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AHC Media

CMS rule raises bar on quality

Pay more attention to readmissions and HAIs

In August, the Centers for Medicare & Medicaid Services (CMS) released the final rule regarding Medicare payment policies and rates for next year. The rule will affect Medicare payments to general acute care hospitals and long-term care hospitals for inpatient stays, but strengthens the Hospital Inpatient Quality Reporting (IQR) Program by placing greater emphasis on preventing health care-associated infections (HAIs) such as central line-associated bloodstream infections *(CLABSI — see related story on CLABSI reduction page 99.)*. It also outlines a Hospital Readmissions Reduction Program (HRRP) that will cut payments to facilities that have "excess" readmissions for patients with myocardial infarction, heart failure, and pneumonia. The methodology used for determining excess readmissions is based on National Quality Forum methodologies: numbers 330 for heart failure, 505 for myocardial infarction, and 506 for pneumonia. *(For sample methodology see box, page 98.)*

For the most part, the rule will emphasize areas of import that quality professionals at the best facilities are already working on, says **Susan Wallace**, MEd, RHIA, CCS, CCDS, director of compliance and inpatient consultant for Administrative Consultant Service, LLC, of Shawnee, OK. But it still requires notice. "With continued expansion of the inpatient quality reporting, value-based purchasing, Medicare spending per beneficiary ratio and the Readmission Reduction Program, we see more and more emphasis on risk adjustment," she says. "While age is certainly a risk-adjustment factor, so are the patient's comorbid conditions. When CMS evaluates claims data for risk adjustment of these measures, it is important to remember that there are very specific guidelines for what can and cannot be reported, and everything has to originate with the physician's documentation."

The way to ensure the kind of accurate documentation that will legitimize severity of illness is to have a clinical documentation improvement (CDI) program. Wallace says a fair number of hospitals have yet to create one. It entails having clinical professionals review patient records while they are still in the hospital to see if they need to query a physician for clarification so that the record reflects the real severity of the patient's condition.

Wallace says some hospitals are doing this facilitywide, but for many, that would require too much financial and staff resources. "It would be great if they could do this for every patient, but the reality is that it is hard

to find the resources to do that." She adds that such hospitals can use audits to determine the type of patient who might need extra attention to his or her documentation.

Even hospitals that have CDI programs should be evaluating their scope, she says. "In the beginning, many of them focused on accuracy of the MS-DRGs. But in today's environment, it is important to recognize that MS-DRG accuracy is only part of the picture. Many conditions that impact severity of illness may not necessarily impact the MS-DRG." As an example, Wallace cites a patient who has a secondary diagnosis of diabetes. That is not as precise as documenting that the patient has specific diabetic manifestations such as diabetic neuropathy or diabetic nephropathy.

"Official coding guidelines prevent a coder from assuming a relationship between those conditions; it must be documented by the physician. If you do not have a solid CDI program, or are inadequately staffed for comprehensive CDI review, then you are probably underreporting diagnoses and may not get appropriate credit for severity of illness," Wallace says.

At the very least, hospitals should be monitoring what is going on at the NQF, since measures it endorses are on the CMS radar for future inclusion in the IQR program, Wallace notes. "We also see

Sample Excess Readmission Measurement

Source: National Quality Forum

•Methodology for Heart Failure
Number 0330

Numerator

Outcome: 30-day all-cause readmissions for patients discharged from the hospital with a principal diagnosis of heart failure, as measured from the date of discharge of the index heart failure admission

Denominator

Included population: Index admissions for Medicare fee-for-service beneficiaries age 65 or over admitted to the hospital with a principal ICD-9-CM discharge diagnosis of heart failure and discharged alive

Exclusions

Age <65

In-hospital deaths

Incomplete data (without FFS Part A, without 12-mo enrollment prior to discharge, without 1 month enrollment post discharge)

Transfers out

Additional HF admissions within 30 days

• Complete methodology, including risk adjustment variables, is available at http://www.qualityforum.org/Measures_List.aspx#k=0330&e=1&st=&sd=&s=n&so=a&p=1&mt=&cs= ■

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an increasing correlation between CMS measures, HAIs and the CDC's National Healthcare Safety Network initiatives." That means being aware of issues like CLABSI, catheter-associated urinary tract infections, ventilator-associated pneumonia — not just the infection control staff, but all physicians, coders, and anyone working on CDI, too.

Wallace adds that at the start of next year, CAUTI becomes an abstracted measure for the IQR, and hospitals will have to provide more detailed information on cases. "The HAI measures are risk-adjusted, so even when they occur, hospitals should assure that the patient's risk of developing the condition was appropriately recognized with physician documentation of the patient's comorbid conditions."

For the readmissions portion of the final rule, Wallace says that it is "important for hospitals to evaluate physician documentation and reporting practices to assure these conditions are being appropriately sequenced as the principal diagnosis. CDI programs can help by identifying those conditions early in the patient's stay and querying the physician for clarification if there is any ambiguity regarding the correct principal diagnosis. If heart failure was not truly the reason for the patient's admission, the case should not be included in the heart failure measure."

One other item of note from the final rule: Hospitals will have a $1.13 billion, 1.1% increase in payments for 2012 compared to 2011.

The full rule is available on line at http://www.ofr.gov/OFRUpload/OFRData/2011-19719_PI.pdf.

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CLABSI reduction projects with a twist

Improved education leads to dramatic results

There have been nearly 200 studies about central line-associated bloodstream infections (CLABSI) published since the start of 2011. Many of them talk about similar methods for reducing infection rates — using kits and bundles, putting up posters to remind providers of protocols and pathways, or giving clinicians pocket reminder cards. But with an increased emphasis on hospital-acquired infections evident in Medicare rules (see related cover story), finding novel approaches to reduce infections like CLABSI has taken on new urgency. Two recent efforts have shown new ways to achieve spectacular effects — in one case leading to nearly six months without a single CLABSI case.

At the University of Maryland Medical Center, the 19-bed surgical intensive care unit (SICU) had a troubling rate of CLABSI. While the national benchmark was 2.7 per 1,000 central line days, in 2010, the unit had 5.5 per 1,000 line days. The goal was to reach 2.3 for the 2011 fiscal year.

To do this, the team decided to use an infection control nurse (ICN) five days a week to assist with insertion and removal of central lines, provide education to staff, and audit practices such as hand hygiene, contact isolation precautions, and dressing surveillance. The facility chose ICN bedside nurses who were considered leaders and would help empower the nursing staff as a whole to stop insertions or removals that were considered aseptic or in breach of any part of best practices. They, in turn, were trained by infection control practitioners on how to ensure those best practices were followed.

When the effort was instituted in July 2010, an ICN was expected to be present at every central line insertion, get blood cultures from peripheral veins rather than from central lines, check dressings daily, and make sure that central lines were removed and replaced within 24 hours of admission to the SICU. The ICN was also responsible for enforcing a zero-tolerance policy for breaches in hand hygiene and isolation precautions, and that needleless access ports were scrubbed for 15 seconds with 70% alcohol prior to use. All nurses on the unit received training, watched a video, and completed the post-assessment quiz.

The results were better than anyone expected: For 25 weeks, there were no central-line infections. Since that streak was broken, another streak of 15 weeks without infection has developed.

Cindy Rew, RN, nurse manager for the SICU, says people became very invested in the run without infections. People talked about it in the halls, asked about it over lunch, and when the streak hit 20 weeks, there was a facilitywide celebration attended by the hospital CEO and chief medical officer.

"Before we did this, we were using the bundles, but with very sick, very complex patients, it was not enough," Rew says. "We weren't going to sit

back and accept this, though." Education to ensure everyone did the same thing, the same way, using simulators, helped to bridge the gap. "Everyone learned something," Rew says.

Giving nurses an education in proper central line insertion techniques was another key to the success, she says. Knowing what was supposed to be done meant they could speak up if they saw something that was outside the protocols.

Rew also credits the assistance and leadership of her colleague **Michael Anne Preas**, RN, the infection control professional who developed many of the strategies. Preas was in charge of a lot of the education at the facility, and presented the results at a conference of the Association of Professionals in Infection Control.

At the conference, she outlined some of the savings achieved by reducing the infection rate, estimated at more than a quarter of a million dollars over six months, or more than $200,000 after taking into account the cost of the infection control nurse.

Rew says she and Preas both knew that something had changed when that streak of 25 infection-free weeks broke. "Everyone wanted to know who the patient was and what happened," says Rew. "Everyone wanted to know how it happened so that we could make sure it wouldn't happen again. Before, another infection wouldn't mean anything to anyone. It would have passed by unnoticed. Now that's changed."

Next up is an initiative on catheter-associated urinary tract infections (CAUTI). Preas says she wouldn't be surprised to see that rates for that and other infections are already on the decline. Hand hygiene is up at the facility overall, and other organizations have seen a carry-over effect from one infection control project to another. "The best practices we implemented for CLABSI will easily transfer to CAUTI and other efforts," says Preas.

VA rolls out CLABSI reduction project

In the *British Medical Journal*'s Quality and Safety publication in August, a U.S. Department of Veteran's Affairs (VA) project on CLABSI reduction used the requisite bundles, but focused on education and spreading the word in a manner appropriate to each VA facility[1]. The result was a decline from 3.8 CLABSI infections per 1,000 line days to 1.8 per 1,000 line days.

Marta Render, MD, one of the researchers on the project, said the focus had to be on learning because the VA is a "gargantuan system. We had to think about how to get learning out to people who needed it. We did not want to have to push this out to everyone, but have them pull it in."

The project focused on projecting a need — which encourages people to want to help — and encouraging them to find what works for them to achieve the shared end goal, says Render. Many facilities had some or all of what they needed in place; others needed to get better at data collection. Some needed help in creating a team in the ICU. In each case, Render and her team were there to coach and talk them through strategies. But what they did in the end was specific to their own needs and their own facilities.

To spread the knowledge, they developed web-based tools and kits, including the critical development of the daily goal sheet. "It is a great tool that changed the way we work together," Render says.

If a patient was on pressors and the physician wanted that patient off, the sheet would include goals that led to that end — pushing two liters of fluid but not more. The physician knows to go back and check that goal sheet and ask how the patient is doing and reevaluate the goal if necessary. "The nurses will keep track, and we create the expectation that certain things will happen. We give people permission to speak up if something doesn't seem right. Even the residents know what the expectation is."

Once implemented and data collection started, Render and the team worked with outliers, conducting structured interviews and setting achievable goals — find a team leader in the next week, check the data the next day. Then the team would follow up on those goals, finding out what went wrong if the goal was not achieved and suggesting potential solutions.

Render thinks that building buzz around the topic also helped. They would print and leave around the ICU scholarly papers about CLABSI reduction. The physicians would inevitably pick them up and read them.

She also says that concentrating on getting a single champion on board helped many facilities get great results. The team leader would take one amenable physician and do training with him or her, then another. It made the process seem exclusive and special. "Pretty soon people would clamor for the training."

The results were initially rolled out in ICUs, but have since been spread to other inpatient units and VA community living centers. CAUTI and ventilator-associated pneumonia are next on the list.

For more information on this topic, contact:

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• *Marta Render, MD, Cincinnati VA Medical Center, Cincinnati, OH. Marta.render@va.gov.*

Reference:

1. Render ML, Hasselbeck R, Freyberg RW. Reduction of central line infections in Veterans Administration in tensive care units: an observational cohort using a central infrastructure to support learning and improvement. *BMJ Qual Saf* 2011: 20:725-732. ■

Accreditation field report

Two Baptist facilities win Gold Seal status

Three years ago, when Baptist Hospital in Pensacola, FL, had its Joint Commission survey, the 392-bed facility did not have a great result. According to **Wanda Kaye Tillery**, BSN, MBA, vice president of quality and patient safety for Baptist Health Care and its four acute care hospitals — including Baptist Hospital — it was a big come-down from a few years earlier, when the facility won the Malcolm Baldrige award for its high quality of care. The health plan and its leadership were determined that the next survey, which took place in June 2011, would be better. They just did not think it would be so much better that Baptist and its 167-bed sister hospital Gulf Breeze — which was surveyed a month before Baptist — would achieve Gold Seal status, indicating that it met all quality standards immediately, without having to make any significant corrections.

"There was no vice president of quality three years ago, and there was not a lot of focus on patient safety at the time," Tillery says. "I was hired a year later to put an emphasis on safety and quality, and I did that from the start." First, she hired some consultants to do an assessment. They validated what the hospital had heard from Joint Commission surveyors and its Strategic Surveillance System report, as well as recent Oryx measures. "We knew some of the systemic issues we had to address early on," she says. For example, documentation was a problem, without strict discipline or adherence for inappropriate time outs or abbreviations. And with a 60-year-old building, there were considerable safety vulnerabilities.

The latter issue led Tillery to hire a safety consultant specifically to address the problems the building had. After that, there were 18 months to get ready for the next survey. "I was behind from the minute I walked in the door and I knew it," she recalls. But she had some things that were in her favor. First and foremost, her peers and superiors knew she was behind, understood that there were vulnerabilities, were unhappy with the results of the previous survey, and knew that they needed her to lead the charge to prepare for the next one. "It was a tall order to get ready and they knew it. It would have been harder if I had to do a lot of convincing."

While money doesn't grow on trees in the Florida panhandle, Baptist Health was willing to spend money to improve quality and safety. "They were willing to let me hire the consultants and make the plant modifications that were necessary," Tillery says. "Most of our electrical system was 60 years old. There were panels in the ceilings that couldn't be covered that all had to be stripped out. We had a behavioral health unit that was not purpose built whose plumbing had to be completely pulled out and replaced. Two whole wings needed to be replaced just because of ceiling issues."

Another factor in her favor was the understanding that they were doing this not for some vague reason like "standards," but for the safety and health of patients and staff. "The environment in Florida isn't always kind to buildings," she says. "The buildings were a real concern. It made it easier for everyone to get behind."

As difficult as the building situation was, so was the documentation on life safety issues. Code books, manuals, plans — it all had to be created or recreated. A consultant helped with that, and money had to be spent to get it done.

If time was not on her side, the culture was. "When we won the Baldrige award and won Press Ganey awards for patient satisfaction, it reinforced our culture of just getting it done and doing it together. There is a high level of engagement among the staff." Getting ready for the survey required all hands on deck, and those hands came willingly. "Once we communicated the issues and the solutions, there were no questions. People just buckled down and did it. I did not have to resort to begging or pleading or threats. Every single

person wanted us to do well. They knew this was about creating patient-centered care, and that is everyone's quest here."

Medical staff were happy to pitch in, too. As long as they knew the rationale behind an initiative, they were happy to help. Often, they came up with their own suggestions — tools, order sets, forms, or stamps that would prompt them to create the best documentation they could.

For instance, the time-out issue resulted in conversations between surgical staff — not about major issues, but nuances, says Tillery, such as whether to start over when any other team member comes in the room. "The issue isn't about not wanting to do a time out or not, but about surgeons and other staff being clear about when it starts or needs to restart."

Medical staff also received more feedback and data on their performance in the run up to the survey. "They used this so that if there was an outlier, they were told and coached for improvement," she notes.

Ch-ch-changes

Tillery says she's participated in Joint Commission surveys for years, and what struck her more this time than any of the other ones she has had is how much more attention the surveyors paid to the compassion and care given to patients, as opposed to focusing solely on the standards. "They knew the standards; they scored by the standards, but rather than rigidly focusing on them, they looked at various situations and circumstances and praised and complimented staff about what they were doing. They talked about how much the compassion staff showed mattered in terms of keeping patients safe." Tillery says surveyors seemed to look more at the bigger picture of healthcare as it is delivered rather than at the minutia of the standards. Again, she emphasizes that the standards and meeting them was vital. But they were noticing other things in addition to adherence to standards.

Tillery thinks this is something that has changed at The Joint Commission itself, not just among the surveyors she dealt with. "I went to a hospital in Mobile [AL] during its survey," she says, noting that she is part of a consulting consortium that supports such visits to increase knowledge among members. "They were different surveyors, but seemed to be doing the same thing: paying attention to standards and conditions of participation, but also the quality of the work they do with patients." Her peers are saying similar things.

An example of what she experienced came from a particular surveyor who asked everyone she talked to, "What would you ask of me for the benefit of the patient? How can I help you take care of your patients better?" Tillery says that she found that kind of question "new, different, and refreshing. I felt like they had the same goals we had, and it reinforced what we tell our staff and employees: that this is all about the patients. It made the survey something other than a test, but reinforcement for our clinicians."

Tillery made sure to tell the surveyors when they left that they had helped further the cause of patient safety by creating a great enthusiasm, particularly among the nurses, for everything they did. "There was no collateral damage here, but collateral benefit, and a benefit we really can't measure."

Being awarded Gold Seal status was a "pleasant surprise," Tillery says. "I'm paid to be a pessimist. There were things we had been working hard on but I was not sure we were there yet." Documentation was one issue she worried about. "We had been looking at data, had a great, tight feedback loop, and we knew what was in our charts. But one doctor on a bad day can make a slip. No one is perfect all the time." There were also concerns in the life safety area, but they had a rigorous surveyor and found just a single ceiling area with uncovered electrical panels that had to be fixed. "They were very complimentary of our plans, documents, and risk assessments. We did a lot of hazard vulnerability analyses and they weren't collecting dust on a shelf. We were actively working to make our plant safe."

The overall feedback both hospitals and their staff got from the survey was positive and consultative, Tillery says. "They were interested in sharing knowledge and teaching us. I had told our board that I wanted The Joint Commission to find us to be a best practice in something that The Joint Commission could take forth and share with others." Tillery is waiting to see if that happens, noting that the surveyors took the ongoing professional practice evaluation and focused professional practice evaluation from the medical staff chapter with them to share with their superiors. She hopes to find it on the Best Practice portal at the Joint Commission website soon.

After a poor showing three years ago, for two hospitals in the system to have full accreditation the instant the surveyors left was a great feeling, Tillery says. More than a just bonus to tout to

potential patients, it is a great thing to share with the staff. "We had an unpleasant survey three years ago, and we had worked very hard to get this far. That immediate gratification and reinforcement meant a lot to all of us. We are a small enough community to know that another system in our area had surveyors leave without that full accreditation. It was great to know that we give quality, safe care."

The surveyors made the announcement of Gold Seal status at a Friday afternoon meeting. Everyone who could show up did. The surveyors provided feedback and again talked about how the compassion for patients and the passion for quality care "exuded" from the staff, Tillery recalls. "We were wowed by what they said. We are still celebrating it."

There is no back to normal. While Tillery says they are "still riding the high," the Monday after the survey is business as usual. "There are always people giving patient care here, and it is nice to have that validation that it is good care. But the to-do list is still there. We haven't stopped our monitoring and our feedback. Maybe the intensity isn't as high, but we still monitor. We still have our meetings of all the committees we had before the survey. You can't stop this."

For more information on this topic contact Wanda Kaye Tillery, BSN, MBA, Vice President of Quality and Patient Safety for Baptist Health Care, Pensacola, FL. Telephone: (850) 434-4011. Email: Wandakaye.tillery@bhcpns.org ■

Florida hospitals link to improve surgical care

ACS program adapted for state use

The Florida Hospital Association (FHA) has partnered with the American College of Surgeons and its National Surgical Quality Improvement Program (NSQIP) to improve the care surgical patients get through increased use of data. The data used will not come from insurance claims, but will be abstracted directly from charts by clinical personnel. The data will also be risk-adjusted and will include evaluations of the patient's status after 30 days.

The Florida effort will be smaller than the national one, which may make it more amenable to cash-strapped hospitals. However, its creators say it will still lead to "actionable quality outcomes information." Rather than the 20 measures in the national program, the state endeavor will focus on four measures:

- surgical-site infection;
- urinary tract infection;
- colorectal surgery outcomes;
- outcomes for elderly surgical patients.

The FHA chose these four data points because they are associated with high morbidity and mortality, and are applicable even to smaller hospitals. The association hopes that if these four outcomes are chosen by the National Quality Forum — the American College of Surgeons has submitted them for endorsement — then Florida hospitals participating in the program will have a leg up in addressing the concerns these measures raise.

The goals of the program include not just getting hospitals to participate — and more than 100 have already signed up — but to reduce complications and save lives of surgical patients by 2013, says FHA president **Bruce Reuben**. The initial group of 61 hospitals has received training and is collecting data. The second group is being organized.

After the data are collected, they will be analyzed by the ACS, says Reuben. Participants can then look at where they stand compared to others, find anomalies, and develop protocols for improvements. "This works the same as the NSQIP program, but allows a broader range of participants in terms of size and scope."

When Reuben came to his position in 2008, the association board was concerned that the talk about geographic disparity in costs and quality would create "a big target on Florida's back. We had higher cost and a perception of lower quality. So we wanted to look at some strategic efforts to change the benchmarks and make it clear that we are as committed to quality and good outcomes as any other state. But what could we do that would have a big positive impact that we could measure, and who is doing something that we could leverage from?"

The NSQIP program came up in conversation, but Reuben says it demanded a lot in terms of time, personnel, and financial commitment. "We wanted a way to help hospitals get into it quicker with lower up-front costs. And we wanted to have a statewide impact."

Focusing on these four areas allows pretty much any hospital with an OR suite to take part. And if you have an OR suite, then chances are, you have

these issues, Reuben says. It did not hurt that there was an increasing emphasis on hospital-acquired infections such as UTIs and SSIs.

The first data should be out at the start of 2012. Efforts to improve that data will take up the second year of the program. Just seeing where you are should be enough to get some facilities to work hard to improve, he says. "For some, just having data helps to eliminate outliers. But there will be other challenges. We will have to figure out best practices. But I think the hospitals will come together as a group to drive that change and create the programs that address the outliers."

Diffused efforts will not create the change the association and its members want, so the participants will be brought together frequently to talk. "The appeal is working together, and I think that the FHA is leading this will help create that collective mentality." Issues of proprietary information likely will drop if everyone understands that it is in no hospital's interest to have issues of geographic disparity and that patient safety is paramount.

This distillation of a national project is something of interest all by itself, Reuben adds, noting that there are other states who are watching this Florida endeavor with interest and considering following its lead.

• *For more information on this topic, contact Bruce Reuben, President, Florida Hospital Association, Tallahassee, FL. Telephone: (850) 222-9800.* ■

Two states put radiology on patient safety radar

PA and MA both push for better efforts

Patient safety organizations in both Pennsylvania and Massachusetts issued alerts over the summer related to patient safety in radiology. Both organizations noted that they had received an increasing number of reports of reportable events that have led to them putting reviews of the issues and strategies for preventing them on their websites and for release in their regular newsletters.

The Pennsylvania Patient Safety Authority released its report in June, noting that in 2009 there were reports of more than 650 events that exposed patients to potential harm. Half were related to the wrong procedure or test, 30% related to the wrong patient, 15% to the wrong side of the patient, and 5% were wrong-site errors. Some were scheduling or order errors, while others showed inadequate procedure variation processes. Most of the errors happened in radiography (45%), followed by computed tomography (CT) scan (18%), mammography (15%), magnetic resonance imaging (MRI) (6%), and ultrasound (5%). The breakdown for the kinds of errors and the type of service was:

Radiography: 93 wrong patient, 104 wrong procedure, 75 wrong side, 24 wrong site

Computed Tomography: 36 wrong patient, 69 wrong procedure, 4 wrong side, 6 wrong site

Mammography: 7 wrong patient, 87 wrong procedure, 4 wrong side, 0 wrong site

MRI: 7 wrong patient, 27 wrong procedure, 5 wrong side, 0 wrong site

Ultrasound: 13 wrong patient, 13 wrong procedure, 6 wrong side, 3 wrong site

Nuclear Medicine: 4 wrong patient, 8 wrong procedure, 0 wrong side, 1 wrong site

Interventional: 3 wrong patient, 8 wrong procedure, 0 wrong side, 0 wrong site

Dexa Scan: 1 wrong patient, 1 wrong procedure, 0 wrong side, 0 wrong site

PET: 1 wrong patient, 0 wrong procedure, 0 wrong side, 0 wrong site

Not specified: 31 wrong patient, 14 wrong procedure, 2 wrong side, 0 wrong site

Minimizing the risk is as simple as using the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery as outlined by The Joint Commission, says the clinical director of the authority, **John Clarke**, MD. While developed for surgery, the protocol can be easily adapted to other areas of medicine. "These protocols, while targeted toward preventing surgery mistakes, can be used to standardize procedures in other areas of care to ensure that patients are accurately identified and procedures correctly scheduled and performed across the board, not just in the operating room," Clarke says. The authority can direct interested parties to assessment tools, sample policies, and teaching modules that can help prevent such mishaps.

For more information about the studies and data regarding radiology services, go to the Advisory article "Applying the Universal Protocol to Improve Patient Safety in Radiology Services" at the Authority's website http://patientsafetyauthority.org/ADVISORIES/

AdvisoryLibrary/2011/jun8%282%29/Pages/63.asp.

Massachusetts released its report in July, noting that there had been some 70 cases reported to the Quality and Patient Safety Division associated with interventional radiology procedures, most of which meet the organization's criteria for reporting Type 4 Events for unexpected patient outcomes. Of those 70 events over the last few years — the report did not specify the timeline — 19 resulted in death, 27 were bleeding complications that happened during or following a procedure, and 12 were bleeding complications following biopsy of the liver, kidney, lung, or breast (7, 2, 2, and one case respectively). There were common themes: liver disease, issues with anticoagulant/anti-platelet medications, or missing information on the patient's clotting status.

Of the bleeding complications, 15 involved disruption of a vessel or organ during the procedure, including three brain bleeds for patients on Alteplase and/or Heparin.

The Massachusetts report, available online at http://www.mass.gov/Eeohhs2/docs/borim/physicians/pca%20notifications/ir_complications.pdf, includes case studies, as well as some suggestions to prevent problems in the future. Among the suggestions:

- Identify patients at risk for bleeding complications and ensure good communication of that information between services.
- Clear information on patient drug protocols that include anti-coagulation, anti-platelet or NSAID use before a procedure.
- Consistent monitoring of vital signs for 24 hours for all patients receiving thrombolytics.
- Use smaller biopsy needles in at-risk patients.
- Consider co-management of interventional radiology patients with anesthesia in the operating room and admitted to the surgical unit. ■

OB/GYN gearing up for QI push?

Federal efforts increase focus on quality

When the American College of Obstetrics and Gynecology released an opinion on preparing for clinical emergencies last April[1], it was part of what one physician thinks is a ramp-up of emphasis on improved patient safety and quality improvement initiatives in the specialty.

"There are a couple of moving pieces that are driving this," says **Eduardo Lara Torre**, MD, residency program director and an associate professor in the department of obstetrics and gynecology at Virginia Tech's Carilion School of Medicine in Roanoake, VA. "The first is that the federal government is moving to pay for performance, which means we need to focus on being much more outcomes-based," he says. That means that specialties that had not yet focused on pathways and protocols are starting to do so as a way to keep patients out of the hospital.

The second issue is related to educational endeavors. The Accreditation Council for Graduate Medical Education (ACGME) is shifting its focus to quality improvement and training physicians to think in terms of QI. Lara Torre says that residents now have to create quality projects during their residency and learn to look at system-based practices to assess how they operate and look for ways to improve both cost-effectiveness and outcomes.

More simulations?

Lastly, Lara Torre believes that liability issues have led to some positive changes as a way to mitigate insurance costs. As one example, in Virginia, they created a simulation program for shoulder dystocia. Every single physician and nurse went through training. It led to a break in insurance rates and also ensured that when it occurs, it is more easily managed. Lara Torre says that he can point to the two cases he had of shoulder dystocia in the last 12 months and know they went more smoothly because he had practice in a simulated event.

Another project using simulations on postpartum hemorrhaging started recently, too. "Everyone goes through these. We all have to be checked out on how we manage it from the first interventions through any surgical intervention, from phone calls to action." While the data have not shown that such efforts work yet, Lara Torre is convinced. In the next six months, a protocol on neonatal emergencies that will involve rescue drills is planned.

The push for more QI and patient safety initiatives may result in more and more simulations, something traditionally done in emergency departments and surgery, as well as obstetrics because it is just not possible to

practice emergencies on real patients. Most of the things that can go wrong in an obstetrics unit are blessedly rare. But that makes knowing what to do when they happen even more important.

In an article introducing a special patient safety and quality issue of the *American Journal of Perinatology*[2], **William Grobman**, MD, MBA, says that many obstetric emergencies are preventable. In an interview, he adds that while there is good QI work being done already, there is certainly more that can be done. "Do we ever know absolutely the best way to do things? No. But simulations provide an organized and systematic approach to safety" that can benefit patients and providers alike.

"How else can we practice," Lara Torre concludes. "Knowing all the steps, and knowing everyone knows them dramatically increased your comfort level in managing the patient."

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2. Grobman WA. Obstetric patient safety: an overview. *Am J Perinatol*. 2011 Aug 4. ■

TJC readies new standard for ORYX measures

Standard puts teeth behind reporting requirement

Most accredited hospitals have been reporting ORYX performance data to the Joint Commission (JC) on a monthly basis since 2002. But beginning on January 1, 2012, the JC is putting teeth behind these measures, requiring an 85% compliance rate on a single composite rate, reflecting all accountability measures, in order to meet accreditation standards.

"This is really the first time the Joint Commission will be implementing a standard directly addressing performance on the reported measures," explains **Stephen Schmaltz**, PhD, the JC's associate director in the Center for Data Management and Analysis, Division for Healthcare Quality Evaluation. The new standard does not apply to critical access hospitals.

Schmaltz emphasizes that how individual hospitals are performing on these measures should not come as any surprise because the JC has been providing regular feedback on their ORYX performance data and how they compare against other hospitals nationally. Further, at the end of this year, the JC will begin providing to hospitals the overall composite measure that they will be judged by, so they will see it before the standard goes into effect, adds Schmaltz.

The composite rate will be calculated using the most recent four quarters of data that is available at the time a hospital is surveyed. "For most organizations we will be looking at the third and fourth quarters of 2010 and the first and second quarters of 2011," stresses **Sharon Sprenger**, RHIA, CPHQ, MPA, senior advisor, Measurement Outreach, Division of Quality Measurement and Research. "But keep in mind that it will be a rolling four quarters going forward, so it may vary a little bit from hospital to hospital depending on when they are surveyed."

The composite measure is derived by taking the sum of all numerator counts of a hospital's accountability measures from all measure sets, and dividing that by the sum of all the denominator counts from the same accountability measures.

Standards will rise

The current accountability measures pertain to care that is provided to patients that have experienced heart attacks, heart failure, and pneumonia. In addition, there are measures related to surgical care and to the care of children with asthma. "We believe that these are the measures that have the greatest positive impact on patient outcomes when hospitals demonstrate improvement," explains Sprenger. "We have come to realize that only certain measures should be used for purposes of public reporting, accreditation, and pay for performance."

Sprenger notes that the JC selected these measures based on four criteria, including:

- strong scientific evidence that compliance results in improved outcomes;
- a close linkage between the process and an outcome;
- ability to accurately assess or measure the process of care;
- the process of care is associated with minimal unintended adverse effects.

In 2010, the JC began to comb through its data to determine which measures met the threshold for being accountability measures, says Sprenger, noting that the accrediting agency began with four measure sets that it has in common with the Centers for Medicare and Medicaid Services (CMS) and one measure set that the JC collects that CMS posts on its Hospital Compare website. "We identified or reviewed 28 measures, 22 of which we felt met the accountability criteria," she says. "Then we identified six measures we labeled as non-accountability measures, which we believe are more suitable for secondary uses."

The non-accountability measures include providing smoking cessation advice to patients with heart attacks, heart failure, and pneumonia; providing antibiotics to patients with pneumonia within six hours of arrival to the hospital; and providing discharge instructions and LVS function assessments to patients with heart failure.

The JC fully intends to add more accountability measures to the mix soon, but these data points will be collected for 12 months before they are calculated in the composite measure. The agency also intends to gradually inch up the compliance standard for accreditation. "We anticipate moving that up to a 90% threshold eventually," says Schmaltz. In 2010, the JC reports that 98% of hospitals met an 80% compliance rate and 92% met a 90% compliance rate.

Share best practices

As of January 1, 2012, hospitals that fail to meet the 85% compliance rate for the accountability measures at the time of their survey will receive a requirement for improvement (RFI) in their accreditation report, and they will have an opportunity to address the problem, explains Sprenger. To assist these organizations and any accredited hospitals that are striving to improve their performance on these measures, the JC

CNE QUESTIONS

9. CMS rules will monitor excess readmissions of
   A. CHF and CLABSI
   B. Pneumonia and CABG patients
   C. CHF, MI, and pneumonia
   D. MI and VAP

10. The longest streak so far for no CLABSI cases at UMMC is
   A. 25 weeks
   B. 15 weeks
   C. 30 weeks
   D. 35 weeks

11. Gold Seal Status for surveys means
   A. You achieved a perfect score
   B. You corrected any deficiencies within 45 days
   C. You improved from your previous survey
   D. You were certified as providing safe quality care immediately

12. FHA's surgical care improvement program will look at which set of criteria?
   A. surgical-site infections, UTI, CLABSI and pneumonia
   B. CAUTI, CLABSI, VAP, and wrong-site surgery
   C. UTI, surgical site infections, outcomes for the elderly and pneumonia
   D. colorectal outcomes, surgical-site infections, UTI and outcomes for the elderly

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

COMING IN FUTURE MONTHS

- Simulations for patient safety
- Tracer tools for JC surveys
- Interventional radiology QI initiatives

launched a "Core Measures Solutions Exchange," an online tool that enables hospitals to share their success stories and offer up strategies that have proven to be effective.

"We are really trying to facilitate dialogue between hospitals so that they can help each other learn," says Sprenger. "They can search for solutions, post comments, rate the usefulness [of a strategy], and note if they think a particular solution is transferable to another organization."

The solutions can be searched by measure so if a hospital is having difficulty with a particular measure, administrators can pull up that measure to see what organizations have done to improve their performance in this area, adds Schmaltz. The online exchange is only available to accredited organizations to review. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■