Quality Reporting Measures for Critical Access Hospitals

Vicki Tang Olson

Minnesota Rural Health Conference
June 24, 2013
Goal for Today
Objectives

• Understand the different quality programs
• Give a visual framework to make sense of quality programs and measures
• Discuss the senior leader’s role in improving their hospital measures
Why is it so confusing and hard?

• Acronyms
• Complicated and detailed
• Resource intensive
• Long term gain
• Disconnect with value
• Difficult to meet the expectations of perfection
National Distribution of Critical Access Hospitals (CAHs) and Maryland (MD) Hospitals (FY 2009)
National Distribution of Full APU Hospitals (FY 2009)
National (PPS) Quality Requirements

CMS Inpatient Quality Program (IQR)

CMS Outpatient Quality Program (OQR)
State and National (PPS) Quality Requirements

- MN 62 J Infection Reporting
- CMS Inpatient Quality Program (IQR)
- CMS Outpatient Quality Program (OQR)
- Statewide Quality Reporting and Measurement System (SQRMS)
State and National (PPS) Quality Requirements

- CMS Inpatient Quality Program (IQR)
- CMS Outpatient Quality Program (OQR)
- Statewide Quality Reporting and Measurement System (SQRMS)
- Other measures
- MN 62 J Infection Reporting

Other measures include:

- Other measures that are not specifically mentioned in the diagram.
State and National (PPS) Quality Requirements

CMS

Inpatient Quality Program (IQR)

Outpatient Quality Program (OQR)

Statewide Quality Reporting and Measurement System (SQRMS)

Other measures

MN 62 J Infection Reporting

CMS Inpatient Quality Program (IQR)

Medicare Beneficiary Quality Improvement Program

CAH only
State and National (PPS) Quality Requirements

- CMS Inpatient Quality Program (IQR)
- CMS Outpatient Quality Program (OQR)
- MN 62 J Infection Reporting
- Statewide Quality Reporting and Measurement System (SQRMS)
- Medicare Beneficiary Quality Improvement Program
- Other measures
- Value-based Purchasing Program

PPS only
State and National (PPS) Quality Requirements

CMS Inpatient Quality Program (IQR)
CMS Outpatient Quality Program (OQR)
Statewide Quality Reporting and Measurement System (SQRMS)
Medicare Beneficiary Quality Improvement Program
Other MN requirements
CMS 10th Scope of Work Initiatives
Other measures

MN 62 J Infection Reporting
Value-based Purchasing Program

Hospital Engagement Network

Stratis Health
Hospital Priorities

- Culture: All health care settings (MAPS)
- Collaborative Healthcare Associated Infection Network (CHAIN)
- Partnership for Patients: Hospital Engagement Network 10th Scope of Work
- Reducing Avoidable Readmissions Effectively (RARE)
- Calls-to-Action
- Community

- TCAB
- HAI
- ADE & VTE
- OB
- Value-Based Purchasing
- PU
- Falls
- Safe Surgery
- Retained Objects
- Medicare Spending per Beneficiary
- Care Transitions
- Mortality
- Palliative Care

StratisHealth
Minneapolis Hospital Association
Partnership for Patients Campaign

Accountable Care Act

Department of Health and Human Service

Center for Medicare & Medicaid Innovations

Partnership for Patients

- Hospital Engagement Network (MHA)
- Q10 10th Scope of Work (Stratis)

12 focus areas

- Falls
- Pressure Ulcers
- Adverse Drug Events
- Perinatal Safety
- VTE
- HAI's
- Readmissions
- Culture
- TCAB
# Outcome Measures

<table>
<thead>
<tr>
<th>HAC</th>
<th>Measure</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td># of falls</td>
<td>Q1’ 2013</td>
</tr>
<tr>
<td>Falls with Injury</td>
<td># of falls w/injury</td>
<td>Q1 ‘2013</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td># of Stage II – Unstageable</td>
<td>Q1 ‘2013</td>
</tr>
<tr>
<td>VTE</td>
<td># of VTEs</td>
<td>MHA (claims)</td>
</tr>
<tr>
<td>ADE – anticoagulants</td>
<td># of patients with INRs &gt;5</td>
<td>Q2 ‘2013</td>
</tr>
<tr>
<td>ADE – hypoglycemia</td>
<td># of patients with blood glucose &lt;40</td>
<td>Q2 ‘2013</td>
</tr>
<tr>
<td>ADE – Opioids</td>
<td># of inpatient narcan administrations</td>
<td>Q2 ‘2013</td>
</tr>
<tr>
<td>CLABSI</td>
<td># of CLABSI cases</td>
<td>Q2 ‘2013</td>
</tr>
<tr>
<td>CAUTI</td>
<td># of CAUTI cases (house-wide)</td>
<td>Q1 ‘2013</td>
</tr>
<tr>
<td>SSI</td>
<td># of SSIs (across all procedures)</td>
<td>Q1 ‘2013</td>
</tr>
<tr>
<td>EED</td>
<td># of EEDs not meeting exclusion criteria</td>
<td>Q1 ‘2013</td>
</tr>
<tr>
<td>Wrong Site procedures</td>
<td># of events</td>
<td>MHA (AHE)</td>
</tr>
<tr>
<td>Wrong Procedures</td>
<td># of events</td>
<td>MHA (AHE)</td>
</tr>
<tr>
<td>Wrong Patient Procedures</td>
<td># of events</td>
<td>MHA (AHE)</td>
</tr>
<tr>
<td>Retained Foreign Objects</td>
<td># of events</td>
<td>MHA (AHE)</td>
</tr>
</tbody>
</table>
Statewide Quality Reporting and Measurement System
# CY2013 SQRMS Hospital Measures Timeline

**Minnesota Statewide Quality Reporting and Measurement System (SQRMS)**

<table>
<thead>
<tr>
<th>JANUARY</th>
<th>FEBRUARY</th>
<th>MARCH</th>
<th>APRIL</th>
<th>MAY</th>
<th>JUNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDH, with input from key stakeholders, defines the focus for the upcoming measurement year. Stratis Health reviews Hospital Measures Steering Committee membership and, recommends changes to MDH for final approval.</td>
<td>Stratis Health convenes the Hospital Measures Steering Committee.</td>
<td>The Hospital Measures Steering Committee completes its work. These public meetings are advertised in the weekly health reform newsletter.</td>
<td>The Hospital Measures Steering Committee provides recommendations to MNCM who submits to MDH.</td>
<td>The annual public forum is held to gather public input and share recommendations for all SQRMS measures – physician clinic, hospital and ambulatory surgery centers. MDH also invites and accepts written comments on the recommendations from the public during this time.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>JULY</th>
<th>AUGUST</th>
<th>SEPTEMBER</th>
<th>OCTOBER</th>
<th>NOVEMBER</th>
<th>DECEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDH drafts the proposed rule and appendices for the upcoming measurement year.</td>
<td>MDH publishes the proposed rule and appendices with a 30-day public comment period.</td>
<td>MDH revises the proposed rule and appendices based on public comments and facilitates the State's approval process. Stratis Health provides education to hospitals on the final rule and appendices for that year and reinforces with meetings and communications throughout the year.</td>
<td>MDH publishes the final rule and appendices.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Focus areas in past years

- Alignment with national measures
- Pediatrics
- Rural sensitive measures
Recommendations for 2014

• Add: elective delivery prior to 39 weeks
• Suspend: ED Transfer Communication
Recommendations for 2014

Remove:

• Inpatient Emergency Department Throughput (ED1a through 2c)
• Children’s Asthma Care (CAC-3 Home Management Plan of Care document given to patient/caregiver)
• AHRQ measures other than composite measures – PSI-90 and PDI 19
Future discussion

- Stroke
- Readmissions
- Behavioral/mental health
- Nurse sensitive conditions
- Safety culture
- Infections
Medicare Beneficiary Quality Improvement Program (MBQIP)
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Last 4 qtr</th>
<th>MN 3qtr 2012</th>
<th>US 3qtr 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF-1 Discharge Instructions</td>
<td>68.93% of 737 pt</td>
<td>73.1%</td>
<td>81.96%</td>
</tr>
<tr>
<td>HF-2 Evaluation of LVS Function</td>
<td>81.74% of 1183 pt</td>
<td>81.55%</td>
<td>85.48%</td>
</tr>
<tr>
<td>HF-3 ACEI or ARB for LVSD</td>
<td>81.82% of 286 pt</td>
<td>84.62%</td>
<td>87%</td>
</tr>
<tr>
<td>PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital</td>
<td>93.2% of 941 pt</td>
<td>97.89%</td>
<td>94.65%</td>
</tr>
<tr>
<td>PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients</td>
<td>85.08% of 1186 pts</td>
<td>87.07%</td>
<td>88%</td>
</tr>
</tbody>
</table>
## MBQIP-CMS Retired Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF-4</td>
<td>Adult Smoking Cessation Advice/Counseling</td>
</tr>
<tr>
<td>PN-2</td>
<td>Pneumococcal Vaccination</td>
</tr>
<tr>
<td>PN-4</td>
<td>Adult Smoking Cessation Advice/Counseling</td>
</tr>
<tr>
<td>PN-5c</td>
<td>Initial Antibiotic Received Within 6 Hours Of Hospital Arrival</td>
</tr>
<tr>
<td>PN-7</td>
<td>Influenza Vaccination</td>
</tr>
</tbody>
</table>
Phase 2 MBQIP

• Outpatient 1-7 on AMI/Chest pain and outpatient surgery
• HCAHPS
Phase 3 MBQIP

• ED Transfer Communication
• Pharmacy review of medication orders
History of CMS Measures

Required CMS Measures for Inpatient Program

Number of Measures

CMS Fiscal Year


0 10 20 30 40 50 60

Stratis Health
Popular website resources

2013 Hospital Measures

VBP fact sheet
Specification manuals

- Inpatient manual
- Outpatient manual
- Joint Commission
- NHSN modules
- ED Transfer Communication guide
- Stroke registry
Support on Specifications

• Abstracting webinar for new specifications for inpatient and outpatient measures
• NHSN users group
• Annual webinar in December/January for state measures
Data Collection

• Concurrent, Monthly, Quarterly
• CART or Vendor
Improvement

Validate Data

Report ing

Specifications

Rule or Quality Commitment

Measure

Data Collection

Data Submission
Data Submission

- Clinical Process of Care
- Healthcare Associated Infections
- ED Transfer Communication - suspended
- Asthma
- Late sepsis/meningitis in NICU
- HIT survey

Logos:
- QualityNet
- NHSN National Healthcare Safety Network
- Minnesota Hospital Association
- Minnesota Stroke Registry
- Stratis Health
Validate Data

Improvement → Reporting → Specifications → Data Collection → Data Submission → Validate Data → Reporting

Rule or Quality Commitment → Measure → Data Collection
Validation

- Rural Flex monies
- Offer validation for Critical Access Hospitals
- Bring common issues to Core Measures meetings
Reporting

- Hospital Profile Reports
- Hospital Compare Comparison graphs
- VBP worksheets upon request
Quality Reporting & Improvement

Inpatient Process Measures and HCAHPS Survey Dimensions

December 2011
Stratis Health Support
Stratis Health

• Medicare Quality Improvement Organization for Minnesota

• Program areas
  – Health disparities
  – Health information technology
  – Rural health
Stratis Health’s Role in Supporting Public Quality Reporting

- CMS 10th Scope of Work
  - Inpatient & VBP
  - Outpatient
  - Technical assistance
  - Improvement support

- MDH/Minnesota Community Measurement
  - Hospital recommendations
  - Education on requirements
  - ED Transfer Communication User Guide

- ORHPC Flex Funding
  - Support for health care reform
  - MBQIP
  - Validation

Stratis Health's Role in Supporting Public Quality Reporting
Stratis Health website

- Abstraction specifications calls twice yearly
- Monthly NHSN users group webinars

Site visits

- Core Measures Meeting
- Spring Regional Meetings
- Abstraction 101
Hospital Communication Distribution List

Stratis Health routinely communicates key information to Minnesota hospitals regarding CMS and Minnesota hospital quality measures. Please list your name and information below and check the topics you would like to receive information about. Please fax this completed form to Robyn Carlson, Stratis Health, 952-853-8503.

YOUR HOSPITAL NAME: ____________________________

Name _______________________________________
Title _______________________________________
Phone ________________________________
Email _______________________________________

☐ Inpatient/Outpatient Core Measures and Abstraction/Measure Changes
☐ Submission Reminders
☐ Healthcare Associated Infections
☐ HCAHPS
☐ Readmission Reduction Program
☐ Value-Based Purchasing
☐ Hospital Check-In Newsletter
Hospital Check-in Newsletter

- Data submission reminders
- Current CART tool
- Short articles on IQR, OQR, VBP changes
- Monthly calendar
- Abstraction column – Robyn Speaking
- Technical and improvement assistance contact information
Value-based Purchasing
What is it?

- Value-based purchasing is an incentive program, in this case, for PPS hospitals where 1% Medicare DRG payments are withheld to fund the program and given back to hospitals based on their performance on specified measures.
Background

• The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care
- Quarterly
- Produced for both CAH and PPS hospitals even though incentive doesn’t apply to CAH
FY2013

1st Year

Results In!
FY 2013 Value-Based Purchasing
Total Performance Score
Minnesota PPS Hospitals

Total Performance Score
Minneapolis Average
National Average

StratisHealth
FY 2013 Value-Based Purchasing
Net Change in Base Operating DRG Payment Amount
Minnesota PPS Hospitals
FY 2014 Domain Weighting

- Outcome Domain: 45%
- Clinical Process of Care: 30%
- Patient Experience of Care: 25%
How Will Hospitals Be Evaluated?
Improvement vs. Achievement

Achievement:
My hospital’s current performance compared to all hospitals’ Baseline Period Performance

Improvement:
My hospital’s current performance compared to my Baseline Period Performance
Clinical Process of Care Domain
Example: AMI-7a – Fibrinolytic Therapy
(Slide 5 of 8)

Baseline Performance

Threshold

Achievement Range

Baseline Rate

Improvement Range

The improvement range “is a scale between the hospital’s prior performance rate on the measure during the baseline period and the benchmark.”

= Baseline Period Rate

= Benchmark (mean of the top decile)
Clinical Process of Care Domain
Performance Standards based on National Measure Rates

This scale represents the percent of eligible patients who received the applicable treatment.

- Threshold (50th percentile)
- Benchmark (mean of the top decile)
Patient Experience of Care Domain
Achievement Range for the 8 HCAHPS Dimensions

- Nurse Comm.
- Threshold
- Benchmark
- Doctor Comm.
- Staff Resp.
- Pain Mgmt.
- Medicine Comm.
- Clean & Quiet
- Discharge Info.
- Overall Rating

- Threshold (50th percentile)
- Benchmark (mean of the top decile)
Best Practices Presentations

• HealthEast – root cause analysis
• Fairview Northland – VBP success
• Maple Grove – VBP success

Recordings on Stratis Health website
Readmission Reduction Program
FY2013 Readmission Reduction Program
Minnesota PPS Hospital Results

Net Change in DRG payment

Stratis Health
Improvement

Rule or Quality Commitment

Measure

Data Collection

Specifications

Reporting

Validate Data

Data Submission

Data Measure
Why Measure?

Weighing a pig doesn’t make it fatter

-African proverb
CMS Ultimate Goal: Shift the Curve
Success Factors

• Senior leadership sets the expectation
• Root cause analysis conducted with every miss
• Improvement cycles are evident
• Improvement teams have a bias for action
• Buy-in is patient focused
• Sense of ownership and pride
How small is too small?

🌟 Missed Opportunities
- It is best to measure missed opportunities rather than the percent of performance.
- One out of 10 seems reasonable, right? Form yourselves in groups of 10 and decide which of you will not receive the right lifesaving care.
- Quality improvement is not about percentages. It is about misses and mistakes.

🌟 The Power of One
- Can one case make a difference? Remember, in collecting data there is human impact.
- The power of one allows you to evaluate how a new or current process performs. Do not wait for more than one missed opportunity to evaluate the process.
- In quality improvement, one is not a lonely number if there is another one on the way.
Defect Analysis
Defect Analysis

• Track every “defect” where a patient measure was not met – concurrent review helps
• Look at most common failures
• Conduct a root cause analysis
• Implement improvement strategies
Barriers to RCA

Taking Time
• Facilitator time
• Hard to get people together

Skill/process
• Development
• Lack of knowledge

Commitment
• Good enough

Process Management
• Lack of standardized system

Fear
• Afraid of blame
• Protecting others
• Hard to admit mistake
• Not sharing relevant information
Barriers to RCA Facilitation

- Tendency to make quick decisions and not tolerate RCA
- Lack of tolerance for ambiguity
- Generalize and not “peel the onion”
- Preconceived decision about why/what happened
- “Leading” facilitator
- Bias toward resolving
- Not getting in frame of mind of the people involved in the situation
Swiss Cheese Model

Complexity Model applied to System Failures: Categories of “Bundles”

The latent failure model of complex system failure - modified from James Reason, 1991
Modified from Richard I. Cook, MD (1997)
Characteristics of High Reliability Organizations

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

Weick and Sutcliffe 2001
RCA flow

- Senior Leadership commitment
- What is your target?
- Get involved staff together
- Education of staff on RCA

Gather information
- Round robin
- Pre-interview
- Flowcharting
- Review policy vs. practice
RCA flow

- Agree on breakdown/variance
- 5 whys
- Problem-solve/solutions
- Create action plan
- Implement action

Share data with senior leadership
<table>
<thead>
<tr>
<th></th>
<th>Checklist</th>
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<tbody>
<tr>
<td></td>
<td>Does our organizational scorecard include the core measures?</td>
</tr>
<tr>
<td></td>
<td>Has my organization reported the measures each quarter?</td>
</tr>
<tr>
<td></td>
<td>Do we have a model of leadership?</td>
</tr>
<tr>
<td></td>
<td>Do we have leadership commitment?</td>
</tr>
<tr>
<td></td>
<td>Do we assess our quality/patient safety culture?</td>
</tr>
<tr>
<td></td>
<td>Do we have a culture of learning?</td>
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<tr>
<td></td>
<td>Have we set our goals to perfection?</td>
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<tr>
<td></td>
<td>Does the board have regularly scheduled updates on quality?</td>
</tr>
<tr>
<td></td>
<td>Have we transitioned as a board to looking at quality as a driver of financial success?</td>
</tr>
<tr>
<td></td>
<td>Do we have the resources and the right skill set to be successful?</td>
</tr>
<tr>
<td></td>
<td>Is your project charter complete and approved?</td>
</tr>
</tbody>
</table>
Implement Evidence-Based Strategies
MAPS Patient Safety Culture Roadmap
### The MAPS Safety Culture Roadmap: A Bird’s Eye View

#### GETTING STARTED
- Endorse culture effort
- Develop steering committee
- Identify champions
- Conduct culture survey
- Analyze survey results
- Develop plan
- Provide education on safety

#### LEADERSHIP
Strategies/tactics for these leaders to set clear patient safety expectations:
- Governance
- CEO/administrator
- Clinician leaders
- Managers

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
<th>JUSTICE</th>
<th>TEAMWORK</th>
<th>LEARNING</th>
<th>ENGAGEMENT</th>
</tr>
</thead>
</table>
| • Structured communication process  
  • Structured handoffs  
  • Stop-the-line policy | • MAPS statement of support  
  • Key stakeholder groups  
  • Just/accountable education  
  • HR practices  
  • RCA process  
  • Clinical practices  
  • Hardwiring/sustaining | • Readiness assessment  
  • Facilitator recruitment  
  • Team training  
  • Gap assessment  
  • Workplans | • Reality rounding  
  • Reporting system  
  • RCA process  
  • Use of report data | • Patient/Resident/Client and Family  
  • Soliciting input  
  • Pt/family empowerment processes  
  • Effective disclosure  
  • Health care literacy and cultural competence |

#### SUSTAINING THE OVERALL CULTURE INITIATIVE
- Measurement
- Metrics analysis
- Course corrections/new actions
- Dissemination of data/findings/actions
- Review of plan
- Education
- Evaluation of performance
MAPS Culture Roadmap Data

Percent of Best Practices implemented

N = 38 hospitals completed roadmap/56 signed up

Getting Started: 73%
Leadership: 63%
Communication: 47%
Justice: 52%
Teamwork: 19%
Learning Environment: Q4-2012
Engagement: 70%
Sustained: 63%
Potentially Preventable Readmissions in Minnesota
2009 - 2012 3rd Qtr

Actual to Expected Ratio

RARE Campaign Launched

Goal
MN RARE

Five Focus Areas

- Patient and Family Engagement
- Transition Communication
- Comprehensive Discharge Plan
- Medication Management
- Transition Support
RARE CAMPAIGN PROGRESS

RARE Campaign: 4,570 Readmissions Prevented to Date

Original Goal of 4,000 Exceeded!

Each person represents 250 prevented readmissions, and 1,000 more rights of sleep in their own beds for Minnesotans

The 2012 date is in and the Minnesota Reducing Avoidable Readmission Effectively (RARE) Campaign participants have collectively prevented 4,570 readmissions in the last two years, exceeding our goal of 4,000. You have successfully helped patients in Minnesota spend 18,280 rights of sleep in their own beds and reduced health care expenditures by more than $40 million. This is truly a reflection of your commitment to better care for our patients, innovative improvement and hard work.

RARE Report
May 2013

News, insights and tools to help you prevent avoidable readmissions. Top stories:
- 4,570 Avoidable Readmissions Prevented Since Campaign Began
- RWJF Grant Will Fund RARE Campaign Mental Health Collaborative
- Upcoming Events and News
- Highlights from April’s Action Learning Day
- Windsor Hospital Achieves Notable Reduction in Avoidable Readmissions

Full newsletter

RARE Campaign Success - in Pictures

Participating hospitals please take a moment to recognize your accomplishments by submitting a photo or video of your RARE team members with pillows representing the number of avoidable readmissions you have prevented since the campaign began. Photos and videos are due Friday, May 31. Win prizes!

Patient and Family Engagement: Understanding the Basics

This May 29 webinar provides information on...
* Indicates that the HEN SIR is statistically different from the estimated national PfP average at $p < .05$. 
* Indicates that the HEN SIR is statistically different from the estimated national PfP average at $p < .05$. 

CAUTI SIR by HEN: Q2 2012 (NHSN Data)
Indicates that the HEN SIR is statistically different from the estimated national PfP average at \( p < .05 \).
About the Collaborative Healthcare-Associated Infection Network (CHAIN)

Healthcare providers are taking action to reduce HAIs

Healthcare-associated infections (HAI) are infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care. Medical advances have brought lifesaving care to patients in need, yet many of those advances come with a risk of HAI. These infections related to medical care can be devastating and even deadly. As our ability to prevent HAIs grows, these infections are increasingly unacceptable.

Recent successes in HAI elimination have been very encouraging. Reductions have been demonstrated for other HAIs as well, but much more remains to be done. Wherever patient care is provided, adherence to Infection prevention guidelines is needed to ensure that all care is safe care. This includes traditional hospital settings as well as outpatient surgery centers, long-term care facilities, rehabilitation centers, and community clinics.

Collaborative Healthcare-Associated Infection Network (CHAIN)

The Collaborative Healthcare-Associated Infection Network (CHAIN) develops and helps carry out effective approaches for reducing and preventing healthcare-associated infections in Minnesota. Healthcare-associated infections (HAI) prevention goals are achieved through interventions focused on hand hygiene, transmission precautions, injection practices, antimicrobial stewardship, environmental cleaning and evidence-based clinical bundles. The partnership is focusing on reducing and preventing the following infections:

- **CLABSI**: central line associated bloodstream infections
- **CAUTI**: catheter associated urinary tract infections
- **CDI**: C. diff. clostridium difficile infections
- **SSI**: surgical site infections

This work aligns with the work of other groups focusing on patient safety, adverse event reporting, transforming care at the bedside, and quality reporting and improvement. The initial focus for prevention is on infections occurring in the hospital setting.

APIC MN, the Minnesota Department of Health, the Minnesota Hospital Association, and Stratis Health formed CHAIN in 2011.

Targeted Settings for Infection Reduction

Initially targeted to hospitals, the project will expand to ambulatory surgery centers, long-term acute care rehabilitation facilities, clinics, nursing homes, home care agencies, and HCC. This work will be aligned with the work of other groups focusing on patient safety, reportable events, transitional care at the bedside, quality reporting and improvement, and improving preventive health by achieving meaningful use of electronic health record systems.

Minnesota Statewide HAI Plan

HAIs are a serious patient safety issue, and reducing HAIs is a national priority. In 2009, the U.S. Department of Health...
Mortality

- Admission
- Discharge with AMI, HF, PN
- 30 Days after discharge
Where to focus efforts: Mortality

- Sepsis
- VAE
- VTE
- Rapid Response Teams

Care Transitions → Follow-up care
Reducing Sepsis

2012 Surviving sepsis guideline

IHI sepsis bundle
http://www.ihi.org/knowledge/Pages/Changes/ImplementtheSepsisManagementBundle.aspx
Study: Hospitals With More Facebook 'Likes' Have Lower Mortality Rates

LINDSAY ABRAMS | MAR 5 2013, 8:07 AM ET

Online popularity reliably indicates quality care -- in this case.
Medicare Spending Per Beneficiary

• Actual/expected
• 3 days prior to index admission, admission, and 30 days after admission
• 7 claims types
Heart Failure

Heart failure is the most common hospital admission diagnosis in patients age 65 or older, accounting for more than 700,000 hospitalizations among Medicare beneficiaries every year. It is associated with severe functional impairments and high rates of mortality and morbidity.

Substantial scientific evidence indicates that the following Process of Care measures represent the best-practices for the treatment of heart failure. Higher scores are better*

*from Hospital Compare

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Description*</th>
<th>Description for patient*</th>
<th>Common failure modes</th>
<th>Best-practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF-1</td>
<td>Discharge instructions</td>
<td>Heart failure patients discharged home with written instructions or educational material given to patient or care giver at discharge or during the hospital stay addressing the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.</td>
<td>The staff at the hospital should provide you with information to help you manage your heart failure symptoms when you are discharged.</td>
<td>Pt dx not clearly articulated/coded before they discharged so not identified as HF patient. Must meet ALL instruction criteria so might miss just one and fail measure. Documentation says pt was given pamphlet and the detail of patient education topics that are covered by the pamphlet are not captured in the record, so can’t give credit for meeting the measure. Discharge med reconciliation is not complete (common error is what MD orders on discharge summary does not match discharge summary meds). Nurses know that pt with frequent admissions have received pt education so reluctant/forget to give it.</td>
<td>Pt education pamphlet topic areas are preprinted on the discharge sheet and can be checked. MD clearly documents in discharge documentation whether the pt had HF. MDs and Nurses clearly understand coding for HF so try to anticipate before discharge. Coding is concurrent. HF pt are identified on admission and there is a “sticker” identifying them on chart. Nurse has discharge checklist to make sure all clinical standards are met.</td>
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Questions?

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.