directors, medical staff and professional service staff demonstrate a consistent endeavor to deliver care that is optimal in an environment of minimal risk.

In keeping with General Hospital's mission:

To be dedicated to providing a healing environment for maintaining and improving the health of residents of the district as well as providing quality healthcare services to those persons visiting or traveling through the district. In carrying out this mission, the DISTRICT will provide a coordinated range of services including acute inpatient and outpatient services, long-term care, education, referral services and recruitment of healthcare personnel to the area.

In support of this Mission, the hospital is pledged to:

- Foster a trust relationship with the communities served which includes broad-based community involvement in the development of services and programs.
- Promote a commonality of goals, objectives, and expectations within the community of

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General Hospital Core Values:

- UNDERSTANDING: Exhibited by the presence of receptivity, assessable and generosity. Creating an environment for fruitful communication.
- TRUST: Our behavior is composed of sincerity, mutual respect and genuiness leading to honest communication.
- LEADERSHIP: We each take responsibility in creating a positive organization in which our values can flourish. We lead by modeling "we go there first".
- QUALITY: Is our constant commitment as evidenced by positive customer outcomes, financial performance, and continuous operational improvement.
- ACCOUNTABILITY: Taking ownership of our responsibilities and actions and following through to contribute to the success of our organization.

The Organizational Performance Improvement Plan allows for a systematic, coordinated and continuous approach to process design and performance measure analysis and improvement, focusing upon the aspects and dimensions that address this mission and values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the Performance Improvement activities at General Hospital. The Organizational Performance Improvement Program, established by the medical staff and interdisciplinary Performance Improvement Committee, with support and approval from the Board of Directors, has the responsibility for monitoring every aspect of patient care, from the time the patient enters the hospital through diagnosis, treatment, recovery and discharge in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

GOALS OF Performance Improvement:

The primary goal of the Organizational Performance Improvement Plan is to continually and

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systematically plan, design, measure, assess and improve performance of hospital-wide key functions and processes relative to patient care. To achieve the primary goal, the plan strives to:

- Incorporate quality planning throughout the facility: Provide a systematic mechanism for the facility's appropriate individuals, departments and professions to function collaboratively in their efforts toward Performance Improvement.
- Provide for a hospital-wide program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others.
- Assure that the improvement process is organization-wide, monitoring, assessing and evaluating the quality and appropriateness of patient care and clinical performance to identify changes that will lead to improved performance and reduce the risk of sentinel events.
- Achieve and sustain improvements made in performance throughout the organization.
- To demonstrate our ability to consistently provide services that meets customer and applicable statutory and regulatory requirements.
- To enhance customer satisfaction through the effective application of the system, including processes for continual improvement of the system and the assurance of conformity to customer.
- Appropriate reporting of information to the Board of Directors to provide it with the information it needs in fulfilling its responsibility for the quality of patient care and safety is a required mandate of this plan.

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Scope of Activities of the PI Plan

- Necessary information is to be communicated among department/services when problems or opportunities to improve patient care involve more than one department/service.
- The status of identified problems is tracked to assure improvement or problem resolution.
- Information from departments/services and the findings of discreet Performance Improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.

The objectives, scope, organization and mechanisms for overseeing the effectiveness of planning, designing, measuring, analyzing and improving performance via the Performance Improvement Program are evaluated annually and revised as necessary. Important key aspects and processes of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, those tending to produce problems for patients, their families or staff, and those that may lead to sentinel events.

SCOPE OF ACTIVITIES:

The scope of the Organizational Performance Improvement Program includes an overall assessment of the efficacy of Performance Improvement activities with a focus on continually improving care provided throughout General Hospital. The program consists of three focus components:

Performance Improvement, quality assessment/improvement and quality control activities. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by all appropriate departments/services and disciplines of the facility in an effort to improve organizational performance. These indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid performance

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measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time.

The X trending reports are tools to be utilized by the facility to identify problems and assure improvement. X documents and reports shall remain confidential and protected. X reports and documents shall be transmitted to the Medical Staff Performance Improvement Committee through the Performance Improvement Coordinator.

The scope of the Organizational Performance Improvement Program includes performance of the following medical staff functions:

The monitoring, assessment and of performance of patient care and the clinical performance of all individuals with clinical privileges. At monthly/bimonthly meetings of medical staff service committees, findings of the continuous Performance Improvement activities of the medical staff and all appropriate departments/sevices and disciplines that impact patient care and medical staff services within the medical staff service committee will be reviewed, assessed and evaluated.

The functions to be measured at a minimum will include the following (as applicable):

- Evaluation of all patient care services and other services provided affecting patient health and safety, quality and appropriateness of the diagnosis and treatment (including outcomes) provided by the PA, NP and nursing staff. This evaluation must be performed by a staff or contract Physician; (485.616(b), 485.641(b)(1); 485.641(b)(3)
- Credentialing and quality and appropriateness of the diagnosis and treatment (including outcomes) provided by Physicians. This credentialing and clinical review must be performed by: (485.616(b), 485.641(b)(4),485.603(c)
- Participation in QualityNet (QIO) measures (485.616(b)(2); 485.641(b)(4)(ii), 485.603(c)(2)
- Annual credentialing and quality review by California Critical Access Hospital Network (CCAHN) or other qualified entity (another CAH or any licensed firms, businesses, or agencies

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Scope of PI Plan and Program

that provide credentialing and QA services. an entity qualified by the state rural health care plan). (485.616(b)(3); 485.641(b)(4)(iii), 485.603(c)(3)

- Threats to patient safety; 485.641(b)(1), (i.e. falls, patient identification, injuries)
- Medication therapy/medication use; (this may include medication reconciliation and the use of dangerous abbreviations; 485.641(b)(2); 485.635(a)(3)(v)
- Infection control system, including hospital acquired infections (HAI); 485.641(b)(2); 485.635(a)(3)(vi)
- Utilization Management System; 485.641(a)(1)(i)
- Customer satisfaction, both clinical and support areas;
- Discrepant pathology reports;
- Unanticipated deaths, adverse and/or sentinel events;
- Adverse event/near miss; and,
- Physical Environment Management Systems
- Operative and invasive procedures; (including wrong site/wrong patient/wrong procedure surgery)
- Anesthesia/moderate sedation;
- Blood and blood components
- Restraint use/seclusion;
- Effectiveness of pain management system;
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of eight hours.
- Other adverse events;
- Critical and/or pertinent processes, both clinical and supportive;
- Medical record delinquency;
- Other aspects of performance that assess process of care, hospital service and operation

Internal Audits (8.2.2) shall be conducted taking into consideration the status and importance of the processes and areas to be audited, as well as the results of previous audits. For a list of internal audits conducted refer to the "Hospital-Wide Quality Assessment and Performance Improvement

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Board is Responsible for Quality of Care

Plan".

Relevant findings from Performance Improvement activities performed are considered part of:

- Reappraisal/reappointment of medical staff members;
- The renewal or revision of the clinical privileges of individuals who practice independently;
- The mechanism used to appraise the competence of all those individuals not permitted by the hospital to practice independently.

ORGANIZATION:

To achieve fulfillment of the objectives, goals and scope of the Organizational Performance Improvement Plan, the organizational structure of the program is designed to facilitate an effective system of measuring, analyzing, and improving the care and services provided throughout General Hospital. The Performance Improvement Director is responsible to ensure the effectiveness of the Performance Improvement Program for the District.

The Board of Directors is responsible for the quality of patient care provided.

The Board of Directors requires the medical staff to implement and report on the activities and the mechanisms for process design and performance measurement, analysis and improvement, monitoring, assessing and evaluating the quality of patient care, for identifying and reducing the risk of sentinel events; for resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect effect on patient care, including management and administrative functions.

The Board of Directors provides for resources and support systems for the Performance Improvement

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Role of MEC in PI Plan and Program

functions and risk management functions related to patient care and safety.

The Board of Directors has a responsibility to evaluate the effectiveness of the Performance Improvement activities performed throughout the hospital and the Organizational Performance Improvement Program as a whole to assure that improved performance is achieved and sustained.

With authority delegated by the Board of Directors, the medical staff strives to improve and assure the provision of quality patient care through the monitoring, assessment and evaluation of performance measurement and outcome.

The medical staff provides effective mechanisms to monitor, assess and improve the quality and appropriateness of patient care and the clinical performance and competency of all individuals with delineated clinical privileges. Performance Improvement opportunities are addressed, with improvement strategies and actions implemented, to assure improved performance is achieved and sustained.

The Medical Executive Committee delegates the oversight responsibility for performance activity monitoring, assessment and improvement of patient care services provided throughout the facility to the Performance Improvement Committee and Medical Staff Performance Improvement Committee.

With designated responsibility from the Performance Improvement Committee, Performance Improvement (PI) Teams will operate as functional groupings of individuals in the organization who meet to evaluate and improve a specific process, system or function within the hospital. Performance Improvement Teams are comprised of departmental leaders, medical staff on an as needed basis, and those individuals designated from each department, as appropriate, who may have the highest degree of knowledge regarding a given Performance Improvement topic.

Performance Improvement teams meet as necessary and are defined by the team, to perform the Performance Improvement processes required for improving processes involved in patient care and organizational function. Team reporting is performed at the organizational Performance Improvement

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Hospital Uses PDCA and FOCUS

team level, through the Organizational Performance Improvement Committee and medical staff committees, as appropriate. Performance Improvement team activity may also be incorporated into individual departmental Performance Improvement programs as the activity relates to that department.
METHODOLOGY:

FOCUS - PDCA process is utilized to plan, design, measure, assess and improve functions and processes related to patient care and service throughout the organization:

FOCUS	PDCA
Find the process to improve	**P**lan the improvement
Organize to improve the process	**D**o the improvement
Clarify current knowledge of the process	**C**heck the results
Understand the process improvement	**A**ct to hold the improvement
Select the process improvement	

Responsibility
Assign responsibility for monitoring, assessing and improving performance.

Scope
Delineate the scope of care and services provided;

Important Aspects/Processes
Identify important key aspects of care, focusing on those aspects and processes that relate to the health and safety of the patients services, or that may result in a sentinel event if not optimally managed.

Measurement
Identify objective and statistically valid performance measures for monitoring and improving performance aspects/processes of care. Performance measures include processes performance

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Focus on High Risk and High Volume

measures and outcome performance measures that affect a large percentage of patients; and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or are likely to be problem prone; and/or may result in sentinel events.

Performance measures are structured to focus on high risk, high volume, high cost, or problem prone areas; are based on current knowledge and clinical experience; and are structured to reflect cross-departmental, interdisciplinary processes, as appropriate. Measures will be further categorized whether the focus is to evaluate:

- Health Outcome
- Patient Safety
- Quality Care
- Medical Error/Adverse Events
- Satisfaction
- Quality Control and
- Compliance

The following criteria are utilized when determining appropriate performance measures to utilize to improve performance:

- The measure can identify the events it was intended to identify;
- The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;
- The measure has defined data elements and allowable values;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities;
- The data intended for collection are available and accessible;
- Results can be reported in a manner that is useful to the organization and other interested healthcare participants.

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Collect Data and Monitor

Data Collection: Monitor, assess and improve the important aspects/processes of care by assessment of data collected. Collected data allows the hospital to:

- Monitor its performance;
- Monitor performance of areas targeted for further study;
- Monitor the performance of processes that involve risks or may result in sentinel events (i.e. Quantros Report);
- Make informed judgments about the stability of existing processes; Identify opportunities for incrementally improving processes:
- Identify the need to redesign processes:
- Decide whether improvements or redesign of processes meet objectives. Data collection focuses upon:

Processes, particularly those that are high-risk, high-volume, problem-prone and/or may result in sentinel events; Outcomes; Comprehensive performance measures; Other gauges of performance; Evaluate/Analyze; Aggregating, analyzing and evaluating data allows the hospital to draw conclusions about its performance in relation to a process or the nature of an outcome. The following criteria are considered during data analysis and evaluation:

- Were the design specifications for new processes met?
- What is the current level of performance? How stable are current processes?
- What are the priorities for possible improvement of existing processes or implementation of

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Identify Change and Implement

new processes?

- Is the data displayed utilizing appropriate statistical techniques to allow for optimal analysis?
- Does analysis include internal (historical) and external data comparison? Is internal and external data displayed in a format that allows for comparison over time?
- Does the data include information that will lead to the reduction of sentinel events?
- Was a strategy to stabilize or improve performance effective (as appropriate)?

Identify Change
Changes required to improve performance and reduce the risk of sentinel events are identified based on the analysis of data, either from ongoing monitoring or targeted study results.

Improve
Implement actions to improve the performance of new or existing processes, systems and/or functions, as well as to reduce or eliminate sentinel events.

Evaluate
Evaluate whether the change(s) implemented and actions taken to improve have been effective, documenting the achievement of improved performance, monitoring the aspect/process until there is documented proof that the improvement is (or can be) sustained.

Report
Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services, the Hospital Performance Improvement Committee, Medical Staff Performance Improvement Committee and to the Governing Body.

Any variation, or deficiency identified shall be addressed by appropriate corrective or preventive

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Quality Improvement Activities 283

- Standard: The hospital must collect data to identify opportunities for improvement
- Standard: Hospital must set priorities that focus on high risk, high volume, or problem prone areas
- Must consider the incidence, prevalence, and severity of problems in those areas
- Look at issues that affect health outcomes, patient safety and quality of care
- Track performance to ensure improvements are sustained

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Patient Safety, Medical Errors, AE 286

- Standard: PI program must include indicators to identify and reduce medical errors
  - Track medical errors and ADE
- Analyze their causes and implement preventive actions
  - Example would be a RCA or root cause analysis
- Board is responsible for the operations of the hospital
- Medical staff and administrative staff are accountable to make sure clear expectations for safety

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Identify and Reduce Medical Errors 286

- Need a system that includes feedback and learning throughout the hospital
- First, the hospital need to identify that there is a medical error
  - It needs to be reported into the PI system
  - Risk management and hospital staff cannot fix a problem they do not know exists
- Second, the hospital evaluates it to determine what processes can be put in place to prevent it from occurring
- RCA and FMEA are two tools that can be used

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Identify and Reduce Medical Errors 286

- Medical errors may be difficult to detect in hospitals and are under reported
- Make sure incident reports filled out for errors and near misses
- Are there any diagnostic errors, equipment failures, blood transfusion injuries, or medication errors
- Trigger tools by IHI can assist in finding medical errors and opportunities for improvement
  - Classen DC, Resar R, Griffin F, et al. Global Trigger Tool shows that adverse events in hospitals may be ten times greater than previously measured. Health Affairs. 2011 Apr;30(4):581-589.

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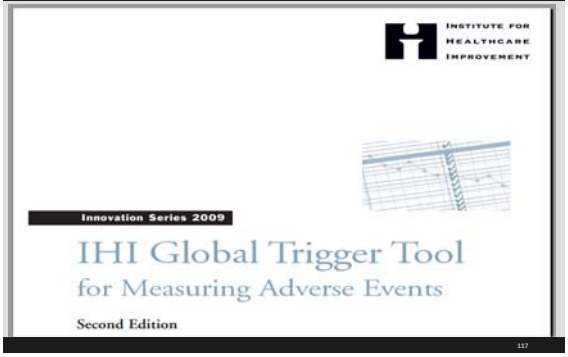
IHI Global Trigger Tool wwww.ihi.org



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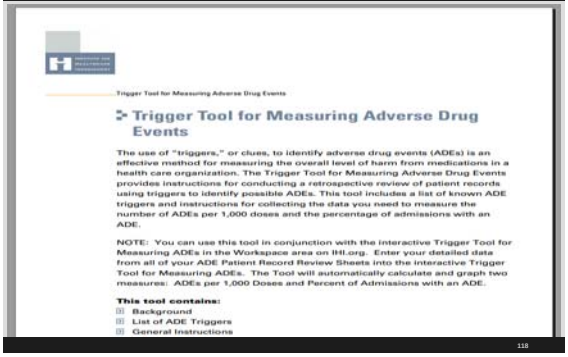
Trigger Tool for Adverse Drug Events


Trigger Tool for Measuring Adverse Drug Events

Trigger Tool for Measuring Adverse Drug Events

The use of "triggers," or clues, to identify adverse drug events (ADEs) is an effective method for measuring the overall level of harm from medications in a health care organization. The Trigger Tool for Measuring Adverse Drug Events provides instructions for conducting a retrospective review of patient records using triggers to identify possible ADEs. This tool includes a list of known ADE triggers and instructions for collecting the data you need to measure the number of ADEs per 1,000 doses and the percentage of admissions with an ADE.

NOTE: You can use this tool in conjunction with the interactive Trigger Tool for Measuring ADEs in the Workspace area on IHI.org. Enter your detailed data from all of your ADE Patient Record Review Sheets into the interactive Trigger Tool for Measuring ADEs. The Tool will automatically calculate and graph two measures: ADEs per 1,000 Doses and Percent of Admissions with an ADE.

This tool contains:
- Background
- List of ADE Triggers
- General Instructions

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Resources

- Griffin FA, Classen DC. Detection of adverse events in surgical patients using the Trigger Tool approach. Quality and Safety in Health Care. 2008 Aug;17(4):253-258.
- Classen DC, Lloyd RC, Provost L, Griffin FA, Resar R. Development and evaluation of the Institute for Healthcare Improvement Global Trigger Tool. Journal of Patient Safety. 2008 Sep;4(3):169-177.
- Resar RK, Rozich JD, Simmonds T, Haraden CR. A trigger tool to identify adverse events in the intensive care unit. Joint Commission Journal on Quality and Patient Safety. Oct 2006;32(10):585-590.

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PI Projects 297

- Standard: Hospital must conduct PI projects
- How many the hospital does depends on how big they are and what types of services are provided
- May develop and information technology system to improve patient safety and quality
- Document the projects and reasons for doing
- Can participate in a QIO project or do one that is of comparable effort

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CMS Hospital CoPs QAPI

- QIO to advance quality of care for Medicare patients
- Every state has a QIO or Quality Improvement Organization under contract by CMS
- Sign up with your state QIO to get newsletters and other information
- CMS has a website on information about QIOs
- CMS has the mission to improve services provided to Medicare patients

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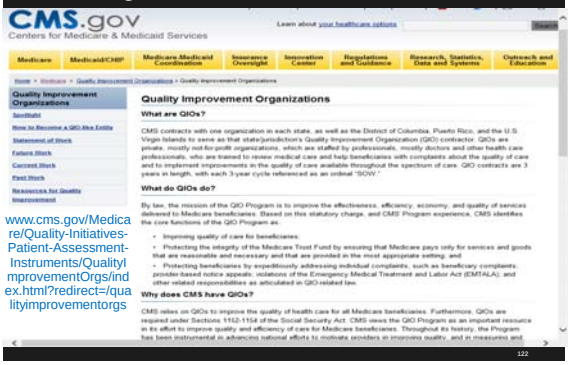
CMS QIO Website



www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs

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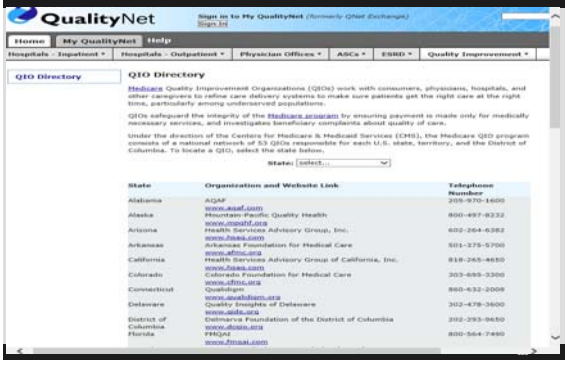
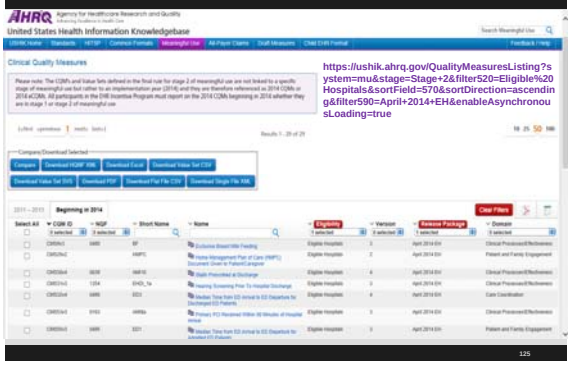
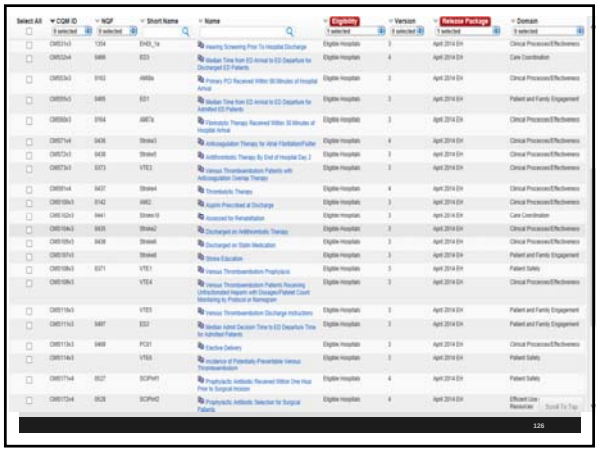
List of QIOs



Outpatient Data Collection

AHRQ Health Information Knowledgebase





Executive Responsibilities 309

- Standard: Board assumes full legal authority and responsibility for the operations of the hospital
- Medical Staff and Administrative officials are responsible and accountable for the following:
  - Ongoing PI program that includes patient safety including reducing medical errors
  - Hospital wide PI and patient safety program
  - A determination of the number of PI projects that is conducted annually

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Adequate Resources 315

- Standard: The board, Medical Staff, and Administrative Officials are accountable for measuring, assessing, improving and sustaining the hospital's performance
- This also requires reducing risk to patients
- Example; hospitals created a process to ensure MI patients got their thrombolytics timely, that PCI was done before 90 minutes and pneumonia patients got their antibiotics and blood culture timely
- Process to make sure the improvements continue

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QAPI Patient Safety

- This means people who can attend meetings, data so analysis can be made and other resources
- Safer IV pumps, new anticoagulant program, implement central line bundle, sepsis, and VAP bundle, preventing inpatient suicides, wrong site surgery, retained FB, new processes for neuromuscular blocker agents, implement policy on Phenergan administration and Fentanyl patches
- So what's in your PI and Safety Plans?

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National Quality Forum NQF

- NQF is an excellent resource
- Has the ABCs of measurement
- A list of NQF endorsed standards
- A list of consensus projects
- Resources
- Can do a search of measures such as AAA repair mortality rate, accidental puncture or laceration rate, 30 day post hospital MI discharge care transition rate, stroke mortality rate, adherence to medication for diabetic patients, etc.

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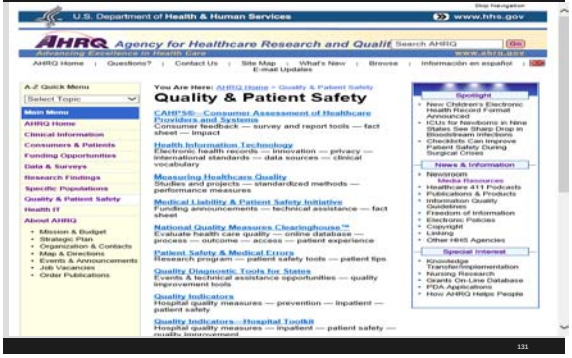
AHRQ Has Excellent Resources



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Quality Indicator Toolkit

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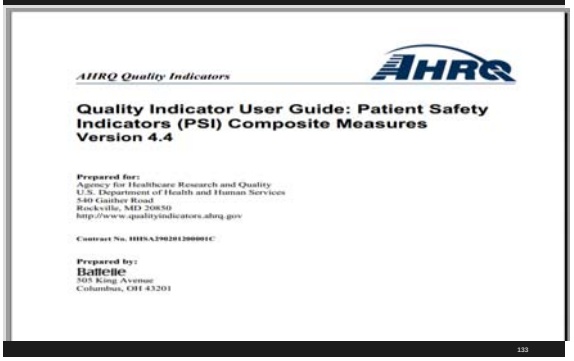
Patient Safety Indicators



AHRQ Quality Indicators

Quality Indicator User Guide: Patient Safety Indicators (PSI) Composite Measures Version 4.4

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
http://www.qualityindicators.ahrq.gov

Contract No. HHSA290201200001C

Prepared by:
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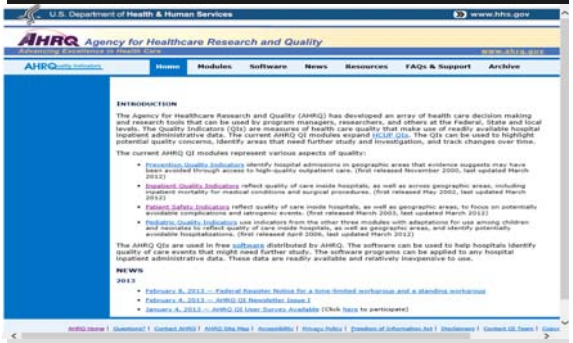
Types of Indicators; Inpatient, PS, Peds,



U.S. Department of Health & Human Services — www.hhs.gov

AHRQ Agency for Healthcare Research and Quality

Home | Modules | Software | News | Resources | FAQs & Support | Archive

INTRODUCTION

The Agency for Healthcare Research and Quality (AHRQ) has developed an array of health care decision making and research tools that can be used by program managers, researchers, and others at the Federal, State and local levels. The Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The current AHRQ QI modules expand HCUP QIs. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care. (first released November 2000, last updated March 2012)
- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. (first released May 2002, last updated March 2012)
- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. (first released March 2003, last updated March 2012)
- Pediatric Quality Indicators use indicators from the other three modules with adaptations for use among children and neonates to reflect quality of care inside hospitals, as well as geographic areas, and identify potentially avoidable hospitalizations. (first released April 2006, last updated March 2012)

The AHRQ QIs are used in free software distributed by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

NEWS

2013

- February 8, 2013 -- Federal Register Notice for a one-time workgroup and a standing workgroup
- February 4, 2013 -- AHRQ QI Newsletter Issue 2
- January 4, 2013 -- AHRQ QI User Survey Available (Click here to participate)

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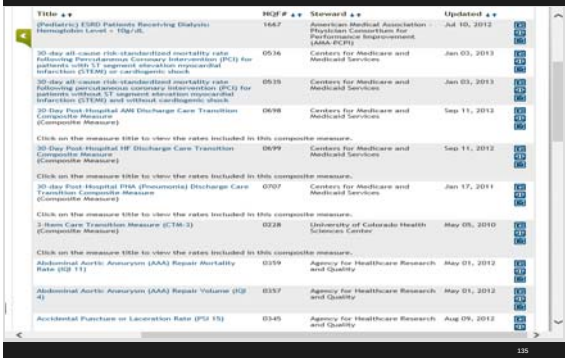
List of NQF Measures



Title	NQF #	Steward	Updated
(Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	1667	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Jul 10, 2012
30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock	0536	Centers for Medicare and Medicaid Services	Jan 03, 2013
30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock	0535	Centers for Medicare and Medicaid Services	Jan 03, 2013
30-Day Post-Hospital AMI Discharge Care Transition Composite Measure (Composite Measure)	0698	Centers for Medicare and Medicaid Services	Sep 11, 2012
Click on the measure title to view the rates included in this composite measure.			
30-Day Post-Hospital HF Discharge Care Transition Composite Measure (Composite Measure)	0699	Centers for Medicare and Medicaid Services	Sep 11, 2012
Click on the measure title to view the rates included in this composite measure.			
30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure (Composite Measure)	0707	Centers for Medicare and Medicaid Services	Jan 17, 2011
Click on the measure title to view the rates included in this composite measure.			
3-Item Care Transition Measure (CTM-3) (Composite Measure)	0228	University of Colorado Health Sciences Center	May 05, 2010
Click on the measure title to view the rates included in this composite measure.			
Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (QI 11)	0559	Agency for Healthcare Research and Quality	May 01, 2012
Abdominal Aortic Aneurysm (AAA) Repair Volume (QI 4)	0557	Agency for Healthcare Research and Quality	May 01, 2012
Accidental Puncture or Laceration Rate (PSI 15)	0345	Agency for Healthcare Research and Quality	Aug 09, 2012

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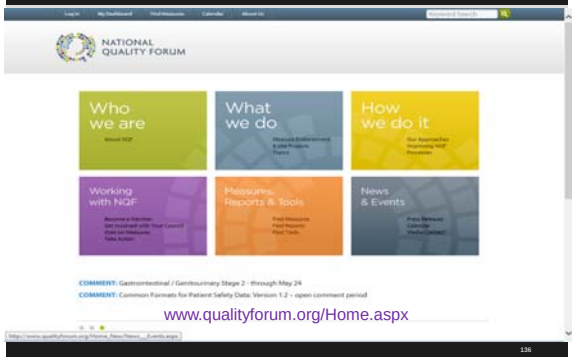
National Quality Forum NQF



www.qualityforum.org/Home.aspx

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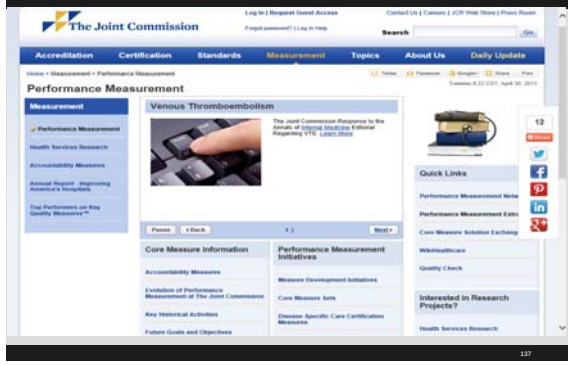
TJC Performance Measurement



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In the Future

- AHA wants a more deliberate and focused approach to quality measurement
  - Including public reporting and pay for performance
- Hospitals overwhelmed by deluge of quality measures asked to report
- Letter to Measure Applications Partnership (MAP) Coordinating Committee
- Has set principles for choosing quality metrics
- Included list of 11 prioritized areas to focus hospital measures

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December 22, 2014 AHA Letter

Measure Ideas	NQS Category
Harm Rates	Safety
Risk Adjusted Mortality	Clinical Effectiveness
Effective Patient Transitions	Care Coordination
Infection Rates	Safety
End of Life Preferences	Patient and Family Engagement
Cost per Case or Episode	Efficiency
Readmission Rates	Care Coordination
Adherence to Guidelines for Commonly Overused Procedures	Efficiency
Medication Errors	Safety
Diabetes Control	Population/ Public Health
Obesity	Population/ Public Health

The principles AHA members suggested for selecting and using quality measures are:

- Data should be reported in a manner meaningful to consumers so that the public is engaged and understands what the measures signify.
- Outcome measures are most important and preferable to process measures, but must be:
  - crafted carefully to ensure they have appropriate, valid, well-defined numerators and denominators
  - consistent with available science

www.aha.org/advocacy-issues/letter/2015/150105-let-map-qualitymeasures.pdf

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IOM 15 Core Measures

- IOM, now called the National Academy of Medicine, has proposed 15 core measures
- These represent the most vital signs for tracking progress toward improved health in the US
- These include: Life expectancy, Well-being, Overweight and obesity, Addictive behavior, Unintended pregnancy, Healthy communities, Preventive services, Care access, Patient safety, Evidence-based care, Care match with patient goals, Personal and population spending burden, individual and community engagement

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IOM 15 Core Measures

- Report is called Vital Signs: Core Metrics for Health and Health Care Progress
- We need to measure the most crucial health outcomes in order to improve health
- These core measures are intended to drive progress toward better outcomes
- We need to reduce redundancy and decrease the burden on providers and facilities and calls on HHS to use these to reduce measure reporting to HHS
  - www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx

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Advising the nation • Improving health
ABOUT THE IOM
REPORTS
ACTIVITIES
MEETINGS
BROWSE HISTORY
Report
Print
Vital Signs: Core Metrics for Health and Health Care Progress
Released: April 28, 2015
REPORT AT A GLANCE
Recommendations (PDF)
Infographic (HTML)
Infographic- Print Version (PDF)
Report Brief (PDF)
Download an introductory slide for this report >>
Thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and
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VITAL SIGNS
Core Metrics for Health and Health Care Progress
To achieve better health at lower cost, all stakeholders — including health professionals, payers, policy makers, communities, and members of the public — must focus on what matters most. What are the core measures that will yield the clearest understanding of health and well-being in America? Vital Signs, a 2015 report from the Institute of Medicine, proposes a set of 15 core measures for health and health care. Explore the infographic to see examples for each measure.
LIFE EXPECTANCY
WELL-BEING
OVERWEIGHT & OBESITY
ADDICTIVE BEHAVIOR
UNINTENDED PREGNANCY
HEALTHY COMMUNITIES
PREVENTIVE SERVICES
CARE ACCESS
PATIENT SAFETY
EVIDENCE-BASED CARE
CARE MATCH WITH PATIENT GOALS
PERSONAL SPENDING BURDEN
POPULATION SPENDING BURDEN
INDIVIDUAL ENGAGEMENT
COMMUNITY ENGAGEMENT
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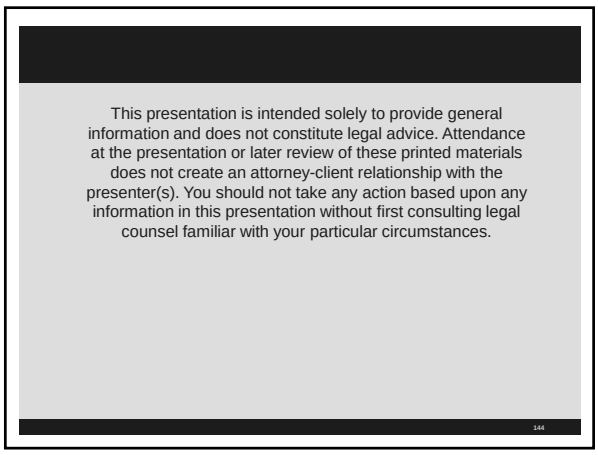
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Thanks for attending! Questions??

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