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AHC Media

Is confidential peer review in jeopardy?

That depends on how you claim privilege

Several legal cases decided in recent months have rendered material discoverable that doctors thought was protected. These cases — in places as varied as New York, New England, and Illinois — have caused some physicians to question whether they should participate in peer review processes if their comments and discussions can end up being used against them in civil litigation.

In a case in Maine last May, a judge said that patients have the right to defend themselves in criminal trials, and they can use materials created during a peer review process if it helps them do so. That case is being appealed. A month earlier, a New York court ruled in a credentialing case that comments during a peer review meeting may be disclosed, and ordered a private review of the notes from the meeting. Other cases went against peer review in places such as Florida — where confidentiality of peer review was largely repealed by state vote — and Massachusetts.

Not all the challenges to confidentiality are upheld. In a case involving Walgreens drug stores in Illinois, courts upheld the dismissal of a suit from a state agency asking three pharmacists to divulge reports on medication errors that they believed were part of the peer review process *(http://www.kattenlaw.com/files/upload/The_Department_of_Financial_and_Professional_Regulation_v_Walgreen_Company.pdf)*. This case was the first that was brought where the defense used provisions of the Patient Safety and Quality Improvement Act and the use of patient safety organizations (PSOs).

The Illinois decision in particular is good because "any erosion of the protection afforded by the privileged nature of peer review will have a detrimental impact on care," says **Kevin Troutman**, chair of the national healthcare practice of Fisher & Phillips, a labor and employment law firm in Houston. "If it chills the doctor's willingness to participate in peer review or their feeling that they can speak freely, then you lose what the peer review process is supposed to be about."

In almost every case where discovery of peer review materials has been allowed, Troutman says mistakes were made by not "carefully prescribing when and how you engage in peer review activity." If it's peer review activity, it must be only peer review activity. Nothing else can be mixed in, he says.

The minutes of meetings should reflect that, Troutman continues, and if there is someone participating in a particular committee meeting who is not involved in peer review and that topic comes up, that person should be asked to leave.

Such cases can occur when peer review reports are channeled up to the executive committee, he adds.

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Editorial Questions

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In addition, forms should be appropriately identified and marked as being solely for peer review, says Troutman, and hospitals should train physicians so that they know never to have casual discussions about peer review cases outside the confines of peer review meetings. If the wrong person hears or finds out about such discussions, the entire work product related to that case could end up being discoverable.

Michael Callahan, a partner at Katten Muchin Rosenman LLP in Chicago, worked for the defendant on the Walgreens case that was decided the first week in June. "Most states have had confidentiality provisions for peer review for some time," he says. "As a general proposition, courts have, with some degree of regularity, supported them as a means to help achieve better care."

Indeed, like Troutman, he thinks that if confidentiality is seriously challenged, then physicians will stop participating. That said, courts generally proceed in a case with the idea that everything is discoverable, including items that a hospital or a physician thinks is protected work product. It is up to the person asserting privilege to prove that it isn't, Callahan says.

According to Callahan, there have been maybe 40 or 50 cases in Illinois where state law governing privilege was a factor. In one case, he recalls, a hospital's department of risk management created an incident report and then presented it to the peer review committee, which prepared its own report. A malpractice suit followed, and while the hospital claimed protection for both the peer review committee report and the one by risk management, the court ruled that you can't take a document you made for one purpose, run it through the peer review committee, and call it privileged. It's discoverable if it wasn't originally created for peer review purposes.

In another case, an anesthesiologist suspected a surgeon was doing surgeries that were unnecessary or upcoded. He brought that to the attention of the chairman of the board, who told the doctor to write up a report. He did. The surgeon was asked to respond. He sued the anesthesiologist for defamation. The anesthesiologist objected, saying he prepared the report at the request of the board chairman and it should be protected. The court said no, the individual is not a committee and the report doesn't count as privileged work product of the committee.

While all state laws governing privileges are different, Callahan says they tend to be very simi-

lar, and the above examples "show how hypertechnical the cases can be. The courts won't stretch. Even if you can argue that the chairman of the board is a designee of the peer review committee, even if that seems obvious to you, you had better make sure you can prove to the court that it's true."

In the end, the general rule is that there are no general rules, he says. There are specific rules, actual parameters that govern what is protected and what isn't. The cases that have happened in the last six months show instances where those parameters weren't followed, or where people tried to stretch them. "Where providers often fail," Callahan says, "is they assume that everything is protected and do not consider the steps that have to be taken to ensure that something is. They don't know the rules."

Look at the issue of profiling reports, Callahan says. These reports include information on physician use of medications, the consultants they use, the average length of stay for their patients, and how their quality of care compares to their peers. Those reports often mark outliers in utilization and quality metrics. "If I serve a subpoena on you for those reports, and it shows that there are the same outliers on quality time and again, and that you did nothing to modify their behavior, it provides a great paper trail for a suit. And it's not confidential because you didn't have a peer review committee ask for those profiling reports to be generated."

Indeed, the rule for hospitals — and the one they should be teaching their physicians — is to assume that nothing is confidential unless you can prove that it is — and not to your peers, but to a judge, because that is the person who will ultimately decide, Callahan says.

Judges don't know from the Patient Safety and Quality Improvement Act, he continues. It states that patient safety organizations (PSOs) don't need to document that something is protected for peer review purposes. "But you still have to convince a judge that the statute applies in this case."

Standing on principle doesn't work, Callahan says. It can be obvious to you and even to your lawyer that something is confidential and the courts can rule against you because you haven't explained why it is peer review. "A lot of people have had to learn that lesson the hard way."

Along with educating your physicians and other committee members on the specifics of your law and adhering to it to the letter, you should be ready to counter the kinds of arguments that people can make to undermine assertions of privilege, Callahan says. "We will get more and more challenges."

Because of this, Callahan says more organizations will start to embrace the PSO protections — like in Florida, where there is no statute protecting confidentiality any more. And PSO protections apply not just to doctors, but to all licensed providers. "The reality is that there are few providers who are taking advantage of PSOs right now. That will change."

So if PSOs offer these protections, should you let it all hang out and figure you are safe from discovery? No way, Callahan says. You need to use the provisions of both your state laws and the Patient Safety and Quality Improvement Act. While now you have the ability to protect even management activities, as well as other patient safety programs and materials from the prying eyes of plaintiffs and their attorneys, "you have to do it the right way," he says.

That means following some basic rules, Callahan says, such as knowing:

- if the information you want to protect is part of the patient safety evaluation system (PSES);
- if it was collected and reported to the PSO, and whether you have documentation that it was;
- that you have a record of all your PSES policies related to documentation;
- if it wasn't reported to the PSO yet, why not and how long has it been held? And is such a delay standard or not in your organization?;
- whether you have used any of the requested information for any other purpose;
- if you report this information as part of some mandatory reporting to state or federal agencies or organizations.

The challenges to peer review product are not over, says Troutman. If anything, he expects they will increase. "Ultimately, though, as medical staffs and hospitals understand what is leading to privilege not being upheld, they will adapt and get better at ensuring that their peer review processes and materials cannot be successfully challenged."

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Leapfrog releases hospital safety scores

No Ds or Fs yet — but too many Cs, group says

In a first-of-its-kind survey, The Leapfrog Group graded more than 2,600 hospitals of all sizes and types in the United States on how they performed in more than two dozen weighted patient safety measures — both process and outcomes.

While there were many A grades, including at small rural facilities and safety net hospitals in inner cities where one might not expect it, there were far too many hospitals getting C grades or no grades at all. Those who didn't receive a letter grade in this iteration may find themselves getting Ds or Fs when the survey is repeated late this year: Low scorers were given a reprieve from getting a nasty mark for the first survey, says **Leah Binder**, president and chief executive officer of the Washington, DC-based organization. In all, about half of the 2,652 hospitals graded received a C or no grade (1,243), while a quarter each earned an A or a B, with slightly more of the former — 729 vs. 679.

While there is a lot of lip-service paid to patient safety, Binder says that progress in patient safety has been "anemic. We need to engage the public in understanding better how important it is to protect themselves when they are in the hospital, and in turn, to put pressure on those hospitals to do better."

The organization had a panel of nine experts determine the best methodology for measuring hospital safety, using publicly reported data. While not all of the hospitals had data for each of the 26 metrics — some were chosen from Leapfrog Group reporting, which is voluntary, Binder notes — it took just 14 metrics to generate a score.

All of the scores were "earned," and are appropriate for the data, she says. But that doesn't mean she wasn't surprised at some results. Cleveland Clinic had a high CLABSI rate, she says, which was one thing that contributed to that august facility getting a C grade. "Even hospitals that have a robust reputation for quality aren't necessarily doing what they have to do to keep patients safe," she says.

Meanwhile, Bellevue Hospital in New York City, Montefiore in the Bronx, and Detroit Receiving Hospital — all serving extremely challenged populations, all safety net hospitals — received As for their safety efforts. "No matter how frail or demographically challenged your patients are, whether you are rural, safety net, or a small community medical center, you can get an A," Binder notes. "The wide range of top-graded hospitals shows that anyone can put patient safety first; you don't have to be an academic medical center."

Binder was quick to note that while press coverage of the report focused on the big-name hospitals like Cleveland Clinic getting a C, the Cleveland Clinic facility in Florida got an A.

While plenty of organizations rate hospitals, Binder says this scoring effort is different because it doesn't just show the top performers, but also the ones who need to improve. "We ourselves have a report that shows the highest achievers," she says. "But it is a good thing to see the range of performance, too."

In the next six months, Binder says the poorest performers will likely be doing some heavy-duty quality improvement: Final grades will be given in November, and after that, the report will happen annually.

For those working in patient safety and quality improvement, Binder suggests looking at your score as a first step (http://hospitalsafetyscore.org/). If you can't find yourselves, it means that Leapfrog didn't have enough data to include you. That might include small facilities in rural areas that don't have ICUs, for example, or organizations that don't participate in Leapfrog surveys or report data to CMS.

After that, look at how other hospitals like yours and those in your area are doing. But don't stop there, she says. "This is a national score, and you might think you are doing well compared to your community, but what if your community isn't doing well compared to the rest of the country? You should know that best performance out there and figure out how to get there."

Go through the list of hospitals, she says. Find the ones most like you that got an A. Then call them, visit them, and ask how they got that grade. "Even if you got an A, you want to continue to look for new ideas so that you can keep that status."

Generally, Binder says, hospitals just don't take enough advantage of the lessons that other hospitals learn. That might mean that the C hospital this round that gets an A in November would be a great facility to call for thoughts — you can bet its quality staff would have learned

some lessons.

Binder thinks that shining a spotlight on patient safety in this way will help those working directly in that area because it promotes making it a high priority and gets the attention of C-suite level executives. If a hospital gets a C, you can bet that management will be caring about how to improve that grade, she says. "It shines a light on safety and helps to set a safety-driven agenda."

She wanted to give a special shout out to nurses who lead quality efforts. "In the score we have a pretty heavily weighted measure on the nursing workforce and nursing leadership," Binder says. "If you have a hospital that has achieved Magnet status, you get more points. Nursing staff as a benefit to patient safety is well known, and they should get credit for what they do."

For more information on this topic, contact Leah Binder, President and CEO, The Leapfrog Group, Washington, DC. Telephone: (202) 292-6713. ■

Measuring safety culture — can it be done?

Determine where culture needs strengthening

Everyone knows that in order to have the kind of hospital that gets an A grade in safety from The Leapfrog Group *(see related story page 76)*, you need to have an organization whose culture values safety. But how do you know that you do? And is there a way you can measure it?

Yes, says **David M. Gaba,** MD, associate dean for immersive and simulation-based learning and director of the Center for Immersive and Simulation-based Learning (CISL) at Stanford University School of Medicine. He recently spoke on the topic at a conference of High Reliability Organizations (HROs) sponsored by The Joint Commission.

People often compare healthcare and its safety efforts to industries such as aviation or nuclear power — industries that have an element of intrinsic hazard, where the kind of culture you have can determine if there are failures or successes, and where failures can cost lives.

"People aren't airplanes, I know, but much of what we do is intrinsically hazardous, and we have regular situations that can harm patients, if not kill them," he says.

That's why people make the comparisons and aim to improve safety records to the reliability level of those kinds of industry. It will never be the same — he uses the analogy that if safety is a clock, then aviation is at four and healthcare is at eight. "We don't need to get to four o'clock, but we do need to change the time."

This emphasis on other industries has a parallel when you try to measure the culture of safety, Gaba notes, because to do so in a way that is even close to accurate, you have to use ethnographic and anthropologic techniques, with embedded observers. "But that's expensive, hard to do on a large scale, and takes a long time."

So what do you do? Forget about measuring the entire culture. To use a weather analogy, you may want to describe the climate in a location in general. But to get there, you need to know what the weather is outside on a day-to-day basis, he says. Using interviews and surveys, you can learn about the way things look on the surface. "It's not very precise, but it can give you a really good handle on things and point you to some of the things you need to study further."

Gaba objects to looking for the easy or cheap way to do something — like measuring safety culture. "We have done easy and cheap stuff and we are still hurting people," he says. "Let's be realistic: There are constraints of both time and money. But we can either look at the same things we've always measured and not change, or do something harder, that's different and can promote change."

His objection to "easy" noted, Gaba says that the kind of study you want to do isn't really very hard, and can help you determine where your culture needs strengthening.

For example, in his research, Gaba and his co-investigators use the same kinds of questions you see in surveys done by organizations such as the Agency for Healthcare Research and Quality (AHRQ). But rather than look at the majority answers — those that might indicate you do something 80% of the time or that 90% of respondents think you have a really responsive organization — look at the minority answers.

"You want to know how big a minority answer needs to be before it makes a difference," he explains. In HROs, at a minority response of 10%, the powers that be get worried. At that level, the H in HRO is jeopardized. For an example of how Gaba has looked at those minority answers

to gauge hospital safety, see his 2003 paper in Quality and Safety in Healthcare, "The culture of safety: results of an organization-wide survey in 15 California hospitals" *(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743680/pdf/v012p00112.pdf)*.

He also mentions a study of naval aviators and health care professionals where the difference in those minority "problematic answers" was considered. For naval aviators, the problematic response rate was 4%. For healthcare professionals, it was around three times that level. That comparison holds for most of the 90 hospitals in the study, and for all work areas. There were a very few that were down near the aviation percentage, and some that were as high as 20% in problematic response rates. "Who those were and what they do differently, we haven't figured out yet," he says.

So knowing your problematic response rate is a start. It might not tell you what's going on, he says, but it can give you an idea of the degree of problem.

Rewarding staff for speaking up

In another study, Gaba looked at senior executives and managers versus ordinary workers. "There is a 5% or so gap between them in how they view the safety culture," he says. Managers and executives think things are better, safer, on average, than the front line staff.

To Gaba, that means that those upper-echelon workers need to get out and about more often and see what really goes on. "If you ask them if they have seen x, y, or z, they say no more often than the staff who do the work. If you ask them if staff takes safety seriously, they say yes more often than other workers. They can't just sit in their offices. They have to get out and look under the rocks."

One way to improve the safety culture once you have an idea of how good it is, he says, is to actually reward people for speaking up and raising "credible safety concerns" even if it turns out they are wrong. If someone says something, it's checked, and it turns out to be nothing, Gaba says people will often grumble about wasted time or effort. But having someone who is willing to speak up regardless of the potential for causing a delay or some work that proves unnecessary in the end is exactly the kind of culture you should strive for. "We need to reward them for that, or next time they might not speak up."

Calls for help are good, and people who are willing to make them are good for the organization, he says. "That's the kind of culture we need to have."

"It's always a struggle to figure out how to measure dedication to safety," says **Roger Paveza**, manager of Illinois-based Assurance Safety Consulting, who has 18 years experience in healthcare. One thing he thinks is helpful is to look first not at the responses of the common employee, but to start with management and executives. "Safety is a management process, not something that other people do," he says.

Consider how management implements policies and procedures, for instance. If they tout their great safety manual but don't do anything to ensure that the great information in that manual is used and flows down the chain to other employees — to every employee — then you have a gap.

Roxanne Osborne, RN, a risk management consultant for healthcare at the company, says you should also ask employees about how they see the involvement of leadership and management in issues of safety. Like Gaba, she says there is valuable information about your safety culture in any gap between what they view as their organization's safety culture and their leadership's role in it and what management says about that subject.

Perception surveys can also serve to open the eyes of management to deficiencies in safety culture. If the scores given by staff are low, says Paveza, leadership may re-evaluate its position, actions, and emphasis on safety.

"Questions about whether staff feels supported, if they feel mistakes are reviewed positively, if they feel comfortable bringing up issues — they are all telling about a safety culture," says Osborne. Measurement is important.

But Gaba emphasizes that you should not just look at the big numbers you get in such a survey, but the small minority proportion, as it can give you information that is just as vital.

For more information on this topic, contact:

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NCQA creates all-cause readmissions measure

First time this measure will be reported

The National Committee for Quality Assurance (NCQA) has created a new measure — now endorsed by the National Quality Forum (NQF) — that will require health plans for the first time to report all readmissions that occur within 30 days of discharge — something that happens to about a fifth of Medicare patients.

"Our vision in doing this is not to create an additional hassle for hospitals," says **Robert Saunders**, assistant vice president of research and analysis. "But we have never asked this in the past. We have never measured readmissions."

It seems strange, particularly given all the emphasis on preventing unplanned readmissions, that this hasn't been measured, he says. Certainly one key to making meaningful reductions is doing so.

Indeed, says **Mary Barton**, NCQA's vice president of performance measurement, this is a huge topic of interest now, and hospitals will soon be able to make use of this data to influence downward their own 30-day readmission rates.

Barton says she envisions hospitals being able to begin doing things before any patient even comes to the hospital — to either prevent an admission to begin with, or to ensure a stay is no longer and no shorter than it has to be to ensure the discharged patient goes home and stays there. "This should be welcomed by hospitals as a way to start doing things that will smooth a visit and wrap around the entire continuum of care to prevent readmissions," she says.

There is so much that can go wrong in a hospital — not that it always happens, or even often happens at every hospital, Barton continues. Patients are sicker and more complex than they have ever been. "You have to do things to ensure you don't create new problems. You have to titrate treatment levels to a sick person and then make sure they are changed appropriately during the stay and again after discharge."

Saunders says that this new measure will give plans and hospitals a good peg for partnering together on this issue. "Hospitals often feel that the further away on the calendar a patient is from discharge, the less control they have," he notes. "This measure will offer you another way in to improve care coordination."

Hospitals are scurrying now to affect readmission rates in any way they can — having pharmacists make follow-up calls to patients after discharge, working with primary care providers to ensure easy access to follow-up appointments, and helping physicians improve hand-offs and communication. "Cynical people often say they want to do this to save money, or that CMS wants to save money," Barton says. "It's more accurate to say that we see a quality problem that has an answer. There are concrete things that can and should be done. But we have to line up the incentives." Part of that includes measuring the problem and creating a starting point for discussions between hospital and health plan on how all areas of care can work together to reduce this.

And making it the plan that has to report these figures? Well, that puts more pressure on the plan to do something to fix a problem that had always been viewed as that of hospitals. "It's not just a hospital problem," Saunders concludes. "And health plans are in a position to do something about it."

For more information on this topic, contact Mary Barton, Vice President of Performance Measurement or Robert Saunders, Assistant Vice President, Research and Analysis, NCQA. Washington, DC. Telephone: (202) 955-3200. ■

NQF endorses chronic conditions measures

Effort to look at patients across the continuum

As the National Committee for Quality Assurance hopes that all-cause readmission rate reporting by health plans will assist in creating more consideration of patient care across the continuum *(see related story this page)*, the National Quality Forum (NQF) hopes a new measurement framework for multiple chronic conditions will likewise help improve care in and out of the hospital.

"This is a guide that can help inform decision-making," says **Karen Adams**, PhD, MT, vice president of national priorities for the organization. "This provides a way for us to look at care not by patient, and not by setting, but through something else."

A patient might be in a hospital, in rehab, having home health care, or just at his or her primary care physician, she continues. This is a way to approach care across phases and look at performance measurements that meet the needs of patients. Looking at issues such as care coordination, functional status, hand-offs and shared accountability could change the game. "This puts the patient as the unit, not the place where the care is given."

Among the concepts key to the new framework, the framework document notes, are:

- optimizing, maintaining, or preventing further decline in function;
- seamless transitions between providers and sites of care;
- determination of what outcomes are important to the patient;
- avoiding inappropriate, non-beneficial care, including at end of life;
- access to usual source of care;
- transparency of cost;
- shared accountability among patients, family, and providers;
- shared decision making.

"I think of the value of the framework as how it would be used and what work it would inform," says **Tom Valuck**, MD, JD, senior vice president for strategic partnership at NQF. It could impact policy makers and researchers, and how payers reward and punish providers for the care they give to these patients. It might even help consumers make better decisions, he adds.

Valuck says the framework will also be instrumental in helping determine measurement gaps for this population.

This all started from the previous framework on patient-focused episodes of care, Adams explains.

"This was when we first started to think across settings," she says. "We looked through various conditions — cancer, diabetes, substance abuse, AMI. But what's important from that learning is that for a large portion of the population, you aren't just someone with one of those, but with multiple conditions. This evolution of looking at multiple diseases is different."

If you instead used the measures for each of a patient's individual conditions, you could end up with some unintended consequences, she notes — harm to the patient, extra work for various providers, and greater cost for payers.

Adams would like to see professionals throughout the healthcare community gain a real understanding that the care doesn't end at the door to their office or facility. "I know they want to provide high-quality care in that setting," she says. "But there have to be hand-offs, and providers know that they can't achieve good outcomes in isolation. We want them to think about how to orient their quality improvement, how they respond to external entities along the continuum of care. When you think of transitions, what measures do you want to pilot or use? Think of that. Be ahead of the game."

Organizing around outcomes

Valuck worries that there is a cacophony of disorganized quality measurement on the front line of healthcare. This kind of framework — applied specifically here, but bootstrapped elsewhere in the future — can help rationalize and organize all the work that patient safety and quality improvement staff do. "If we can make measurement line up in ways that make sense to QI and providers alike — wouldn't that be great?" he asks.

The key is to organize the process around patient outcomes. "If Javier has depression, COPD and diabetes, we could do a lot of process measures around each of these diseases," Adams says. "If we provide guidelines for each of these, are we paying attention to what matters most to this patient? One might want to walk across the room to pick up his grandchild. That means regimented A1C measurement might make him too wobbly to do that. But we can titrate that so that we meet health needs and patient goals."

That's what this is all about, Valuck concludes. "It's about triaging, and prioritizing at the highest level opportunities. It's about helping the provider focus on what's most important."

The entire measurement framework report is available at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71227.

For more information on this topic, contact Tom Valuck, MD, JD, Senior Vice President of Strategic Partnerships, and Karen Adams, PhD, MT, Vice President of National Priorities, National Quality Forum. Washington, DC. Telephone: (202) 783-1300. ■

New survey tools for patient safety COPs

Nationwide pilot under way

For years, the Centers for Medicare & Medicaid Services (CMS) state operations manual has had guidelines for surveyors to assess issues related to patient safety at hospitals. But there is such a wide range in size and scope of hospitals, says **Marilyn Dahl**, CMS director of the division of acute care services, that the organization decided it would be a good idea to create some sort of prompt for surveyors to use.

The organization began a process a couple of years ago to create the new tools after picking three areas — infection control, quality assurance and performance improvement, and discharge planning. Expert panels helped create the guidance and tools. They included patient safety experts from a variety of organizations, and for the infection control tool, there was assistance from the Centers for Disease Control and Prevention, she says. They also used the much simpler ambulatory surgery center infection control tool as a starting point, says Dahl *(see lists of sections from the three sample tools, below and page 82)*.

Piloted initially in 11 states, Dahl says, surveyors tested the tool beginning in the fall of last year. Not every state tested every tool, and all did varying numbers of surveys with them. "We have them test the tools in isolation on hospitals they identify to run them," she says. The tests are non-punitive, although statements of deficiencies were issued. But barring any findings so serious that patients were in imminent danger, no enforcement actions occurred.

Last December, with feedback from the states that did the pretests, they made some simple revisions — mostly typographical errors and changes in wording, Dahl says.

The infection control tool had the most work done, says **Daniel L. Schwartz**, MD, MBA, chief medical officer for the survey and certification group. While most of the changes were related to how the tool was organized, Schwartz says that there were some questions added, and some issues that users felt needed work. One example was that the section on hand hygiene didn't include guidance for surveyors to look for staff with long or false fingernails.

By the spring of this year, CMS was doing training with hospital accreditation organizations and providing detailed instructions to the states on doing pilot tests, says Dahl. By the end

QAPI survey tool

Pre-Decisional Surveyor Worksheet
Assessing Hospital Compliance With the Condition of Participation for Quality Assessment & Performance Improvement (QAPI)

Pilot Program Draft Version

Part 1 – Hospital Characteristics

Part 2 - New Hospital Worksheet Section - Purposely Omitted From Pilot

Part 3 – Data Collection And Analysis - Quality Indicator Tracers

Part 4 – Applying Quality Indicator Information - Activities And Projects

Part 5 – Patient Safety – Adverse Events And Medical Errors

Part 6 – Broad QAPI Requirements And Leadership Responsibilities

Discharge planning survey tool

Pre-Decisional Surveyor Worksheet
Assessing Hospital Compliance with the Condition of Participation for Discharge Planning

Pilot Program Draft Version

Section 1 – Hospital Characteristics

Section 2 – Discharge Planning – Policies and Procedures

Section 3 – Discharge Planning – Reassessment and QAPI

Section 4 – Discharge Planning Tracers

of September, every state is expected during the pilot phase to do at least one survey using each tool. They can volunteer to do more. After that, and for the next several months, CMS may ask that some test all three of the tools in a single survey.

"As surveyors become more familiar with the tools — they are very comprehensive — there is a lot of review to do," Dahl says. "If we combine all three together, is there any efficiency we can realize? Or will it be simply additive?"

The pilot will last through January, she says, and will continue to be non-punitive — again, barring any findings that show patients are in immediate danger. Examples of that would be egregious breaches in infection control, or dropping surgical instruments on the floor, picking them up and using them, Dahl explains. A facility that had a number of wrong-site surgeries but didn't have a program in place to analyze what happened or do a time out —that would be considered immediate jeopardy and a serious enough threat to patients to require punitive action.

After a last round of user feedback, the tools will be finalized, Dahl notes. "At that point, they will become a standard part of the survey process."

Hospitals that are part of the pilot program are welcome to provide feedback, too, she adds.

National associations related to hospitals have been involved from the start in updating this guidance, and Dahl says they are very supportive of the efforts. "There is a lot that hospitals

Infection control survey tool

Pre-Decisional Surveyor Worksheet

Assessing Hospital Compliance with the Condition of Participation for Infection Control Pilot Program Draft Version

Section 1 – Hospital Characteristics

Module 1 – Infection Control/Prevention Program

Section 1. A. Infection control/prevention program and resources

Section 1. B. Hospital QAPI systems related to Infection Prevention and Control

Section 1. C. Systems to prevent transmission of MDROs and promote antibiotic
stewardship, Surveillance

Section 1. D Personnel Education System / Infection Control Training

Module 2: General Infection Control Elements - to be applied to all locations (e.g., general wards, critical care units, labor and delivery, emergency department, endoscopy suites, radiology)

Section 2. A. Hand Hygiene

Section 2. B. Injection Practices and Sharps Safety (Medications, Saline, Other
Infusates)

Section 2. C. Personal Protective Equipment/Standard Precautions

Section 2. D. Environmental Services

Module 3 – Equipment Reprocessing

Section 3.A. Reprocessing of Semi-Critical Equipment

Section 3. B. Reprocessing of Critical Equipment Sterilization of Reusable Instruments and Devices

Section 3. C. Single-Use Devices (SUDs)
Module 4: Patient Tracers

Section 4. A. Urinary Catheter Tracer

Section 4. B. Central Venous Catheter Tracer

Section 4. C. Ventilator/Respiratory Therapy Tracer

Section 4. D. Spinal Injection Procedures

Section 4. E. Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)

Section 4. F. Isolation: Contact Precautions

Section 4. G. Isolation: Droplet Precautions

Section 4. H. Isolation: Airborne Precautions

Section 4. I. Surgical Procedure Tracer

Section 5. A. Protective Environment (e.g. Bone Marrow patients)

are expected to do, but these tools are assessing current regulations," she says. "In the past, we haven't been so explicit in our expectations. So while this may look like a change, it isn't. We are just outlining expectations for regulations that are already there."

Creating the tools wasn't easy. The Quality Assurance and Performance Improvement (QAPI) tool was particularly difficult. But the level of work required to create it won't preclude CMS from developing further tools. After these three have had their initial outings and been "digested," Dahl says others will be considered.

Schwartz says he would encourage hospitals to look at these tools now and use them as a guide for self assessment. He says the infection control one, in particular, is great for such activities.

They all are, Dahl says. "We want people to understand them and use them internally," she says. "It will help them do well in future surveys."

All three pilot tools are available in their entirety at http://apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/CMS_revised_hospital_surveyors_worksheets_5-18-12.pdf.

For more information on this topic, contact Marilyn Dahl, Director, Division of Acute Care Services, and Daniel L. Schwartz, MD, MBA, Chief Medical Officer, Survey and Certification Group, Centers for Medicare and Medicaid Services. Washington, DC. Telephone: (202) 690-7183. ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/. *Hospital Peer Review*'s executive editor Russ Underwood and associate managing editor Jill Drachenberg both contribute. ■

COMING IN FUTURE MONTHS

- Accreditation field reports
- The best in discharge planning
- Hospital staff and flu vaccines

CNE QUESTIONS

1. Patient Safety Organizations can provide protection from discovery of:
   A. All committee documents and materials
   B. Materials related only to credentialing and peer review processes
   C. Materials related to peer review and patient safety
   D. Management and board work product

2. The number of metrics used to look at hospital safety in the recent Leapfrog study was:
   A. 24
   B. 9
   C. 18
   D. 26

3. Problematic answers in aviation are about what proportion of those in hospitals, according to one study?
   A. a third
   B. 20%
   C. 4%
   D. 12%

4. The pilot of the new patient safety survey tools includes tools in what three areas:
   A. quality improvement, patient safety, and infection control
   B. infection control, quality assurance, and performance improvement
   C. discharge planning, quality assurance/performance improvement, and infection control
   D. infection control, patient safety, and discharge planning

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.

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%.
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