Quality and Safety in an Era of Healthcare Reform

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Disclosure Statement

I have *no* financial or non-financial conflicts of interest with the materials being presented today!

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Objectives

1. Name three quality programs resulting from healthcare reform legislation, and describe the related financial implications of these programs.
2. Describe at least one concept about the "science" of safety, and identify one related behavior that can improve safety.

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What is YOUR definition of quality?

Quality in healthcare is…

Doing the right thing, at the right time, for the right person, and having the best possible result.

~Agency for Healthcare Research & Quality (AHRQ)

- Safe
- Effective
- Efficient
- Timely
- Person-Centered
- Equitable

What Areas Does "Quality" Address?

Performance Improvement	High Reliability	Patient Safety	Risk Management
Accreditation/ Regulatory	Patient Experience	Infection Prevention	Associate Safety

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Quality Measures

Process Measures
- Core Measures

Outcome Measures
- Complications
- Readmissions
- Mortality

Efficiency Measures
- Length of Stay
- Cost of Care

Patient Perception of Care
- HCAHPS

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Healthcare Reform

From volume to *value*!

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Value-Based Healthcare Reform Programs

"Instead of payment that asks, *How much did you do?,*
the Affordable Care Act clearly moves us
toward payment that asks, *How well did you do?*,
and, more importantly, *How well did the patient do?*"
~Don Berwick

- Value-Based Purchasing Program (VBP)
- Hospital-Acquired Condition (HAC) Reduction Program
- Reducing Readmissions Program

Value-Based Purchasing

- Program began October 2012
- Evolves annually
- Based on Federal Fiscal Year cycle, October 1-September 30 each year, most recent report for FY2017
- Payments impacted by FY2017 program October 1, 2016 to September 30, 2017
- Generally based on data from 2015 (varies by element)
- Currently collecting data for FY18 or FY19 on most measures

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Value-Based Purchasing

- Methodology uses greater of “Achievement” or “Improvement” points
- Achievement points are earned by performing above the national benchmark
- Improvement points are earned by improving performance over your organization’s previous results, even if below benchmark

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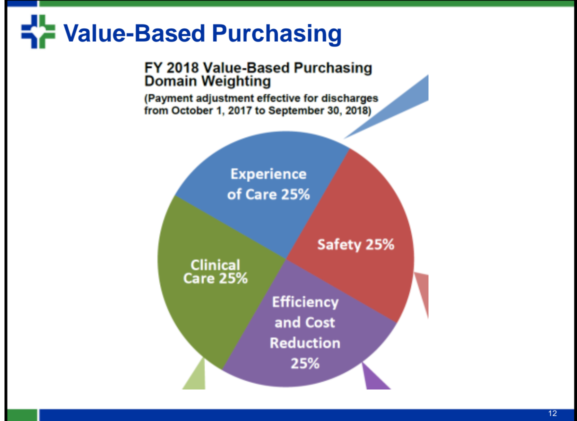
Value-Based Purchasing



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VBP Patient Experience of Care (25% weight)

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Pain Management
- Communication about Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital
- Care Transitions Measure (NEW for FY18)

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VBP Patient Experience of Care

- 2nd Score for "Consistency" Points
- Reward hospitals with scores above 50th percentile in ALL 8 measures for HCAHPS.
- Lowest scoring measure is used to calculate.

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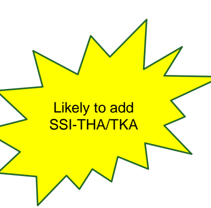
VBP Safety (25% weight)

- PSI-90 Composite (stay tuned for HAC Reduction!)
- Perinatal Care Core Measures: Elective Deliveries Prior to 39 Completed Weeks Gestation (MOVED for FY18 from Clinical Care—Process)
- Healthcare-Associated Infections
  - CLABSI
  - CAUTI
  - SSI: Colon
  - SSI: Abdominal Hysterectomy
  - C. difficile
  - MRSA



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VBP Efficiency (25% weight)

- Medicare Spending per Beneficiary

Likely to add Cost per Episode of Care for AMI, HF, PN

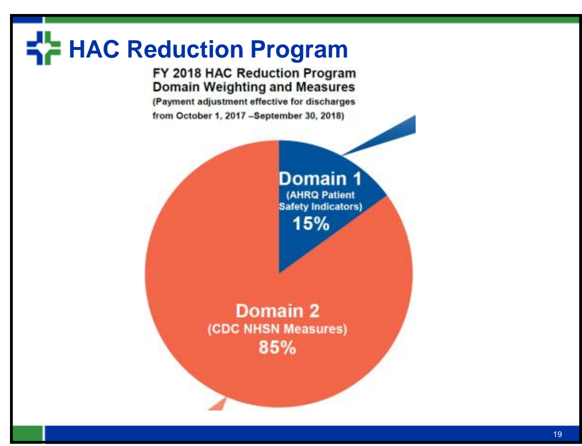
VBP Clinical Care (25% weight)

- Acute Myocardial Infarction 30-day Mortality
- Heart Failure 30-day Mortality
- Pneumonia 30-day Mortality

Likely to add COPD, Stroke, CABG

VBP Financial Impact

- Program at 2% “Take-Back” and scheduled to stay at that level for now.
- This program does have an “upside” for high-performing hospitals.



HAC Reduction Program

DOMAIN 1	
	Performance Period July 1, 2014 – September 30, 2015
AHRQ* Modified PSI 90 Measure**	Winsorized Z-Score
PSI 03 Pressure ulcer rate	
PSI 06 Iatrogenic pneumothorax rate	
Removed! ~~PSI 07 Central venous catheter-related blood stream infection rate~~	
PSI 08 In-hospital fall with hip fracture rate	
New! PSI 09 Perioperative hemorrhage or hematoma rate	
New! PSI 10 Postoperative acute kidney injury requiring dialysis rate	
New! PSI 11 Postoperative respiratory failure rate	
PSI 12 Perioperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (respecified)	
PSI 13 Postoperative sepsis rate	
PSI 14 Postoperative wound dehiscence rate	
PSI 15 Unrecognized abdominopelvic accidental puncture/laceration rate (respecified)	

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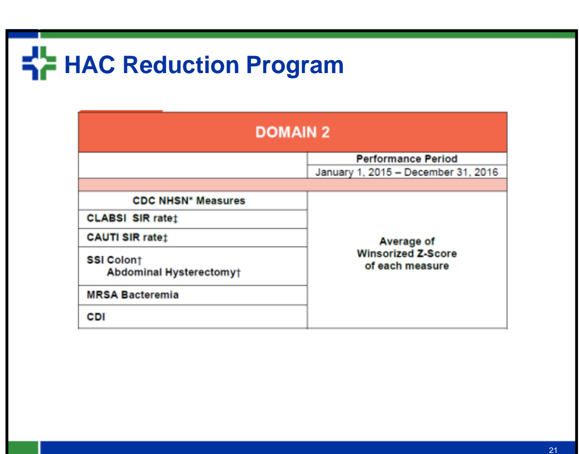
HAC Reduction Program

DOMAIN 2	
	Performance Period January 1, 2015 – December 31, 2016
CDC NHSN* Measures	Average of Winsorized Z-Score of each measure
CLABSI SIR rate‡	
CAUTI SIR rate‡	
SSI Colon† Abdominal Hysterectomy†	
MRSA Bacteremia	
CDI	

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VBP Safety (25% weight)

- PSI-90 Composite (stay tuned for HAC Reduction!)
- Perinatal Care Core Measures: Elective Deliveries Prior to 39 Completed Weeks Gestation (MOVED for FY18 from Clinical Care—Process)
- Healthcare-Associated Infections
  - CLABSI
  - CAUTI
  - SSI: Colon
  - SSI: Abdominal Hysterectomy
  - C. difficile
  - MRSA

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HAC Reduction Program Financial Impact

- Score calculated for each measure
- Multiplied by weight for domain
- Score ranked top to bottom by hospital

- 1% Payment Penalty to bottom quartile

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Reducing Readmissions Program

Measure [a]	Number of Eligible Discharges at Your Hospital [b]*	Number of Readmissions of Your Hospital's Eligible Discharges [c]*	Predicted Readmission Rate [d]*	Expected Readmission Rate [e]*	Excess Readmission Ratio [f]*	National Observed Readmission Rate [g]

Ratio is calculated for each measure, based on:
- "Predicted" Readmission rate vs.
- "Expected" Readmission rate.

AMI
COPD
HF
Pneumonia
CABG
THA/TKA

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RR Program Financial Impact

- Ratio > 1.0 is penalized
- Penalty is based on ratio and volume
- Max penalty is up to 3%

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Objectives

1. Name three quality programs resulting from healthcare reform legislation, and describe the related financial implications of these programs.
   A. Value-Based Purchasing Program = 2% penalty or incentive
   B. HAC Reduction Program = 1% penalty
   C. Reducing Readmissions Program = Up to 3% penalty

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The Process for Achieving Excellence

Current Care

Transformation through Action

ACT PLAN STUDY DO

Better Care

based on evidence

defined by the consumer

demonstrated by measurement

Switching Gears…

Safety is…

- The state of being "safe"
- The condition of being protected against physical, social, spiritual, emotional, psychological or other types of errors, accidents or harm
- The control of recognized hazards to achieve an acceptable level of risk

Patient and Associate Safety

1999

- 44,000 to 98,000 patient deaths per year from medical errors

To Err is Human, Institute of Medicine (1999)

2013

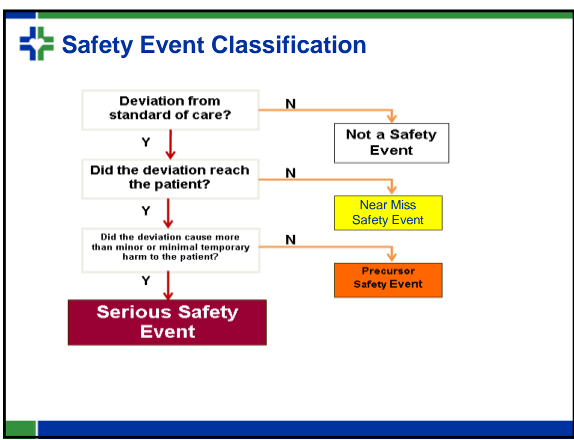
- 210,000 – 400,000 deaths per year associated with preventable harm in hospitals
- Serious harm seems to be 10-20 fold more common than lethal harm

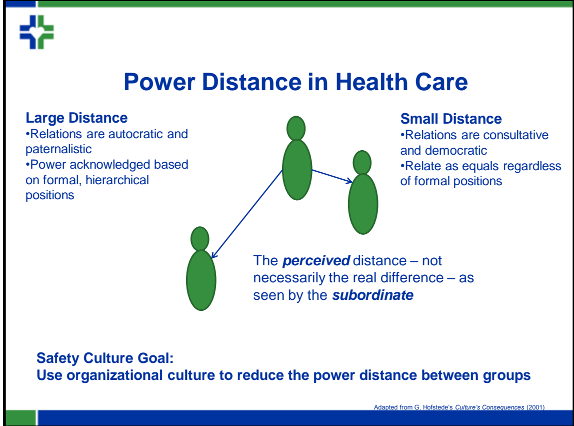
Journal of Patient Safety, September 2013

John T. James, PhD

Healthcare leads all industries in worker injuries.

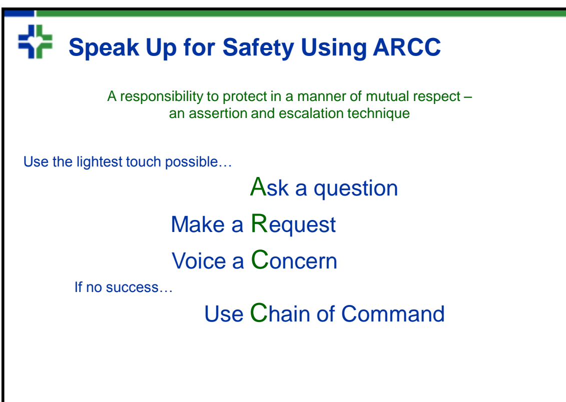
Approximately half of injuries are from lifting & handling.

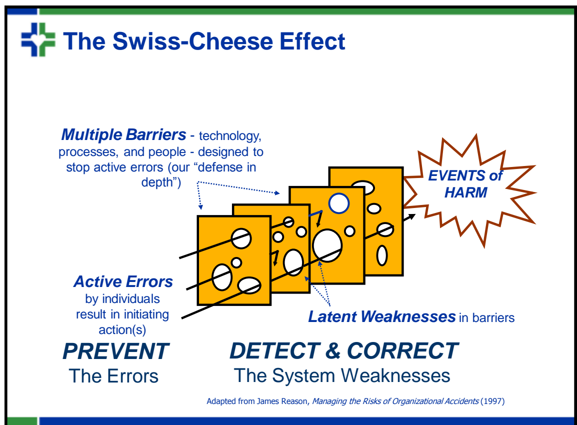


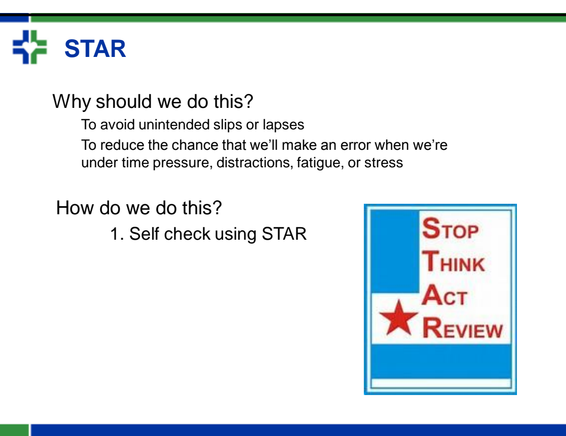


Set the Tone

1. Smile and greet others
   - Eye contact, say hello
2. Refer to others by preferred name
   - Usually first name
3. Listen with empathy and intent to understand
4. Provide opportunities for others to ask questions


Speak Up for Safety Using ARCC
A responsibility to protect in a manner of mutual respect – an assertion and escalation technique
Use the lightest touch possible…
Ask a question
Make a Request
Voice a Concern
If no success…
Use Chain of Command


The Swiss-Cheese Effect
Multiple Barriers - technology, processes, and people - designed to stop active errors (our "defense in depth")
EVENTS of HARM
Active Errors by individuals result in initiating action(s)
Latent Weaknesses in barriers
PREVENT
The Errors
DETECT & CORRECT
The System Weaknesses
Adapted from James Reason, Managing the Risks of Organizational Accidents (1997)


STAR
Why should we do this?
To avoid unintended slips or lapses
To reduce the chance that we'll make an error when we're under time pressure, distractions, fatigue, or stress
How do we do this?
1. Self check using STAR
Stop
Think
Act
Review

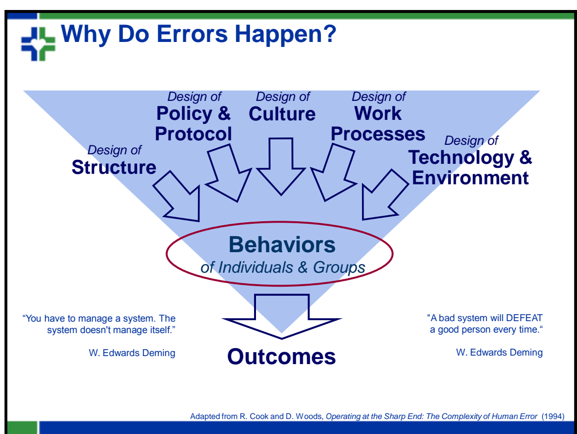
Teach Back

Instead of asking: “Do you have any questions?” or “Do you understand?”

Ask: Tell me…Show me

- **Tell me** what you know about…
- **Tell me** how you would explain that to…
- **Tell me** how you would know if…
- Can you **tell me** an example of…
- **Tell me** what you would do if…
- **Tell me** who you would call if…
- **Show me** how you would…
- **Show me** what you would do if…

Why Do Errors Happen?



“You have to manage a system. The system doesn't manage itself.”
W. Edwards Deming

“A bad system will DEFEAT a good person every time.”
W. Edwards Deming

Adapted from R. Cook and D. Woods, *Operating at the Sharp End: The Complexity of Human Error* (1994)

200% Accountability

- Today and everyday I am 100% accountable to the right thing
- Today and every day I am part of a team and I am also 100% accountable that the team does the right thing

Report problems, errors and events

"Every system is perfectly designed to get the results it gets"

–Donald M. Berwick, M.D.
Previous Administrator, Centers for Medicare & Medicaid Services *(CMS)*

We can't fix what we don't know about

It's about fixing the system so the right thing is the easy thing

Reporting should not be punitive

Objectives

2. Describe at least one concept about the "science" of safety, and identify one related behavior that can improve safety.

   A. Power Distance
      - Set the tone
      - ARCC

   B. Swiss-Cheese Model
      - STAR
      - Teach Back

   C. Blunt End-Sharp End Model
      - 200% Accountability
      - Report problems, errors and events

Parting Thoughts

- *"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives" - William A. Foster*

- *"Quality is everyone's responsibility." - W. Edwards Deming*

Questions?

Other Resources

- Institute for Healthcare Improvement
- Agency for Healthcare Research and Quality (AHRQ)
- National Quality Forum
- Joint Commission
- Center for Improving Healthcare Quality
- Press Ganey (NDNQI, HPI)

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