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AHC Media

How do you promote quality when quality doesn't pay?

Study suggests surgical complications lead to higher reimbursement

When a study in the *Journal of the American Medical Association* (JAMA) reported in April that surgeries with complications lead to higher reimbursement from payers[1] — public and private alike — the mainstream press jumped on it with headlines that seemed to implicate the medical profession with some sort of scam: By not doing the best job, they could make more money. "Hospitals profit from surgical errors," said the *New York Times*. NPR's modulated the tone a bit with "Quality conundrum: complications boost hospital profits." CBS News added the word "error" into its Internet headline — something sure to grab readers' eyes.

Essentially, the headlines were true. The study, by **Sunil Eappen** and his coauthors, found that hospitals gain financially from surgeries with complications, getting higher reimbursement than surgeries that do not go wrong. The accompanying editorial[2] noted right at the top that while they never said hospitals are purposely flubbing surgeries or thwarting quality programs that would reduce complications, that's the message many will hear.

The study showed that a surgery with complications paid for

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by private insurance would garner almost $40,000 more in profit — equal to an increase of about 300% — than the same surgery without them. Even Medicare payments for the surgery with complications would lead to about $1,700 in additional profit for a hospital, or almost double the profit for a normal surgery.

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The basis for the numbers was more than 34,000 surgeries done at 12 hospitals in Texas. The authors chose 10 potential complications, including surgical-site infections, DVT, pneumonia, or being on a ventilator for more than 96 hours. Patients experiencing one or more complications stayed in the hospital for an average of 14 days, compared to about three days for patients without complications.

Encouraging quality

The accompanying editorial doesn't dwell on the implications drawn by the headline writers of the mainstream media — that there is a disconnect between payment and quality — but instead focuses on the "shell game" of allocating costs, and ends with an admonishment that there needs to be more focus on how costs are attributed to specific service lines.

This may be in part because of the advent of the Affordable Care Act and its emphasis on accountable care organizations, value-based purchasing, and a carrot and stick approach to quality (or its lack).

To the wider community, though, the issue is one of how to encourage quality in a system that doesn't always reward it. And given the need to convince hospital boards and executives to fund quality initiatives — along with everything else — it becomes more difficult for quality leaders to make an argument to spend on something that perversely may cost the hospital money.

Lead author **Sunil Eappen**, MD, a professor at Harvard School of Medicine and the chief medical officer at Massachusetts Eye and Ear Infirmary in Boston, says it's difficult for financial managers to find the money for everything that various stakeholders want paid for, so it would not surprise him at all if quality initiatives that address surgical complications fall by the wayside specifically because the financial impact is negligible or negative. "I think that actually does happen. But I do not think they are thinking when they make those decisions that they do not want to improve surgical outcomes because it will cost them money. It's more general than that: What will have the bigger financial benefit, this project or that one? Which do you choose if you can only afford one?"

That's the sick part of the system — that you can actually improve quality and hurt your

financial position. It could be that the accountable care organization structure will water down the effect Eappen and his co-authors found in the study. "It could make a huge impact, but the reality right now, today, is that we have a DRG-based system where complications change the DRG and you get paid more." What payers should be doing is changing the payment system to pay hospitals and doctors the same regardless. He uses the example of a hip replacement, where compensation can triple if there are complications. The issue with paying the same amount for every hip replacement is that it doesn't take into account that every patient is different — an 80-year-old with a hip replacement is a different surgery from an athlete who is 30. It needs an element of risk adjustment.

"And in a perfect system, every hospital would take care of equal numbers of sick patients, not cherry pick the healthiest ones. And inner-city hospitals with poorer patients are likely sicker. So how do you set an appropriate fee?"

Those permanent fixes are down the line, Eappen says. For now, he suggests that quality managers talk about the disconnect with the executives and the board and let them know that improving quality is the right thing to do, and in the future is likely to result in better reimbursement and no penalties.

"The executives should be talking to payers about this, too," he says. "They should be encouraging the insurers to reward them for quality, because they are the ones who are paying more for complications. Rather than pay more for them, they should pay more for quality outcomes."

Put your money where your mission is

Another point to emphasize — and one that the editorial makes — is that having patients in the hospital for as much as four times longer when they have complications ties up beds that could go to other patients who have other surgical needs.

New research suggests that you should be talking to your board about quality, too. A study in *Health Affairs*[3] reported that U.S. hospital boards are more concerned with financial metrics as opposed to quality metrics than their counterparts in Britain.

It may take Medicare and private insurance changing their payments to really get hospital boards and executives to put in the money, time, and dedication it takes to accomplish quality, safety and patient experience initiatives, says **Charon Blaney**, RN, PhD, an oncology clinical supervisor at Our Lady of Lourdes Hospital in Lafayette, LA.

In the interim, patients are reading the headlines — and not the editorials and "study limitations" sections in peer-reviewed journals. "The financial aspects will be impacted by the power of the consumer," she says. "Patients have the ability and knowledge to shop around for the best, most cost-effective health care. So if the C-suite is reluctant now, they will either feel the impact from patients or payers."

If you want them to change their tune now, show them how investing in quality and safety can improve their bottom line by highlighting projects that have saved money, time, and even lives, Blaney says.

Eappen says that the more you educate board members about quality and get them involved, the better the quality that gets delivered to patients. "Invite them to your quality committee meetings," he says. "Immerse them in your world so they see the impact of what you do."

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What makes for good care coordination?

Start by asking your patients

Ask a doctor if she thinks her hospital does a good job at care coordination — or an administrator or board member — and she'd probably say yes. She might admit to room for improvement, but in all likelihood, she would think she and her peers do a good job taking care of patients in and out of the acute care setting. But the reality is different, says quality guru and Harvard professor **Lucian Leape**, MD, chairman of an eponymous institute at the National Patient Safety Foundation.

"I teach a course on quality and safety in health care, and the first day, I ask the students to find a patient — any patient — with a serious medical problem who will talk to them about it, and interview them about their experience," he says. "It's very worthwhile for the students. I read the essays and this year, three quarters of them had patients that reported serious care coordination problems. These are people with complex problems. And my take away is that this is endemic. These are patients from all over the country. It's a huge problem, and yet most places think they coordinate care well."

A starting point

Leape says one of his colleagues has decided that talking to patients about their perception of care coordination is so vital, that she has developed a survey tool just for that[1]. It's currently being piloted. He says that hospitals can get a sense of patient views from other patient experience surveys, but those other surveys are not focused on how well patients think providers care for them across the continuum. Consider developing questions that would help you determine how your organization does in the eyes of patients.

There are some existing tools that offer a starting point, such as one created in Australia in 2003 (available at http://intqhc.oxfordjournals.org/content/15/4/309/T5.expansion.html).

Part of the problem is that the consequences of doing a bad job seem to fall on the patients, not providers. "Who sees it when you do not do a good job? And for the poorest or those in the worst health? Well they're not really a vocal bunch are they?"

Another issue is that the position of "care coordinator" is not dignified by payers financially. "If you have a patient with more than two diagnoses, we need payers to pay for someone to actively coordinate their care," Leape says. "There is a ton of data that shows asthma patients, for example, have fewer emergency room visits and fewer hospitalizations when they have highly coordinated care. What we need is a certified care coordinator position whose time is billable and paid for by insurers."

Some organizations seem to do it well — Group Health in Seattle, for instance, and Cambridge Health Alliance. The latter provides safety net services for a "difficult" population of poorer, less healthy people in Massachusetts, Leape says. "But they have put a big emphasis on coordinating care for a long time."

Cambridge Health Alliance has certified five outpatient sites as patient-centered medical homes in the last 18 months, says **David Osler**, MD, MPH, senior vice president of ambulatory services for the organization in Somerville, MA. Most of the ambulatory sites for the organization are staffed with care coordinators, too. They have achieved some cost savings and some improved outcomes as a result, he says.

What he thinks would help would be a unified electronic medical record that both inpatient and outpatient providers can readily access. They have also had success by putting some patients on risk-based contracts. Perhaps the best thing a hospital can do is work with area providers to ensure every patient has ready access to outside primary care providers.

The playbook

"The hospital is like the quarterback in the football team," says **Angel McGarrity-Davis**, RN, a healthcare consultant based in Clearwater, FL. "The hospital must lead the other members on the team to perform their duties," she says. "They have to know what every person's job is in the post-acute care arena. They must be able to relay to the various players what their responsibilities and accountabilities are. And they need to have input into the playbook."

That book would be the various clinical path-

ways and processes they use, as well as the evidence on which they are based.

Share that playbook throughout the healthcare community, she continues. Get out of the silos that isolate the various parts of the continuum — have joint training, for instance. Gather the team members to discuss what works and what doesn't. "Working together is key," McGarrity-Davis says. "Get together with the skilled nursing facilities, long-term acute care hospitals, and home health agencies. Everyone should be on the same page for discharge planning, and the entire multidisciplinary team should be involved to follow up."

Most organizations will admit that such collaboration sounds like a great idea. Many may already do it.

But McGarrity-Davis adds another layer in that echoes a suggestion Leape makes: Get patients and their caregivers and/or families involved in the process, too. Have them work with the rest of the team to create forms that work, information that is understandable, and procedures that take the patient into account in the process.

Payers introduced penalties for unplanned readmissions for a reason, she says. "It's not because hospitals are responsible for or the cause of the readmissions all by themselves. But they are the industry leader. So if the hospital seeks solutions, creates a plan, and says it should be done, then the rest of the continuum will follow suit."

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What can you learn from your data?

Using the information you have

Just how many data points are collected for every patient every day in your hospital? It numbers in the thousands, and much of the information is never used. Imagine what you could do if you harnessed all the data you have at your fingertips.

That's a discussion the Institute of Medicine's (IOM's) Clinical Effectiveness Research Innovation Collaborative (CERIC) hoped to spur when it released a report in mid-April called "Making the Case for Continuous Learning from Routinely Collected Data" (available online at http://www.iom.edu/Global/Perspectives/2013/~/media/Files/Perspectives-Files/2013/Discussion-Papers/VSRT-MakingtheCase.pdf).

While it's not directly aimed at hospital quality and safety professionals, there are still lessons in it for them, says one of the writers, **Michael Murray**, PharmD, MPH, executive director at the Regenstrief Center for Healthcare Effectiveness Research at Purdue University in Indianapolis.

Secondary uses of data

"Our impetus was to get the public thinking about the secondary uses of their data — that other people can benefit from it," he says. But he thinks that people who deal with data every day also fail to understand the potential at their fingertips.

In early May, for example, he was talking to a patient safety group. "They had all this data on smart pump alerts from a variety of facilities," says Murray. "They had formed a collaborative to determine how each facility can best use alert data and are working to be able to view it through a digital hub. They can see where alerts are coming from, what kind of drugs the patients are on."

The group was riffing on issues like how to couple that data with outcomes data from the hospitals. "You could perhaps determine what happened after the alert. Think of what a rich data source that might be — you could end up preventing harm at other hospitals that use similar technology."

Doing something like this is usually reserved for the largest institutions that have data analysis units on site, Murray says. But groups of hospitals that might not have that capability internally might be able to work with a university that can help mine large sets of data. "There is a lot of cleaning, organizing, interpretation, and analysis you have to do to make sense of big data," he says. "Many organizations just do not have the individuals or systems to accomplish that without help."

This has been done in other industries for a long time. The report makes note of the use of data in the financial industries, which can take large data sets and integrate them easily. Healthcare has lagged, though.

With the creation of the Office of the National Coordinator at the Department of Health and Human Services, however, there has been a push to catch healthcare up.

An example cited in the report is the health information exchange created in Indiana, in part by the Regenstrief Institute (http://www.ihie.org).

More disparate networks, like the HMO Research Network, a group of about 20 healthcare organizations, collaborate using administrative and clinical data for research purposes. The information is not centrally stored, thus protecting the integrity of proprietary information while still aiding the group as a whole.

A thousand points of data

So how do you figure out what you have and what you can do with it? Start by getting a group together from every single department that collects data of any kind, says another one of the report authors, **Eric B. Larson**, MD, MPH, MACP, vice president for research and executive director and senior investigator at the Group Health Research Institute in Seattle. Have each department take an inventory of what it collects and what it does with each piece of data. It could be that you have no idea of the vast quantity of information you have access to.

At the same time, Murray says you should be thinking about how that data might help answer specific questions you have or solve a particular problem. "If you have a broad question, you might want to partner with another institution that can help you analyze a lot of data. There is funding available for this kind of project."

A broad project might be combining information on a particular drug. Most new drugs are tested on just a few thousand people. Being able to combine data from many different sources might help determine if there are problems with a drug that you do not see in 3,000 test subjects, but you do in millions of doses.

For narrower concerns that relate more to your own particular set of circumstances, it's possible you can collect and analyze the data without the help of specialists with fancy computers, Murray says.

Larson says he sees quality professionals benefitting from looking for ways to draw off routinely collected information to address quality concerns.

No limit

Maybe you can use natural language processing programs to look for notations by physicians relating to a particular kind of complication. This is the kind of thing you should be thinking of, he says.

"It's already happening in billing. They are much more efficient because of electronic health records. So why can't you use them the same way to detect safety problems or to monitor for problem areas — a ward where there are more falls, a shift that has a cluster of nosocomial infections."

There is no limit to what you can do, Larson says. "Put your effort where you have the greatest patient risk. You should be looking at your data and finding ways to exploit it. What do you collect ever day, and what is the potential for its use? Think big picture."

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Data bank merger: More reports likely

Officials say changes should be seamless

The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) announced a merger in April that became effective last month. According to **Ernia P. Hughes**, MBA, the acting director of the division of practitioner data banks at the Health Resources and Services Administration, the main reason for the unification is to save money and curtail duplication of services.

The new organization, known as the NPDB, can be found online at http://www.npdb.hrsa.gov, where fact sheets, newsletter articles and other resources are available for users.

The HIPDB, created in 1996 as part of the HIPAA law, held information on:

- civil judgments against health care providers, suppliers, or practitioners in federal or state court related to the delivery of a health care item or service;
- federal or state criminal convictions against health care providers, suppliers, or practitioners related to the delivery of a health care item or service;
- actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners;
- exclusions of health care providers, suppliers, or practitioners from participation in federal or state health care programs;
- any other adjudicated actions or decisions against health care providers, suppliers, or practitioners that the secretary establishes by regulations.

The NPDB included reports of adverse licensure, and hospital privilege and professional society actions against physicians and dentists related to quality of care. In addition, the NPDB tracked malpractice payments made for all health care practitioners. It was created in 1990.

The new merged organization will contain all the information from the two independent units in one organization.

Hughes says the Affordable Care Act's passage in 2010 set the stage for the merger, calling for the elimination of duplicative data reporting requirements between the two databanks.

The public doesn't have access to the data — that's part of the laws that created the data banks and remains in effect. Mostly, Hughes says the merger was technical and doesn't impact users' "legal requirements to report to and query the NPBD."

Users shouldn't notice much change and little difference in the way they use the system. What they might note is an increase in reports, Hughes says. "Hospitals have always had access to adverse licensure actions," she notes. "However, prior to the merger, adverse licensure actions taken against practitioners and entities were in one data bank and those same actions against providers and suppliers were in another."

Now, because there is just a single entity, reports on health care providers and suppliers are captured under one umbrella, so licensure and certification actions taken against providers and suppliers can be returned on a search when a hospital queries the NPDB.

In addition, she continues, hospitals now have access to reports on federal health care-related criminal convictions, federal health care-related civil judgments, exclusions from participation in federal health care programs, or other adjudicated actions that are reported by federal agencies and health plans. State actions, federal actions for suppliers and providers, plus information on privileges and malpractice claims will all be in one place.

Costs of operation will continue to be funded by user fees, and Hughes says there may be a savings here, too, because users will not have to query two different organizations. Only one query fee will provide access to all the information to which users are entitled.

Those fees are not going up, either, she says. The annual subscription fee for Continuous Query will continue to be $3.25 per practitioner enrolled. Traditional Query, also known as a One-Time Query, will still cost $4.75 each. Fees for Veterans Affairs hospitals have a different fee structure and should contact the customer service center at (800) 767-6732.

While fees are not set to change, Hughes says that any plans to do so will have to be published in the *Federal Register* first, and users will have to be notified.

If you have any specific merger questions, you can email the data bank directly NPDBPolicy@hrsa.gov. For technical help or general questions, email help@npdb-hipdb.hrsa.gov. ■

AHRQ releases 10 best bets for safety

Proven strategies can save lives

A new report by the Agency for Healthcare Research and Quality (AHRQ) ticks off the top 10 patient safety strategies that providers and organizations can implement right now to positively impact patient care.

Completed by a project team from the RAND Corporation; Stanford University; the University of California, San Francisco; Johns Hopkins University; and ECRI Institute, as well as an international panel of 21 stakeholders and evaluation methods experts, the report is based on an evidence-based assessment of patient safety strategies.

If implemented widely, they have the potential to "vastly improve patient safety and save lives in US health care institutions," the authors believe.

Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices assesses the evidence for 41 patient safety strategies and most strongly encourages adoption of the top 10, which the authors believe can reduce medication errors, hospital-acquired conditions, adverse events, and even bedsores. That list of 41 was culled from an initial list of 158 items that the authors of the report developed from a variety of sources, including The Joint Commission, the National Quality Forum, and the Leapfrog Group.

The list was culled through voting, and 18 were chosen for more in-depth reviews. In the end, the group came up with 41 good ideas, 10 that are slam dunks, and another dozen that are a fine idea. *(See lists, right.)*

The report emphasizes evidence about implementation, how the strategies are adopted, and the influence of the context in which they are implemented.

The idea is to help organizations know what works and whether a strategy needs adaptation to meet local needs.

The entire report, including evidence reviews for all 41 patient safety strategies, can be found at http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html. ■

Patient safety strategies — strongly encouraged

- Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
- Bundles that include checklists to prevent central line–associated bloodstream infections
- Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
- Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes to prevent ventilator-associated pneumonia
- Hand hygiene
- The do-not-use list for hazardous abbreviations
- Multicomponent interventions to reduce pressure ulcers
- Barrier precautions to prevent health care-associated infections
- Use of real-time ultrasonography for central line placement
- Interventions to improve prophylaxis for venous thromboembolisms

Patient safety strategies — encouraged

- Multicomponent interventions to reduce falls
- Use of clinical pharmacists to reduce adverse drug events
- Documentation of patient preferences for life-sustaining treatment
- Obtaining informed consent to improve patients' understanding of the potential risks of procedures
- Team training
- Medication reconciliation
- Practices to reduce radiation exposure from fluoroscopy and CT
- The use of surgical outcome measurements and report cards, such as those from ACS NSQIP
- Rapid-response systems
- Use of complementary methods for detecting adverse events or medical errors to monitor for patient safety problems
- Computerized provider order entry
- Use of simulation exercises in patient safety efforts

NCQA testing new way to measure quality

Using data to measure health outcomes

The National Committee for Quality Assurance (NCQA) and the Robert Wood Johnson Foundation (RWJF) are evaluating a new measurement tool that they hope will be a better gauge of risk factors and focus on improving outcomes for heart disease and diabetes patients.

The NCQA is working with Archimedes, Inc. to develop a Global Cardiovascular Risk (GCVR) score, which will measure how well providers reduce the risk of future adverse outcomes in the populations they serve, like heart attacks, strokes, and diabetic complications. The tool uses electronic health records and the clinical information in them to assess improvement and prevent bad outcomes.

NCQA president **Margaret O'Kane** says the tool may be the first "customized, outcomes-based electronic health record measure used by Medicare and commercial payers. Its widespread adoption could have a profound impact on health care costs because it assesses how well providers engage in prevention and goal-setting for their high-risk patients." She adds that it might just be the new "gold standard" for quality measurement and even replace some traditional measures.

Rather than processes of care and reaching clinically artificial treatment goals for biomarkers that provide little qualitative information about how patients actually do, the new tool will look at actual disease outcomes and evaluate how much the risk of future adverse events declines. The GCVR is a single metric that captures what every provider can do to prevent adverse outcomes, all integrated in a medically and clinically realistic way.

The project announced this spring will allow the NCQA to evaluate the feasibility of collecting data from EHRs to calculate a measurable result for different providers and provider organizations, as well as determine provider views on how useful and meaningful the GCVR score is for predicting risk.

For the next 18 months, NCQA will determine what data it can feasibly extract from health records. It is currently recruiting organizations to participate. The data collection and analysis will occur over the summer and fall of 2013, and NCQA expects to report findings by summer 2014. ■

Checklist improves crisis management

Surgical crisis simulations in three hospitals found that using a checklist rather than relying on memory alone leads to better adherence to critical processes of care. The study, published in the *New England Journal of Medicine*[1], had teams randomly assigned to manage simulated crisis situations in the operating room with a checklist or without. The authors looked at whether the teams adhered to the standard process of care or not.

The members of the teams were randomly assigned to work together. There were 17 of them, participating in 106 simulated surgical-crisis scenarios. Participants included anesthesia staff (attending physicians, residents, and certified registered nurse anesthetists), operating-room nurses, surgical technologists, and a mock surgeon participant. Teams spent six hours in a high-fidelity simulated operating room. They were presented with crises such as air embolism, anaphylaxis, asystolic cardiac arrest, hemorrhage followed by ventricular fibrillation, malignant hyperthermia, unexplained hypotension and hypoxemia followed by unstable bradycardia, and unstable tachycardia.

Checklists resulted in more adherence to protocols. Among the results: in a situation with unstable tachycardia, teams using checklists promptly delivered synchronized cardioversion with all shocks synchronized. Those without did not have a single synchronized shock. In situations with unstable bradycardia, teams using checklists had prompt transcutaneous pacing, while those without had a greater than 10-minute delay in transcutaneous pacing because the setting selected by the provider was below the energy level needed to enable pacing. In cases of anaphylaxis, no checklist teams missed half the critical care processes, including never calling for help and insufficient fluid resuscitation. Without a checklist, it took more than a minute and a half to start chest compressions for patients with ventricular fibrillation, but teams with checklists were able to complete all seven critical care processes for malignant hyperthermia, including dantrolene administration,

cooling, treatment of hyperkalemia, and discontinuation of volatile anesthetic agents.

Checklists include one for before anesthesia, one for before the first incision, and one for before the patient leaves the OR, and can be viewed at http://jvsmedicscorner.com/ICU-Miscellaneous_files/Safe%20Surgery%20Checklist%20NEJM%202009.pdf.

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Study looks at outcomes impact of errors

Malpractice data provides 25 year analysis

Malpractice information from the National Practitioner Data Bank over 25 years has showed that most mistakes come from diagnostic errors, not surgical mistakes or medication errors, according to a study published in the *British Medical Journal's Quality and Safety* journal[1]. Most of those diagnostic issues stem from outpatient, not inpatient visits, but the inpatient errors were more likely to result in death.

Johns Hopkins researchers looked at more than 350,000 paid malpractice claims from 1986-2010. About a third of them came from diagnostic errors, accounting for more than a third of the payouts. Death was a more common outcome for this kind of error than for others — just under 41% versus about 30% for other errors. A third of the claims for diagnosis problems occurred in the inpatient setting, and those in the hospital were more likely to result in death than those from outpatient settings. The inflation-adjusted, 25-year sum of diagnosis-related payments was $38.8 billion, with a mean payout of $387,000 and a median of $213,000. Nonlethal serious injury was as common as death from misdiagnoses.

Errors in diagnosis are defined in the study as delayed diagnosis, missed diagnosis, or wrong diagnosis. The authors note that this kind of error is underreported and under-tracked because they are hard to measure and hard to keep track of.

While the focus of this study was errors that ended up with a malpractice claim, the authors believe that total number of diagnostic errors is between 80,000-160,000 each year in the United States.

The potential cost from diagnostic errors is large, and the authors, who include safety guru Peter Pronovost, say that organizations and stakeholders should start looking at ways to improve diagnostic safety.

REFERENCE
1. Tehrani AS, Lee HW, Mathews SC et al. 25-Year summary of US malpractice claims for diagnostic errors 1986–2010: an analysis from the National Practitioner Data Bank. *BMJ Qual Saf*. 2013 Apr 22. [Epub ahead of print] ■

CMS issues 2014 Medicare IPPS proposal

Recommendations include quality components

Late in April, the Centers for Medicare & Medicaid Services (CMS) released its proposed update to policies and payments for inpatient care in fiscal year 2014. Alongside payment updates, the proposal lays out the framework for a patient safety program to be launched in 2015 that is mandated by the Affordable Care Act, and it clarifies admission and medical review criteria for inpatient services.

The quality improvement and patient safety portions of the proposal include:

• **Reducing hospital-acquired conditions.** Facilities that are in the lowest quartile related to this will lose 1% of their reimbursement. How facilities will be ranked is outlined in the proposal.

The conditions ranked include: pressure ulcer rate; volume of foreign object left in the body; iatrogenic pneumothorax rate; postoperative physiologic and metabolic derangement rate; postoperative pulmonary embolism or deep vein thrombosis rate; and accidental puncture and laceration rate. A composite measure set is also proposed as an alternative to these Domain 1 measures. Domain 2 measures include central line-associated blood stream infection and catheter-associated urinary tract infection.

• **Value–based purchasing.** Incentive payments for performance based initiatives increase to 1.25%, and will total about $1.1 billion. It will

also add new measures to the program.

• **Readmissions.** Payment penalties related to unplanned readmissions increase from 1% to 2%. Two new readmission measures are added and may be used to calculate penalties for fiscal year 2015. Along with heart attack, heart failure, and pneumonia, CMS proposes adding readmissions for hip/knee arthroplasty and chronic obstructive pulmonary disease.

• **Quality reporting.** The proposal updates measures for the Hospital Inpatient Quality Reporting (IQR) and other reporting programs, aiming to reduce the reporting burden by aligning measures with quality measure reporting requirements in the Medicare Electronic Health Record Incentive. IQR measures are published on the Hospital Compare website — http://www.hospitalcompare.hhs.gov — and may be added to the Value-Based Purchasing Program.

The current proposal includes 57 measures, including chart-abstracted measures, such as heart attack, heart failure, pneumonia, and surgical care improvement measures; claims-based measures such as mortality and readmissions; healthcare-associated infections measures; a surgical complications measure; survey-based measures, such as patient experience of care; immunization measures, and structural mea-

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

■ Team effectiveness — how to measure it

■ Accreditation field report

■ Outsourcing data analysis

■ The standards that trip hospitals up most

CNE QUESTIONS

1. Surgeries with complications paid for by private insurers result in how much more profit than surgeries without complications, according to a JAMA survey?
   a. 190%
   b. 30%
   c. $30,000
   d. $40,000

2. What percentage of Lucian Leape's students found patients who experienced problems with care coordination?
   a. about 75%
   b. about 30%
   c. a third
   d. a quarter

3. An example of using disparate data sources to spot a problem is:
   a. Looking for falls on a ward
   b. Where nosocomial infections are most common
   c. figuring out if a drug causes harm post approval
   d. getting a university to help with analysis

4. The NPDB was created in what year?
   a. 1996
   b. 2010
   c. 1988
   d. 1990

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.

sures that assess features of hospitals—such as hospital volume, how the hospital deploys staff, or provider qualifications—to assess their capacity to improve quality of care. The proposal includes two new chart abstracted HAI measures: hospital-onset methicillin-resistant *staphylococcus aureas* (MRSA) bacteremia, and *clostridium difficile*, and reducing the number of records used for HAI validation from 48 to 36 patient charts.

Hospitals will also have the option of transmitting data electronically to meet validation requirements — electronically submit one quarter's data for 16 quality measures from four measure sets, or submit a full year if not submitting electronically. CMS also proposes collection and reporting of this measure data through Certified Electronic Health Record Technologies (CEHRTs).

The proposed rules are available in the May 10, 2013, issue of the *Federal Register*. *Hospital Peer Review* will look into what the proposals mean for quality managers in the next issue. ■

CNE INSTRUCTIONS

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. ■