Quality Framework:
Acute Care Hospital

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HIT Advisor
Objectives for today:

- Critical Access Hospital quality reporting programs and what's involved
- Need for quality data for measuring performance
- CART tool and QM reporting for hospitals
- Chart Abstraction - data falls out?
- Current challenges and solutions
ORYX Data

1997 - The Joint Commission launches ORYX: The Next Evolution In Accreditation™ to integrate the use of outcomes and other performance measures into the accreditation process. For 1998, the ORYX implementation plan applied to hospitals, long term care organizations and health care networks.

1999 – The first real ORYX data is transmitted to the Joint Commission from hospitals and long term care organizations.

2007 - The Joint Commission adds in November an initial set of seven hospital outpatient measures to the complement of core measure sets that may be used to satisfy ORYX performance measurement requirements.
Sample CAH Quality/Safety Structure

- Board of Trustees
- Med Exec
- Joint Quality Council
- Administrative Team
- Quality/UM Chair
- Continuous Improvement Committee (CIC)
- Safety Committee
- Shared Governance Quality Council
- Department PI/Lean Projects & Safety Issues
## Sample CAH Dashboard

### PRHC Strategic Plan Key Indicators - 2008

**October, 2008**

<table>
<thead>
<tr>
<th>Service</th>
<th>Quality</th>
<th>People</th>
<th>Growth</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="image1.png" alt="Graph 1" /></td>
<td><img src="image2.png" alt="Graph 2" /></td>
<td><img src="image3.png" alt="Graph 3" /></td>
<td><img src="image4.png" alt="Graph 4" /></td>
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<tr>
<td>Facility-wide Performance</td>
<td><img src="image5.png" alt="Graph 5" /></td>
<td><img src="image6.png" alt="Graph 6" /></td>
<td><img src="image7.png" alt="Graph 7" /></td>
<td><img src="image8.png" alt="Graph 8" /></td>
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<tr>
<td>Infection Control</td>
<td><img src="image9.png" alt="Graph 9" /></td>
<td><img src="image10.png" alt="Graph 10" /></td>
<td><img src="image11.png" alt="Graph 11" /></td>
<td><img src="image12.png" alt="Graph 12" /></td>
</tr>
<tr>
<td>Core Measures</td>
<td><img src="image13.png" alt="Graph 13" /></td>
<td><img src="image14.png" alt="Graph 14" /></td>
<td><img src="image15.png" alt="Graph 15" /></td>
<td><img src="image16.png" alt="Graph 16" /></td>
</tr>
<tr>
<td>Inpatient Deaths</td>
<td><img src="image17.png" alt="Graph 17" /></td>
<td><img src="image18.png" alt="Graph 18" /></td>
<td><img src="image19.png" alt="Graph 19" /></td>
<td><img src="image20.png" alt="Graph 20" /></td>
</tr>
</tbody>
</table>

**Inpatient Deaths**

- Includes: falls, medication errors, delay in care, excessive blood loss, unplanned returns to surgery, omitted tests/treatments, wrong test ordered, mislabeled specimens, orders without specimen, hospital acquired infections.
Sample Dept Dashboard

Emergency Department/Urgent Care

(Acute Myocardial Infarction) – Heart Attack*

12 Lead EKG within 10 minutes - AMI

Aspirin administered within 24 hours prior to or upon arrival - AMI

(Acute Coronary Syndrome) – Chest Pain*

EKG within 10 minutes of Arrival

Aspirin administered with 24 hrs prior to or upon arrival - (ACS) Chest Pain

*The above quality indicators are nationally accepted best practices in the case of patients with heart attacks (Acute Myocardial Infarction) and chest pain (Acute Coronary Syndrome).

Two patients had an MI in January. Patient had syncopal episode with dementia. Patient arrived at 1200, EKG was done at 1355. Patient was atypical.
CORE Measure Data

- Hospitals began the current core measures nearly 15 years ago as part of hospital accreditation by the Joint Commission.
- Core measures have been aligned with CMS quality measurement for the Medicare program and adopted by the National Quality Forum consensus process.
- Today the measures are used broadly to benchmark hospital clinical performance and spur improvement.
- In many states, they represent some portion of hospital reporting to regulatory authorities.
- Core measure results are also posted on public Web sites such as Hospital Compare to facilitate comparison shopping by consumers.
- Core measures are increasingly linked to reimbursement as part of the Centers for Medicare & Medicaid Services (CMS) Value-Based Purchasing and the pay-for-performance programs of many other payers.
Inpatient (Core) Measures Data

- Section 2.1 - Acute Myocardial Infarction (AMI)
- Section 2.2 - Heart Failure (HF) (Updated 12/14/12)
- Section 2.3 - Pneumonia (PN)
- Section 2.4 - Surgical Care Improvement Project (SCIP) (Updated 12/14/12)
- Section 2.6 - Children's Asthma Care (CAC)
- Section 2.7 - Venous Thromboembolism (VTE) (Updated 10/30/12)
- Section 2.8 - Stroke (STK)
- Section 2.9 - Global Initial Patient Population (ED, IMM, TOB, SUB)
- Section 2.10 - Emergency Department (ED)
- Section 2.11 - Prevention
  - 2.11.1 - Immunization (IMM)
  - 2.11.2 - Tobacco Treatment (TOB)
  - 2.11.3 - Substance Use (SUB)
Outpatient Measures Data

- 1.1 - Outpatient Acute Myocardial Infarction (AMI)
- 1.2 - Chest Pain (CP)
- 1.3 - Emergency Department (ED)-Throughput
- 1.4 - Pain Management
- 1.5 – Stroke
- 1.6 – Surgery
- 1.7 - Imaging Efficiency
- 1.8 - Structural Measures (Updated 2/27/13)
http://www.medicare.gov/hospitalcompare/?AspxAutoDetectCookieSupport=1
Hospital Compare - Measures

- **Timely and Effective Care (Process of Care Measures)**
  - Heart Attack (Acute myocardial infarction (AMI))
  - Heart Failure
  - Pneumonia
  - Surgery (Surgical Care Improvement Project)
  - Emergency Department Care
  - Preventive Care
  - Children's Asthma Care

- **Readmissions, Complications, and Deaths (Outcome of Care Measures)**
  - 30-day death (mortality) rates and 30-day readmission rates
  - Serious complications - AHRQ Patient Safety Indicators (PSIs)
  - Hospital-acquired conditions
  - Healthcare-associated infections

- **Use of Medical Imaging (Outpatient Imaging Efficiency Measures)**

- **Survey of Patients' Hospital Experiences (HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems))**

- **Number of Medicare patients**

- **Spending per hospital patient with Medicare**
Hospital Compare – Inpatient Measures

- Most Critical Access Hospitals (in Iowa) report voluntarily through CART (QualityNet.org) to Hospital Compare regarding Inpatient Quality Measures & HCAHPS pertaining to:
  - Congestive Heart Failure
  - Surgical Care Improvement Project
  - Pneumonia
  - Patient Satisfaction
In 2009, Hospital Compare began to report on ‘Survey of Patients’ Hospital Experiences’ or HCAHPS.

CAH participation is voluntary, but must have at least 300 inpatient discharges in a quarter.

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.
Hospital Compare - HACs

- CMS Adds Hospital Acquired Condition Measures to Hospital Compare Website (UPDATED 4-1-11)

Hospital Acquired Conditions (HAC) are serious conditions that patients get during an inpatient hospital stay. If hospitals follow proper procedures, patients are less likely to get these conditions. Medicare doesn't pay for any of these conditions, and patients can't be billed for them, if they got them while in the hospital. Medicare will only pay for these conditions if patients already had them when they were admitted to the hospital.

**Right now, HACs are not applicable to CAHs in regards to Medicare reimbursement; however many private payors are not paying for HACs.**
Iowa Hospital Association

- Around 2004, the Iowa Hospital Association began a Quality Database for their members.
- In just a few years they had a high percentage of participation (voluntary) from CAH’s.
- Quality measures include:
  - Summary Data
  - Med Error Rates
  - Falls (in different practice settings)
  - Acute Myocardial Infarction Measures
  - Acute Coronary Syndrome Measures
  - Obstetrics
  - Hospital Acquired Infections.
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QualityNet News

**FY 2014 IPPS proposed rule posted, open for public comment**

The proposed rule for changes to the hospital Inpatient Prospective Payment Systems (IPPS) for acute care hospitals and Fiscal Year (FY) 2014 rates is on display and open for public comment. To be assured consideration, comments must be received no later than 5 p.m. EDT on June 25, 2013.

Included in the regulation are proposed changes to quality reporting requirements for: the Hospital Inpatient Quality Reporting (IQR) Program; the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program; Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program; the Hospital Value-Based Purchasing (VBP) Program; and Ambulatory Surgical Centers (ASCs).

Full Article »

**Headlines**

- Hospital Compare Preview Reports now available
- Inpatient hospitals selected for FY 2015 validation
- Contact Help Desk regarding QQR pledge changes
- CMS seeks comment on conversion to ICD-10 specifications for OIF measures
- Inpatient Psychiatric Facility Quality Reporting webinar set for March 14
- New programs added to CMS Questions and Answers tool
- Notice of Participation Form available for Inpatient Psychiatric Facility Quality Reporting
- Cancer Measures Specifications published
- Members named to HVBP Monitoring and Evaluation Strategies Technical Expert Panel

About QualityNet

Established by the Centers for Medicare & Medicaid Services (CMS), QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.

QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices,
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QualityNet is the only CMS-approved website for secure communications (CART) and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.

Provides measure specification manuals
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CART Tool

- CART - CMS Abstraction & Reporting Tool
  - Application for the collection and analysis of quality improvement data
  - Enables hospitals to evaluate and manage quality improvement efforts
  - Ideal for the data collection and analyses
  - Available at no charge to hospitals or other organizations
CART Tool

- **Available for Following Clinical Areas:**
  - Acute Myocardial Infarction (AMI)
  - Emergency Department (ED)
  - Heart Failure (HF)
  - Immunization (IMM)
  - Pneumonia (PN)
  - Surgical Care Improvement Project (SCIP)
  - Stroke (STK)
  - Venous Thromboembolism (VTE)

- CART is available for use on a stand-alone, Windows-based computer, in a computer network or in environments without computing resources (paper tool).
CART Tool

- Extensive login and password requirements
- Application times out after 10 minutes of inactivity
- Required to set up providers
  - Each hospital site, some health systems may have multiple hospitals
- Required to set up users
  - At least one user must be an administrator
  - Recommended to set up a back-up administrator
CART Training Available

QualityNet

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Data Collection (& CART)

CART Downloads & Info
CART Module Designer
Abstraction Resources
Uniform Billing File Layout
CART Training

CART Training

The following recorded training sessions are available to assist with CART. Additional information may be found on the CART Downloads & Info page.

- CART Navigation and Provider/User Set-up, WebEx-17 min (09/30/10)
  - Transcript, PDF-121 KB
- CART Patient Set-up/Abstraction and Import/Export, WebEx-21 min. (09/30/10)
  - Transcript, PDF-111 KB
- Measure Set Integration and Un-Installation, WebEx-5 min.
  - Handout

WebEx Player
To view the recorded trainings, download the WebEx (.WRF) Player.

QualityNet Help Desk | Accessibility Statement | Privacy Policy | Terms of Use

Healthcare Intelligence
CART Screen Shots

Welcome to the Quality Management System

[Image of a software interface with a dropdown menu labeled 'choose an application' and buttons 'OK' and 'Cancel']

Healthcare Intelligence
## Provider Information

### Provider Summary

<table>
<thead>
<tr>
<th>Name</th>
<th>Address 1</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>CMS Cert No</th>
</tr>
</thead>
</table>

### Provider Detail  
* = Required Field

- Name
- Address 1
- Address 2
- Zip
- City
- State
- CMS Cert No
- National Provider ID
- Termination Date
- HCOID
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Chart Validation

Chart Abstraction - data falls out?
- Paper-Based and CART Abstraction Tools are available
- Once the abstractions are complete, they are uploaded through CART to (QualityNet) CMS.
- Random chart validation surveys are conducted
- Hospital must pass chart validation with chart samples or the quality data for the quarter fails
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Solution - Lean Health Care

- What is Lean Health Care? It’s about **Adding Value** and **Recognizing Waste**!

- “The relentless pursuit to reduce and eliminate waste.” - *Taiichi Ohno*

- “Striving for Ideal:
  - Exactly what the patient needs, DEFECT FREE!
  - One by one, customized to each individual patient
  - On Demand, exactly as requested
  - Immediate response to problems or changes
  - No waste
  - Safe for patients, staff & clinicians: Physically, Emotionally, Professionally”
Lean Health Care –
Hand Washing A3 by Quality Council

ISSUE
Increased spread of germs due to poor handwashing practices by PRHC personnel.

BACKGROUND
Healthcare Associated Infections (HAI) affect nearly 2 million individuals annually in the United States and are responsible for approximately 80,000 deaths each year (IHI). Direct observation of handwashing at PRHC varies by department from 20-100% (Feb. 2008).

CURRENT CONDITION
(Place drawing of process here.)

TARGET CONDITION
Culture of Safety established

COUNTERMEASURES
1. Handwashing readily available.
2. Education to all Pella Regional Health Center staff.
3. Establish a hand hygiene monitoring system for Pella Regional Health Center.
4. Establish a culture of safety at Pella Regional Health Center.

IMPLEMENTATION PLAN

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHO</th>
<th>WHEN</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Survey frontline staff input</td>
<td>Quality Council (QC)</td>
<td>6/3/2008</td>
<td>Frontline staff input on sanitizer placement. Ongoing end</td>
</tr>
<tr>
<td>2. Education to all PRHC staff</td>
<td>Dept Mgrs, Cheri &amp; QC</td>
<td>by 1/1/2008</td>
<td>Increased awareness</td>
</tr>
<tr>
<td>3. Implement NEW Monitoring Policy</td>
<td>Dept Mgrs, Cheri &amp; QC</td>
<td>Ongoing</td>
<td>Increased compliance</td>
</tr>
<tr>
<td>4. Logo contest, poster pledge, personal contracts</td>
<td>Cheri &amp; QC</td>
<td>7/13/08</td>
<td>Increased staff &amp; community awareness</td>
</tr>
<tr>
<td>5. Just Culture Training</td>
<td>Sarah C</td>
<td>Fall ‘08</td>
<td></td>
</tr>
</tbody>
</table>

COST
- COST BENEFIT/WASTE RECOGNITION
  - Adverse infection prevention (IHI calculator)
  - Marketing Costs

TEST

FOLLOW UP
1. Ongoing monitoring
2. Press Ganey Survey Question
3. Monitor infection rate

30 days - August 31, 2008
60 days - September 30, 2008
90 days - October 31, 2008

QA RM-906
Patient Safety Component - National Patient Safety Goals

**ISSUE**
Patient care may be delayed due to nurse to nurse report taking longer than 30 minutes at end of shift.

**BACKGROUND**
Nurse to Nurse report is given at end of each shift to pass on pertinent patient information to the oncoming shift - occurs at least 3 times daily. Report between shifts should take 30 minutes; currently takes 20-60 minutes. (2-4 nurses to report to)

**CURRENT CONDITION**
(Place drawing of process here.)

**PROBLEM ANALYSIS**
- RN not available to give report
  - Why? No schedule for report
  - Why? It has never been established - Report time schedule not specified
  - Why? No coverage available for off-going RN to attend report
  - Why? All oncoming staff involved in group report at one time
  - Why? Off-going staff busy finishing end of shift work
  - Why? Coverage unspecified

- Interruptions from other departments, staff into the report room
  - Why? Report Room is public/multi-purpose for mailboxes, ice machine, coffee maker, bathroom, breaks.
  - Why? No space available on unit to separate out for multi-purposes.
  - Why? Interruptions during report time have always been allowed.
  - Why? Clear guidelines have not been specified officially or enforced.

- Too much info given by off-going RN and too many questions asked by on-coming RN.
  - Why? Staff unclear understanding/unaware of hand-off communication policy
  - Why? Competencies done earlier in year, staff may not remember
  - Why? Hand Off communication policy not clearly communicated
  - Why? Questions being asked by on-coming RN focus on IDT issues.
  - Why? Staff unsure about what questions should be asked at report versus IDT rounds.

**TARGET CONDITION**
- Sign posted on door
- Report Scheduled: 7:00, 7:10, 7:20
- > 30 min after the hour

**COUNTERMEASURES**
1. Able to arrange coverage for RNs due to schedule specified for when RN will report to oncoming staff. Off-going staff will be aware when expected for report and will be available.
2. Clear guidelines established for when report is in session - sign posted on door and enforced by requiring knocking if absolutely necessary to enter room, otherwise no intrusions allowed.
3. New report - change of shift communication plan re-designed.

**IMPLEMENTATION PLAN**

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<tr>
<td>4. Staff education.</td>
<td>Angie, Donna, &amp; Peggy</td>
<td>10/06 Staff Meeting</td>
<td></td>
</tr>
</tbody>
</table>

**COST BENEFIT/WASTE RECOGNITION**

*Total Estimated Cost Savings (Annual) = $59,130*

- RN Time: $16/hr (avg) x 3 RNs x $54 x 1 hr = $54 per shift report
  - $54 x 3/shift reports per day = $162/day
  - $162/day x 365 days = $59,130/year (potential cost savings per year)

**TEST**
Dry run pilot on 9/18/2006
Go Live all staff on 11/20/2006

**FOLLOW UP**
December 20, 2006 - time comparisons since go live
January 20, 2007
February 20, 2007
March 20, 2007
Quarterly evaluation thereafter, report to PI Coordinator QA/RM-006
### Customized Fall Risk Assessment – (MediTech screen shot from 2009)

The total risk score is automatically calculated as the nurse documents.
Solution – Be Proactive!

- **Failure Mode Effects Analysis (FMEA)** - is conducted as a facility proactive approach to prevent system failures.

- **Root Cause Analysis (RCA)** - is conducted as a facility reactive approach to ask “Why?” and find the root cause of system failures, in order to prevent the system failures.
Questions?

Thank you!

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