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INSIDE

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Emergency Preparedness CoP Calls For Review, Upgrading Plans

Hospitals are still moving to comply with the CMS Conditions of Participation (CoP) on emergency preparedness, which became effective in late 2016, and some are finding that the plans they had in place previously are not quite enough to meet the CMS expectations. During 2017, many hospitals will be reviewing and revising their emergency preparedness plans before CMS starts checking for compliance. The final rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers went into effect on November 16, 2016, and healthcare providers and suppliers affected by the rule must comply and implement all regulations by November 16, 2017.

> "...EACH HAS ITS OWN SET OF EMERGENCY PREPAREDNESS REGULATIONS INCORPORATED INTO ITS SET OF CONDITIONS OR REQUIREMENTS FOR CERTIFICATION."

CMS says the purpose of the rule is to "establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems." The requirements apply to all 17 provider and supplier types, and each has its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.

As a CoP, hospitals must be certain they are complying and not assume that pre-existing emergency plans will suffice. The final rule requires hospitals to meet four main standards:

- Based on a risk assessment of hazards likely in a geographic area, develop an emergency plan focusing

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on a full spectrum of potential emergencies or disasters identified for that specific location.

- Support the emergency plan by developing and implementing policies and procedures that address potential risks.
- Develop and maintain a communication plan that complies with federal, state, and local laws, across healthcare providers, working with public health departments and emergency management agencies.
- Develop initial training and testing programs, maintain the programs with at least annual trainings, and conduct drills and exercises or participate in an actual incident that tests the emergency plan.

One of the more significant requirements — and one that could be a challenge for some facilities — is for hospitals, critical access hospitals, and long-term care facilities to install and maintain emergency and standby power in accordance with CMS standards. CMS softened components of the rule after feedback from providers, removing the demand for additional hours of generator testing, adding more flexibility for a facility to to choose the type of exercise it conducts in the second year, and allowing a separately certified facility within a healthcare system to participate in an emergency preparedness program for the whole system.

The emergency preparedness Conditions of Participation are available online at: *http://go.cms.gov/2jjHdBO*. The requirements are in line with the The Joint Commission's Emergency Management Standards, which focus on six areas for hospitals to demonstrate they have proper plans and response mechanisms to a disaster. During planned exercises, the organization monitors at least these six critical areas:

- communications, both internal and external to community care partners, state and federal agencies,
- supplies stocked at adequate levels and appropriate to hazard vulnerabilities,
- security that will enable normal hospital operations and protect staff and property,
- staff roles and responsibilities within a standard Hospital Incident Command Structure,
- utilities that enable self-sufficiency for as long as possible, with a goal of 96 hours, and
- clinical activity plans for maintaining care, supporting vulnerable populations, and using alternate standards of care.

Waste No Time Complying

Hospitals should address the four core elements of the CoP immediately, says **Tener Goodwin Veenema**, PHD, MPH, RN, FAAN, an associate professor at the Johns Hopkins School of Nursing in Baltimore. Veenema has served as senior consultant to the U.S. government for emergency preparedness, including work with the departments of Health and Human Services, Homeland Security, Veterans Affairs, the Administration for Children and Families, and, most recently, the Federal Emergency Management Agency. Many hospitals, especially larger facilities and academic teaching hospitals, will find that they at least have a good start with complying, but others may find that the remaining eight months isn't much time if they don't already have a good emergency preparedness plan, she says.

"The challenge is going to be for many of the smaller healthcare facilities that haven't had the resources, the manpower, or the funds to

address emergency preparedness in a meaningful way up to this point," she says. "Chances are good that a healthcare facility already has some elements of this emergency preparedness rule in place. From there, you need to line that up with the four core elements of this rule and look for the gaps."

Veenema says she supports the CMS effort to improve national preparedness, and the recognition that natural and man-made disasters threaten the ability of organizations and staff to maintain continuity of patient care services. The healthcare community has learned from recent disasters that facilities need more robust planning, she says, citing the 2012 experience of NYU Langone Medical Center during Hurricane Sandy in New York City. The hospital lost power and basements filled with water, destroying critical utilities and communications equipment. The hospital evacuated more than 300 patients, without the use of elevators.

NYU Langone has since modified its emergency plans and infrastructure. In addition to moving critical equipment out of the basement, the hospital installed a 12-foot-high steel storm barrier, altered drains and sewage lines to stop water backflow when streets flood, and installed steel doors in critical locations to hold back flood water.

"These healthcare facilities are really at risk of disruption in services from these types of events and there is a lot we can do to anticipate what damage might be done and to prevent or mitigate that damage," Veenema says. "That's why we need to encourage hospital administrators to plan for and finance these efforts proactively, as opposed to waiting until disaster or emergency occurs. We know that it costs far less to harden a facility prior to a disaster than the cost of rebuilding after."

The first step for healthcare administrators is to understand the CMS CoP and the four main components, ensuring that all facets are incorporated into the emergency preparedness plan, Veenema says. She urges hospital leaders to pay special attention to the requirement for continuous and effective communication, which could be hindered in many emergencies and which could be the specific target of attacks.

"Last year, we saw a dramatic increase in cyberattacks on healthcare facilities, and there's no reason to think that won't continue," she says. "The cyberattacks themselves can constitute an emergency if they threaten patient safety or disrupt communication, but they also can come in

Tailor Emergency Plan To Real Threats

Emergency planning for a healthcare facility must be tailored to the specific threats and concerns in your own area, notes **Michael Anderson**, director at IXP Corporation, a company in Princeton, NJ, that assists hospitals with emergency planning. A plan that is effective for a hospital in New York City may not be right for a hospital in northern California.

"The foundation of a plan is identifying what the realistic risks are for your facility," he says. "That changes, sometimes quite a bit, depending on where you are in the country. Hazards on the East Coast are different from hazards in the Midwest, and both are different from California's risk of wildfires. Even within those communities, hazards will be different depending on your exact location, the nature of your facility, and the people you serve, all sorts of factors."

Each realistic hazard must be assessed for what kind of effect it will have on the facility's operations, Anderson says. In what ways will it impair the hospital's ability to continue caring for patients, and how severely? What would be your response, and how would the severity of the situation change that response?

"It's important to include in this assessment the effect that that emergency will have on your community, not just the direct effect on your facility," Anderson says. "What sort of services would be disrupted? Will critical supply deliveries be interrupted? If the morning bread delivery doesn't show up, you probably can deal with that. But if utilities are compromised, or travel is impossible for your medical professionals, that could have a real impact on your operations."

Coordination with local emergency management leaders also is crucial, Anderson says.

"You're really in a bad spot when something happens and you're meeting the local emergency manager for the first time, or you two don't have a good working relationship," he says. "It's important to understand each other's capabilities and how to best work together for the best result at your facility. That's not something you want to try to work out in the middle of a crisis." ■

SOURCE

1. **Michael Anderson**, Director, IXP Corporation, Princeton, NJ. Telephone: (609) 759-5100.

addition to a natural or man-made disaster. Healthcare facilities should anticipate and plan for those scenarios."

Veenema notes that the rule requires communication to be well coordinated within the facility, with other healthcare providers, state and local public health departments, and state emergency management agencies. *(See the story in this issue for more on communication strategies.)*

"This heightened rule for communications recognizes that large-scale disaster events and public health emergencies, like a flu pandemic, will mobilize all members of the community. Not only the hospitals, but community clinics, physician offices, schools, businesses," she says. "It's going to involve everyone in the community, so communication will be a critical component of your emergency response."

A good plan also will include extensive training for staff, along with testing and drills to reinforce the training while also looking for areas needing improvement, she says. Veenema notes that CMS included a significant amount of resources on its website for complying with the rule.

Hospital leaders can underestimate the need to focus on staff in emergency preparedness plans, Veenema cautions. Their need for preparation can be overlooked, she says.

"The one thing that, in my experience, hospitals never pay enough attention to is their most important asset, the people who come to work every day," Veenema says. "A lot of national, state, and local emergency preparedness plans are founded on the assumption that healthcare professionals will know their roles and will know what to do during a disaster event. Studies have shown over and over that many providers do not possess the knowledge base required to be effective in these large-scale events that produce a surge in people needing care. It is critical for healthcare administrators to pay attention to education and training for their staff."

Conduct a Risk Assessment

Others agree that some providers will be challenged to comply with the emergency preparedness CoP by the deadline. **Timothy J. Fry**, JD, an attorney with the law firm of McGuire Woods in Chicago, says hospitals should waste no time between now and the November deadline.

"To stay compliant, providers need to conduct a risk assessment, create and incorporate policies and procedures based on this risk assessment, develop a communication plan, and conduct training and testing to ensure the adequacy of the emergency preparedness program while maintaining documentation of the same for survey purposes," Fry says. "Starting now is key."

Hospitals, along with other inpatient provider types, may find the additional compliance burden of emergency fuel and generator testing to be particularly difficult and expensive, Fry says. Providing alternate sources of energy to maintain things like emergency lighting and fire detection in the face of an emergency also require revision of current facilities management, he says.

Overall, however, the requirement should not be entirely new for most healthcare facilities, because any well-managed facility has some type of emergency preparedness plan, Fry notes. That doesn't mean the existing plan is sufficient, but it should at least provide a good start, he says.

"Many hospitals are already largely complying. For example, TJC requires an emergency operations plan and annual emergency training programs," Fry says. "For such accredited hospitals, some review and updating may be necessary, but this can be accomplished through their annual review process. The rule's burden falls much greater on hospitals without existing plans."

Need Broad Community Connections

Even for facilities with good existing plans, there may be parts of the CMS requirement that are more likely to be missing.

"Certain aspects may be new, like the involvement of community providers or a wider consideration of potential emergencies, but many hospitals will find this fits with their emergency plans," Fry says. "For those

with existing plans, hospitals should make sure the scope does not involve the community only at certain locations or portions of their facility. The CMS rule will apply community considerations more broadly than past accreditation standards."

The requirement for community-wide training may be the most challenging for many hospitals, says **Hilary S. Blackwood**, JD, also an attorney with McGuire Woods in Charlotte, NC. The community-based training is meant to simulate an anticipated response to an emergency involving actual operations and the community, and the practical considerations of making that happen could be daunting.

"Aside from the initial heavy lift of properly coordinating and conducting a risk assessment, the execution of the community-wide training seems likely to pose a challenge for many providers," she says. "One of the two required trainings in most cases needs to be a full-scale exercise that is community-based. Some facilities may need to coordinate across state lines."

Healthcare administrators can begin addressing that by first determining what the community already is doing for emergency preparedness and look for ways to get involved, Fry says.

For example, administrators might look into participating in a regional coalition's work, or assisting with county health departments' tests. Providers will need to consider how an emergency will affect the entire community. "In some regions, efforts already underway will fulfill the hospital's obligations," Fry says, "In other communities, an opportunity to partner with other providers in a new way by leading may be available."

The emergency preparedness plan should be updated at least annually because factors affecting the plan often change, Veenema says.

Don't Forget HIPAA

HIPAA must be factored into emergency plans, Fry notes.

"Hospitals should remember HIPAA continues to apply when crafting their communication plans. Under HIPAA, hospitals can share information with other providers for treatment purposes and the patient's location, general condition, or death with a patient's family, but in an emergency, hospitals can also alert aid organizations like the Red Cross to coordinate family notification, and the media in certain circumstances," he says. "Like always, hospitals should consider what is minimally necessary to accomplish the goal, and if possible, ask the patient before disclosing."

Blackwood cautions that complying with the CMS CoP requires more than just developing a slick manual of policies and procedures to put on a shelf.

"Providers cannot simply set policies and procedures, a communication plan, and conduct trainings and then forget it," she says. "Rather, CMS expects an iterative process with annual reviews and updates informed by experiences and training exercises." ■

SOURCES

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2. **Timothy J. Fry**, JD, McGuire Woods, Chicago. Telephone: (312) 750-8659. Email: tfry@mcguirewoods.com.
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Use Multiple Strategies For Emergency Communication

Compliance with the requirement for good communication in the CMS Condition of Participation (CoP) on emergency preparedness should focus on getting information to everyone involved so that no employee is left without information in a crisis, says **Brian Cruver**, CEO of AlertMedia, a company in Austin, TX, that aids with emergency preparedness. In most hospitals, that will require using several different methods of communication, he says.

"Every second counts in these situations. If you can get people evacuated sooner, or let them know of a particular hazard right away, that can make a difference," he says. "Good communication also includes the people outside your facility, the people who need to respond and

provide help, so they get the information they need in the most effective, dependable way. Cutting that time down from 15 minutes to 15 seconds can have an enormous impact."

For communicating within the hospital campus, the options include the hospital's public address system, particularly useful for an emergency in which everyone in the facility needs to hear important information, such as in the event of a mass evacuation or a shelter in place order, Cruver says. Text messaging through mobile phones, notebooks, and pads also should be included, but Cruver cautions that in healthcare settings, those devices often are not with the employee or immediately accessible.

Desktop computers and landline phones can be included because healthcare staff and physicians often are near a nursing station or other area with those devices, Cruver says. Walkie-talkies also should be incorporated into the plan, he says. Not every staff member will need walkie-talkies, but their use should be expanded beyond security personnel to include custodial and maintenance workers, and others who can aid with directing other employees and communicating back to hospital leaders about conditions in the facility.

Even old-fashioned pagers have a role in emergency communication, Cruver says. Hospitals are probably the last workplace where pagers still are used regularly, and they are reliable even in a power outage, he notes.

Software platforms can integrate those different methods so that a message goes to all the different devices at once, Cruver says.

"One of the biggest problems people make is not keeping contact information up to date," Cruver says. "The best communication system won't work correctly if it has old contact information for former employees or employees who work in different capacity now, or just at a different phone number or email address. The ideal is to have your communications system synced with your master list for contact information, so that it updates automatically." ■

SOURCE

1. **Brian Cruver**, CEO, AlertMedia, Austin, TX. Telephone: (800) 826-0777.

Manage Transition From ED To ICU For Better Quality

ED volumes have risen with expanded coverage through the Affordable Care Act and are likely to remain high, putting more pressure on hospitals for an efficient process for transitioning patients from the ED to the ICU. Tracking key metrics is a first step in improving that transition process, which includes ensuring that patients are not unnecessarily admitted to the costly ICU, where few guidelines exist to establish protocols for ICU admissions and their transition of care.

There are three common scenarios that lead to inappropriate admissions to ICU from the ED, says **Joshua Johnson**, a healthcare consultant with Novia Strategies in Powey, CA. In the first, physicians are unaware that they are over-admitting to the ICU because they do not receive data on a regular basis that help them understand how well they are managing patients from the ED, he says.

"If a hospital is admitting 25% to 30% of its ED patients to the ICU, that starts to become a red flag when the national average is around 20%," Johnson says. "But if the physicians don't have that information, there is no way for them to know they have a problem. Many organizations have protocols for admissions, which is a good start, but if you don't have the data on the back end you're missing the value of those protocols. It's like having a posted speed limit, but no speedometer in your vehicle to know how you're doing."

In the second scenario, physicians know they are over-admitting, but continue because they see an ICU admission as the only way to be sure the patient will get the proper care, Johnson says. He recalls working with a hospital system recently that struggled with over-admitting to the ICU, and when the data were presented to ED physicians, they said they were not surprised but felt their actions were necessary.

"They shared with us that part of the reason behind pushing patients into the ICU was that if they didn't, they couldn't be sure when that patient would be seen by an attending physician," he explains. "There was a real concern that if they put that patient on a med-surg unit they might not be seen for a day or two, and they were concerned that wouldn't meet the needs for that patient."

The hospital addressed the issue by working with hospitalist physicians to ensure more prompt attention on the med-surg unit, and by improving the lines of communication between the

ED physicians and hospitalists. This mistrust sometimes can be identified through the overuse of condition code 44, the term applied when a Medicare patient is admitted to a hospital as an inpatient, but is changed to observation if the hospital determines the services did not meet inpatient criteria.

ED Focused on Throughput

The third scenario involves how hospitals incentivize ED physicians. There has been more emphasis in recent years on moving patients through the ED quickly, reducing the door-to-doctor times and ED stays to a minimum, he notes. Hospitals incentivized ED physicians and staff to reach those goals, aimed at improving patient satisfaction and decompressing the ED. Those were proper goals, but the improvements in ED throughput often come at the cost of other areas in the hospital, Johnson says.

He recalls one hospital where the ED physicians paid very close attention to their ED metrics, monitoring scorecards and times, meeting monthly to review the metrics and strategize ways to improve their performance. But the result was that there was a strong motivation to push people into inpatient status to bring down their ED throughput times.

"If I'm an ED physician and I want to keep my metrics looking good but not compromise the care of the patient, there's an incentive for me to push that patient to a floor rather than holding him in the ED a while longer, after which he might be able to go home," Johnson says. "The patient still receives proper care, but he's someone else's problem in terms of metrics."

Hold Physicians Accountable

Case management also should be a strong component in the ED, helping patients use the proper resources outside the ED rather than returning for things like prescription refills, Johnson says.

While data and metrics are key to improving transitions from the ED to the ICU, Johnson cautions that it is not enough to simply dump information on ED physicians and wait for improvement. The information won't improve anything unless the ED physicians understand how to use it and accept that they are not being punished, Johnson says. Expect a learning curve.

"It's always critical that there is an opportunity for them to learn, so they understand. If you simply take them a scorecard and beat them over the head with data, you're going to face a lot of resistance," he says. "You have to acknowledge that physicians in most cases really are trying to make the best decisions for their patients, and use the data to help them understand when some decisions are not what's best for the patient."

For instance, ED physicians sometimes place patients in the ICU because they perceive that unit as offering a high level of care and attentiveness from physicians and nurses. What they often overlook is that the patient is now on a care trajectory that is going to require more days for the patient to move through the ICU and transition to med-surg or another step-down unit before ultimately being discharged, Johnson says. The ICU becomes an unnecessary detour that subjects the patient to risk of infection, loss of muscle mass, and other damage.

Data also must be shared regularly with ED physicians to create a sense of accountability, Johnson says.

"If I show them their transition metrics one time and it's not good, they'll say sure, they're going to change their ways and fix it. There is very little chance that they actually will," Johnson says. "But if they know that I'm coming back to show them that exact same metric every month at their physician staff meeting, and their performance is going to continue to be measured on ICU admissions, they're going to hold themselves and each other much more accountable for maintaining that improvement." ■

SOURCE

1. **Josh Johnson**, Consultant, Novia Strategies, Powey, CA. Telephone: (858) 486-6030.
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Hospitals Do Not Know Own Outcomes

Hospitals depend so much on outcomes data to determine quality, but one researcher says most hospital don't even know their outcomes. That leads them to make critical decisions based on faulty information, says **Donald Fry**, MD, executive vice president for clinical outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg

School of Medicine.

Fry's conclusion is an outgrowth of his recent research in the *Journal of Bone & Joint Surgery*, in which he found that risk-adjusted complication and readmission rates vary widely between hospitals where joint replacement surgery is performed. In addition, patients are twice as likely to suffer an adverse outcome after they are discharged than while they are still in the hospital. *(For more on the study, see the story in this issue.)*

Fry says the study results confirmed his belief that hospitals often don't know their own outcomes. In too many cases, he says, neither the hospital nor the surgeons know about deaths after discharge or readmissions to another hospital. In his recent research, inpatient major complications of care and deaths represented less than 50% of the adverse outcomes occurring across the entire continuum of care, Fry notes.

"The spectrum for adverse outcomes has to extend into the postoperative period. The era of ever-declining lengths of stay means that more complications of care are not recognized or declared until the patient is in the post-discharge period," he says. "Hospitals have very limited knowledge, if any, about 90-day post-discharge deaths that are not readmitted."

Hospitals could gain a better idea of true outcomes with a database holding encrypted patient identifiers so individuals could be followed after discharge for admissions to other hospitals, and for deaths, Fry suggests. If a state database is not possible, the problem might be addressed with a system in which hospitals in a community communicate with one another when patients are admitted to one facility after being treated in another, he suggests.

Medicare's move toward bundled payments makes it imperative for hospitals to obtain accurate outcomes data, he says.

"Hospitals have to know the results of their care because the hospitals and clinicians under bundled payments will sustain substantial financial penalties when their patients have excessive rates of readmission to the hospital," Fry says. "You can't fix a problem if you don't even know that it is happening."

Hospitals can unfairly benefit from the lack of true outcomes data, Fry notes, though it is not intentional. By not including some post-discharge data, the hospital's quality of care can seem higher than it is, he says.

"They're not being malicious; it's not some sinister plot to avoid the realities of your quality of care," Fry says. "But I do think it's a problem when you declare victory and there's still five minutes left in the first half. That is what exists with our current measurements of inpatient care."

There are multiple reasons that hospitals aren't working with valid outcomes data, says **Alan Cudney**, RN, MBA, a principal healthcare consultant with SAS, a consulting company based in Cary, NC. Lack of analytic maturity is a key reason, along with how data typically are compartmentalized, disorganized, and difficult to access, he says. Many healthcare organizations do not have a strategy for organizing and managing data, or subsequent analytics with that data, he says.

"The process of preparing data for cross-functional analytics is cumbersome and poorly managed, and the culture does not support, empower, and reward data exploration and collaboration to create real improvements in care and service," Cudney says. "There is a lack of appropriate analytic tools and a lack of modern analytic tools that can prepare data for analytics, as well as run complex modeling and queries."

The selection of analytic tools often is based on localized needs and is not aligned with an enterprise strategy, he says. Siloed use of analytic tools makes it more difficult to perform complex analytics across the organization, he says.

"Value-based care is shifting the cost-benefit equation for leaders and clinicians at care delivery organizations. The ability to analyze care and outcomes across the continuum is becoming a capability that is necessary for success and even long-term viability," Cudney says.

Input Good Data

Outcome measures are only as good as the data available to compute them, says **George Dealy**, vice president of healthcare applications at Dimensional Insight, a data analytics company in Burlington, MA. However, with increased adoption of electronic health records (EHRs) and standardization of clinical and quality data, there's more opportunity than ever before to work with measurements that have the potential to help improve care, he says.

In the near term, healthcare providers should be able to refine their approaches and develop the associated competencies, to work with the most useful and reliable measures that exist today, he says. As interoperability of healthcare information continues to improve, additional measures — such as those that require information from multiple health systems — will also become increasingly available and practical. Examples of these measures include those related to readmission rates and complications of care,

which require information from multiple settings of care, potentially across several organizations, he says.

"Government entities are able to help. The example of the difficulty identifying deaths outside of care settings points to the fact that mortality information is not effectively shared as well as it could be," he says. "Both the federal government and state governments track this information closely and could potentially share it, assuming the appropriate level of confidentiality and privacy was adhered to." ■

SOURCES

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2. **George Dealy**, Vice President of Healthcare Applications, Dimensional Insight, Burlington, MA. Telephone: (781) 229-9111.
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High Volume Leads To Better Hip And Knee Outcomes

Larger hospitals and those performing a high number of hip and knee surgeries have significantly lower complication rates and readmissions than other hospitals, per a recent study in *The Journal of Bone & Joint Surgery*.[1]

The study looked at 900,000 surgeries of total hip and total knee replacements and found that hospitals in the top 10% of the lowest rates of complications and readmissions had a 6% percent adverse outcome rate. Hospitals in the bottom 10% had an adverse outcome rate of 20%.

Patients overall were twice as likely to suffer an adverse outcome after discharge than while they are still in the hospital. Forty percent of the hospital readmissions occurred 31 or more days after discharge. The study was led by **Donald Fry**, MD, executive vice president for clinical outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg School of Medicine, who says the results indicate a need for improvement among the poor-performing hospitals, especially with the new bundled payment reimbursement system for these procedures.

Fry and his colleagues identified these common characteristics of suboptimal hospitals:

- No consideration of early implementation of non-steroidal anti-inflammatory medications.
- Narcotics given as needed (instead of on a schedule) and commonly delayed while patient is experiencing severe pain.
- Narcotics given in the postoperative period with impaired mental function and an increased risk for falls, which may lead to damage of the new total joint, fractures, and even blunt head trauma.
- Sustained narcotic administration increases the risk of pneumonia, constipation, abdominal distention, nausea, and vomiting. ■

REFERENCE

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Compliance Alert: First Timely Notification Ding For HIPAA

Compliance leaders take note: The Department of Health and Human Services, Office for Civil Rights (OCR) is paying more attention to timely notification of HIPAA breaches. OCR's first-ever settlement with a healthcare provider for failing to notify in a timely manner signals a change in expectations.

Presence Health, a network serving Illinois with 150 locations, including 11 hospitals and 27 long-term care and senior living facilities, has agreed to settle with OCR by paying $475,000 and implementing a corrective action plan, OCR announced recently.

This is the first time OCR focused on when the provider reported the problem and made it

the crux of the investigation and settlement. Presence reported a breach to OCR on Jan. 31, 2014 — a breach that it discovered on Oct. 22, 2013. The breach involved paper operating room schedules containing the protected health information (PHI) of 836 people.

OCR's investigation revealed that Presence Health failed to notify, without unreasonable delay and within 60 days of discovering the breach, OCR, each of the 836 individuals affected by the breach, as well as prominent media outlets. Media notification is required for breaches affecting 500 or more individuals. The breach went unreported to the OCR for 101 days, to affected individuals for 104 days, and the media for106 days.

The resolution agreement and corrective action plan are available online at *http://bit.ly/2iX7ZjQ.* ■

CMS Alternative Payment Models Gaining Ground

More than 359,000 clinicians are confirmed to participate in four of CMS's Alternative Payment Models (APMs) in 2017, CMS announced recently.

Reimbursement is tied closely to quality for participants in four APMs: the Medicare Shared Savings Program (Shared Savings Program), Next Generation Accountable Care Organization (ACO) Model, Comprehensive End-Stage Renal Disease (ESRD) Care Model (CEC), and Comprehensive Primary Care Plus (CPC+) Model.

CMS reports that more than 12.3 million Medicare and/or Medicaid beneficiaries are served by 572 ACOs across the Shared Savings Program, Next Generation ACO Model, and CEC Model. There are 131 ACOs in a risk-bearing track, including in the Shared Savings Program, Next Generation ACO Model, and CEC Model, along with 2,893 primary care practices participating in CPC+. ■

AHRQ Offers Safety Toolkit On Ventilated Patients

The Agency for Healthcare Research and Quality (AHRQ) is offering a new toolkit to improve safety for mechanically ventilated patients in ICUs.

AHRQ says ICU staff can use the toolkit to apply the principles and methods of AHRQ's Comprehensive Unit-based Safety Program (CUSP) to reduce complications for patients on ventilators, including ventilator-associated pneumonia, which affects as many as 20% of patients who are on a ventilator for more than 48 hours. The toolkit includes resources used by hospitals that participated in the AHRQ Safety Program for Mechanically Ventilated Patients project.

The toolkit has four modules and other resources to help ICUs uncover local defects, implement interventions to prevent ventilator-associated events, and build a sustainable safety culture. The four modules are How To Apply CUSP for Mechanically Ventilated Patients, Technical Bundles, Ventilator-Associated Events and Outcome Measures, Sustainability, and Other Resources.

The toolkit is available online at *http://bit.ly/2k6ouJL.* ■

$1.3 Million From Big Data QI

A Maryland hospital has gone from losing $1.2 million in quality-based reimbursement in one year to gaining $1.3 million the next year, after implementing a number of quality improvement initiatives using big data.

In the first year after the Maryland Health Services Cost Review Commission (HSCRC) initiated payment adjustments to state hospitals' rates according to their per-

formance on a set of quality indicators, Western Maryland Health System in Cumberland ended up ranked 46th out of 46 hospitals.

With one 205-bed hospital that provides care in a rural area across West Virginia, Pennsylvania, and Maryland, Western Maryland already was struggling and decreased reimbursement would only worsen its situation. Looking for a solution, in 2010 Western Maryland was one of 10 Maryland hospitals that volunteered to participate in a demonstration project called Total Patient Revenue (TPR), a model that provided fixed revenue for all inpatient and outpatient services provided in the hospital.

The goal was to encourage the hospital to provide the most appropriate care in the most appropriate setting, says **Susan Mays**, vice president of Dimensional Insight, a data analytics company in Burlington, MA, that assisted Western Maryland with developing quality improvements by mining its data. *(For more on the use of big data, see "Time to Use Big Data for Quality Improvement,"* HPR*, February 2017, pp.13-17.)*

Western Maryland lost $1.2 million in revenue in 2012 due to its low performance on core measures, patient satisfaction, and potentially preventable conditions, so the hospital launched several initiatives for improvement. The hospital wanted to emphasize value over volume, reduce admissions and readmissions, provide care in the most appropriate location, improve chronic care delivery, reduce variation in quality, and reduce utilization rates in the ED, inpatient department, and ancillary service.

Better use of data was necessary for any of that happen, Mays says, so the hospital adopted software that would allow it to extract data on a continual basis, showing quality performance in real time rather than looking backward. Western Maryland also began tracking potentially preventable conditions, which allowed it to reduce the number of patients who acquired preventable conditions while in the hospital. When a patient was diagnosed with a hospital-acquired condition, clinicians used big data analytics to search for previous patients with the same diagnosis and other similar factors, determining which order sets had worked best on those patients.

"They developed a dashboard of quality indicators for their clinicians and quality leaders, using a series of metrics, and were able to report those metrics on a daily basis instead of the historical method of doing chart reviews, sending them out to a quality organization, and getting them back two months later," Mays says. "This was near real time, bringing all this information to them when the patient presents, giving providers a heads-up and the opportunity impact utilization and outcomes while the patient is in house."

Hospital leaders had known for some time that the data for its daily readmission reports were calculated differently than the data used by the state to determine reimbursement rates, setting the hospital up for unnecessary penalties. To fix that, the hospital's director of quality initiatives manually corrected the data in a spreadsheet, which was time-consuming and inefficient. As part of the quality initiatives, that process was automated to produce more accurate data, Mays says.

Western Maryland also developed a care coordination team responsible for following up on high-utilization patients after discharge, using a call list of patients who met specific criteria for outreach. The hospital discovered discrepancies in discharge information between systems, so it created a discharge discrepancy report that could be used to resolve inconsistencies. Care managers also began reviewing mismatches during morning huddles, Mays says.

"Providing more data integrity and making it possible to reconcile those discrepancies gave the care managers much more ability to make sure people didn't slip through the cracks and not receive the kind of discharge follow-up that keep people from being readmitted," Mays says. "It was an example of how issues with data and data analytics can put a hospital's best efforts in an area like this at a disadvantage if those issues are not addressed."

The hospital also created a discharge clinic that patients could visit to ensure they understood their medications and were taking them appropriately.

Better use of big data helped the hospital lower its readmission rate to 11.72%, below the state average of 13.9%. Western Maryland also went from last place to first place in the state rankings of hospitals based on quality-based reimbursement measures. ■

COMING IN FUTURE MONTHS

- These future months text bullets have the "Future months" Paragraph Style applied.
- A link between workplace violence and MSDs?
- Renewed push for a national safe patient handling standard
- Overcoming barriers to safe patient handling

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CE QUESTIONS

1. **Regarding the CMS Condition of Participation on emergency preparedness, Tener Goodwin Veenema, PHD, MPH, RN, FAAN, recommends paying special attention to which requirement?**

   a. The requirement for continuous and effective communication.
   b. The requirement that a board member be included in planning.
   c. The requirement for a minimum number of participants in the task group.
   d. The requirement for uninterrupted food services.

2. **According to Timothy J. Fry, JD, which is true regarding HIPAA during a disaster or emergency conditions at a hospital?**

   a. HIPAA does not apply until the emergency condition ends.
   b. HIPAA applies exactly as it would apply in non-emergency situations.
   c. HIPAA still applies, but hospitals can also alert aid organizations like the Red Cross and the media in certain circumstances.
   d. HIPAA applies normally throughout the hospital, except for the ED.

3. **According to Josh Johnson, what is one reason ED physicians over-admit patients to ICU?**

   a. They fear patients won't be seen quickly enough or receive proper care on the med-surg unit.
   b. They have been taught that a significant portion of patients from the ED should be going to the ICU.
   c. ICU care is reimbursed at a better rate than general inpatient care.
   d. Med-surg units typically are overloaded more than the ICU.

4. **According research by Donald Fry, MD, inpatient major complications of care and deaths represent how much of the adverse outcomes occurring across the entire continuum of care?**

   a. Less than 25%
   b. Less than 50%
   c. Less than 70%
   d. Less than 85%