CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS)

QAPI Standards and QAPI Worksheet
Speaker

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- sdill1@columbus.rr.com
- CMS Email hospitalscg@cms.hhs.gov
You Don’t Want One of These
The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Manual updated more frequently now
  - Tag number 0001 through 1164 and PI starts at tag 263
  - Questions to CMS at hospitalscg@cms.hhs.gov

- First regulations are published in the Federal Register then CMS publishes the Interpretive Guidelines and some have Survey Procedures
  - Hospitals should check this website once a month for changes

Subscribe to the Federal Register

www.federalregister.gov/my/sign_up
Location of CMS Hospital CoP Manuals

Medicare State Operations Manual
Appendix

Questions to CMS at hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

CMS Hospital CoP Manuals new address

<table>
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<th>App. No.</th>
<th>Description</th>
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<tr>
<td>A</td>
<td>Hospitals</td>
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<tr>
<td>AA</td>
<td>Psychiatric Hospitals</td>
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Also Called the State Operation Manual

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 176, 12-29-17)

Transmittals for Appendix A

Survey Protocol

Introduction
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

Email questions
hospitalscg@cms.hhs.gov

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

- Show all items
- Show only (select one or more options):
  - Show only items whose [ ] is within the past [ ]
  - Show only items whose Fiscal Year is [ ]
  - Show only items containing the following word

Show Items

There are 455 items in this list.
# CMS Survey Memos

## Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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<td>18-12-Deemed Providers/Suppliers</td>
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The Conditions of Participation (CoPs)

- The manual is known as the conditions of participation or the CoPs for short.
- The CoP sections are called tag numbers and go from 1 to 1164.
- When interpretive guidelines (IG) are final they are printed in a transmittal and then placed in the manual.
- All the sections contain a tag number so it is easy to go back and look up that section if you want to read more about it.
# CMS Transmittals

## 2018 Transmittals

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Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data

- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com

- This is the CMS 2567 deficiency data and lists the tag numbers

- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov
Number of Deficiencies for QAPI

- CMS deficiency reports show many deficiencies in QAPI
- CMS is updating quarterly
- PI standards were rewritten March 21, 2014 and many changed tag numbers
- Reports lists the name and address of all hospitals receiving deficiencies
- Can read the deficiencies for each one to get an idea of what surveyors are hitting hard
Updated Deficiency Data Reports

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice, Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments.

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct
### Can Count the Deficiencies by Tag Number

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<tr>
<th>A</th>
<th>B</th>
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<th>E</th>
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<td>Provision of Services</td>
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<td>Patient Care Policies</td>
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<td>273</td>
<td>Data Collection and Analysis</td>
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<td>Policies Infection Control</td>
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<td>281-282</td>
<td>Patient Services</td>
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<td>QI Activities</td>
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<td>286</td>
<td>Patient Safety</td>
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QAPI Deficiencies

- Good article on areas that CMS has cited under QAPI
- Notes that CMS requires data on medication errors and adverse event
- Along with high risk, high volume, and problem prone areas
  - No guarantee that CMS will have the same view as to what this is
- Hospital underwent a validation survey and were cited for not following manufacturers instructions for use in sterilizing equipment
- Ask what data they were collecting and analyzing on this and when said none cited for not monitoring a high risk process
  - Is this sort of like playing whack a mole?

Source: Hospital Accreditation: Setting Priorities for Your QAPI Program. CIHQ at http://www.cihq-blog.org/blog.asp
Areas that CMS has Cited under QAPI

MEDICATION USE
- Sterile Compounding and IV Admixture
- Management of Hazardous Medications
- Medication Administration Practices for High-Risk Meds

INFECTION PREVENTION & CONTROL
- Sterilization of Instruments & Supplies
- High-Level Disinfection of Instruments & Supplies
- MDRO and Isolation Practice
- Disinfection and Cleaning of Dialysis Machines & Equipment

PHYSICAL ENVIRONMENT
- Environmental Controls of Sensitive Areas (Temperature, Humidity, Air Balance)
- Maintenance and Operation of Critical Medical and Utilities Equipment
- Life Safety System Testing and Maintenance
- Implementation of Interim Life Safety Measures
- Protection Against Radiation Hazards

FOOD & NUTRITIONAL SERVICES
- Food Service Preparation, Storage, and Cleanliness

CLINICAL SERVICES
- Ordering Restraint & Seclusion
- Monitoring of Patients in Restraint & Seclusion
- Administration of Blood & Blood Products
- Protection of Patients at Risk of Self-Harm
- Administration of Sedation / Anesthesia
- Surgical and Invasive Procedures

Source: Hospital Accreditation: Setting Priorities for Your QAPI Program. CIHQ at http://www.cihq-blog.org/blog.asp
Hospital CoPs for QAPI

- CMS issued a hospital COPs memo for Quality Assessment Performance Improvement (QAPI)
- CMS issues Memo March 15, 2013 which discusses the AHRQ Common Formats
  - Hospitals are required to track adverse events for QAPI
- Starts with tag number 0263
- Short section because the hospital compare program is not part of the CMS CoP
  - Hospital compare is the indicators that must be sent to CMS to receive full reimbursement rates
Report Adverse Events to PI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland  21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE:    March 15, 2013
TO:  State Survey Agency Directors
FROM:  Director
Survey and Certification Group
SUBJECT: AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

Ref: S&C: 13-19-HOSPITALS

Memorandum Summary

Hospitals are Required to Track Adverse Events: The Condition of Participation (CoP) for Quality Assessment and Performance Improvement (QAPI) at 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events. However, several recent reports completed by the Department of Health and Human Services Office of the Inspector General (OIG) indicated that hospitals fail to identify most adverse events.

Use of the Common Formats May Help Hospitals Improve Tracking. The OIG suggested staff failure to understand what events need to be reported to the hospital’s QAPI program contributes to the problems with internal tracking systems. The OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) could help hospitals improve their ability to track adverse patient safety events by disseminating information on AHRQ’s Common Formats. The Common Formats define a systematic process for reporting adverse events, near misses, and unsafe conditions, and allow a hospital to report harm from all causes. Hospital use of the AHRQ Common Formats is voluntary, but a hospital that uses them and is adept at the analysis that they permit will be in a better position...
Adverse Event Reporting

- Hospitals are required to track AE (adverse events)
- Several reports show that nurses and others were not reporting adverse events and not getting into the PI system
- OIG and CMS recommends using the AHRQ common formats to help with the tracking
- States could help hospitals improve the reporting process
- Encouraged all surveyors to develop an understanding of this tool
Adverse Event Reporting

- IOM (National Academy of Medicine) report discussed the need for comprehensive patient safety reporting to address the alarming high incidence of AE occurring in hospitals (Pg. 2)

- OIG report November, 2010 “AE in Hospitals: National Incidence Among Medicare Beneficiaries” encouraged internal reporting of all AE, whether preventable or not

- OIG issues report in January 2012 “Hospital Incident Reporting Systems Do Not Capture Most Patient Harm”
  - 86% of AE are never reported to the PI program
  - 44% are considered preventable
Hospital Incident Reporting Systems Do Not Capture Most Patient Harm

http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp

Daniel R. Levinson
Inspector General

January 2012
OEI-06-09-00091
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS:
NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

Daniel R. Levinson
Inspector General
November 2010
OEI-06-09-00090
Adverse Event Reporting

- CMS QAPI section requires hospital to track AEs and analyze the causes and implement actions to prevent in the future
  - Need to include near misses or close calls as unsafe conditions
  - Also used by PSOs to collect data in an standardized manner
- The internal hospital reporting system represents a foundational capability to determine if the hospital can maintain compliance with the CoPs
- The AHRQ Common Formats are evidenced based
- Common Formats allow for identification and reporting of any AE even if rare and includes NQF 29 never events such as falls and medication errors
## Events That Should be Reported

<table>
<thead>
<tr>
<th>Event Category</th>
<th>Examples of event occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event was an expected outcome or side effect</td>
<td>Thrush</td>
</tr>
<tr>
<td>Event caused little harm and/or harm was ameliorated</td>
<td>Hypoglycemia treated with orange juice (glucose)</td>
</tr>
<tr>
<td>Event was not on the hospital mandatory reporting list</td>
<td>Patient given wrong medication, but no harm; Reporting of Stage 2 pressure ulcers is not mandated in some states.</td>
</tr>
<tr>
<td>Event occurs frequently in hospitals</td>
<td>Medication given late; falls</td>
</tr>
<tr>
<td>Event symptoms became apparent after discharge</td>
<td>VTE diagnosed 10 days after discharge; Surgical Site infection 3 weeks after pacemaker implant.</td>
</tr>
<tr>
<td>Event occurred in a patient with a history of similar events</td>
<td>Falls, Stage 1 or 2 pressure ulcers</td>
</tr>
<tr>
<td>Events not caused by a perceptible error</td>
<td>Postoperative ileus (severe, lasting more than six days) Constipation after narcotics Adverse reaction (rash) to a medication the patient was not known to be allergic to</td>
</tr>
</tbody>
</table>
9 Modules in the Common Formats

1. Blood or Blood Product
2. Device or Medical/Surgical Supply, including Health Information Technology (HIT)
3. Fall
4. Healthcare-associated Infection
5. Medication or Other Substance
6. Perinatal
7. Pressure Ulcer
8. Surgery or Anesthesia
9. Venous Thromboembolism
10. Other (allows collection of information on all other types of events)
The following document outlines the common information to be collected for all patient safety concerns, regardless of event type. The Common Formats contains core and supplemental data sets for Event Reporting – Hospitals Version 2.0. Core data elements are required for event reporting at the local level, by providers, to PSOs and the PSOPPC for national aggregation and analysis. Supplemental data elements may be collected at the local level for additional analysis, and may be reported to PSOs but will not be accepted by the PSOPPC for national aggregation and analysis.

1.0 Type of Event

1.1 A patient safety concern is reported as one of the following types:

1.1.1 Incident: A patient safety event that reached the patient, whether or not the patient was harmed

1.1.2 Near miss (close call): A patient safety event that did not reach the patient

1.1.3 Unsafe condition: Any circumstance that increases the probability of a patient safety event

1.2 A patient safety concern is identified as one or more of the following categories

1.2.1 Anesthesia

1.2.2 Blood or Blood Product

1.2.3 Device or Medical/Surgical Supply

1.2.4 Fall
Welcome to the PSO Privacy Protection Center

The Patient Safety Organization Privacy Protection Center (PSOPPC) was created by the Agency for Healthcare Research and Quality (AHRQ) to support the implementation of the Patient Safety and Quality Improvement Act (PL-109-41), passed by the United States Congress in July, 2005. The PPC provides technical assistance to PSOs by ensuring patient safety event data is nonidentifiable for data submission and reporting to the NPSD, and provides technical assistance on use of Common Formats. Read more about the PPC.

https://psoppc.org/web/patientsafety
Hospital Common Formats

Through a contract with the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF) solicited feedback on the formats from private sector organizations and individuals. The NQF, a nonprofit organization that focuses on healthcare quality, then convened an expert panel to review the comments received, and provide feedback to AHRQ. Based on the expert panel’s feedback, AHRQ further revised and refined the Common Formats that are now available as Hospital Common Formats Version 1.2 & 1.1.

The following Hospital Common Formats are active for reporting are available for implementation and use by healthcare providers and Patient Safety Organizations (PSOs). These versions of the Common Formats are also accepted by the PSOPPC for national reporting.

Hospital Common Formats - Version 1.2
- Event Descriptions, Sample Reports, & Forms
- Technical Specifications
- Users Guide

Hospital Common Formats - Version 1.1
- Event Descriptions, Sample Reports, & Forms
- Technical Specifications
- Users Guide
CMS Proposed Changes
The Hospital Improvement Rule
Hospital Improvement Introduction

- The following is the name given by CMS to the proposed rule published on June 16, 2016
- Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule
- It makes changes to the following CoP sections:
  - Nursing, Infection Control, Patient Rights, Medical Records, QAPI, Lab, and Dietary (CAH)
  - It addresses restraints, implementation of an antibiotic stewardship program, care plans, non-discrimination, LIP
Proposed Changes June 16, 2016 FR


FEDERAL REGISTER

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June 16, 2016

Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Parts 482 and 485
Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule
Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care

A Proposed Rule by the Centers for Medicare & Medicaid Services on 06/16/2016

AGENCY:
Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION:
Proposed rule.
QAPI Program Proposed Changes
Current CoPs require hospitals to examine the quality of its services and implement specific improvement projects on an ongoing basis.

This has resulted in hospitals making progress in delivering safer, high quality care.

CMS is making a minor change to the program data requirements.

Currently hospitals must incorporate patient care data into their QAPI such as data submitted to or from the QIO.
Proposing to require that the hospital QAPI program incorporate quality indicator data including patient care data submitted to or received from quality reporting and quality performance programs

This would include data on readmissions and hospital acquired conditions

Hospitals are already collecting and reporting on a lot of this data so efficient to include some of this data in the QAPI program

- Like HAC Reduction Program, Hospital VBP Program, Inpatient and Outpatient Quality Reporting Program
CAH QAPI Program

- Basically CMS is implementing the QAPI standards under Appendix A for CAH
- CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven QAPI program
  - Has a definition of medical error and ADE
  - Program has to be appropriate for the size and what the CAH does
  - Must involve all departments
  - Must use objective measures to evaluate services
  - Board is responsible for QAPI program
CAH QAPI Program

- Address priorities to improve care and patient safety
- Communicate clear expectations for safety
- Evaluate all improvement actions and go back to the drawing board if not working
- Determine the number of distinct projects
- Implement P&P on what staff should do to prevent and report unsafe patient care practices, medical errors, and adverse events
- Lists program activities such as measures to track and analyze
CAH QAPI Program

- Look at high-volume, high-risk services, or problem-prone areas
- Document QAPI projects
- Use data to monitor the effectiveness and safety of services provided and quality of care
- Identify opportunities for improvement
- Basically, CMS is adopting the similar QAPI standards found in Appendix A which is the manual for larger hospitals
CMS Worksheets
Infection Control, Discharge Planning and QAPI
CMS Hospital Worksheets History

- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, infection control, and QAPI (quality assessment performance improvement)
- Final discharge planning worksheet issued November 26, 2014
- Currently being rewritten to include the proposed changes
Final 3 Worksheets QAPI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Public Release of Three Hospital Surveyor Worksheets

Memorandum Summary

- **Three Hospital Surveyor Worksheets Finalized:** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.

- **Final Worksheets Made Public:** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
Hospitals should be familiar with the three worksheets and QAPI one is 15 pages

Will use whenever a validation survey or certification survey is done at a hospital by CMS

CMS says worksheets are used by State and federal surveyors on all survey activity in assessing compliance with any of the three CoPs

Hospitals are encouraged by CMS to use the worksheet as part of their self assessment tools which can help promote quality and patient safety
And of course completing the forms helps the hospital to comply with those three CoPs

Citation instructions are provided on each of the worksheets

The surveyors will follow standard procedures when non-compliance is identified in hospitals

This includes documentation on the Form CMS 2567

Not used in CAH but good tool for CAH to use

Questions to: hospitalscg@cms.hhs.gov
Form 2567 Statement of Deficiency/POC

www.cms.gov/Medicare/CMS-Forms/CMS2567.pdf
CMS Hospital Worksheets

- Some of the questions asked might not be apparent from a reading of the CoPs
- So the worksheets are a good communication device
- It helps to clearly communicate to hospitals what is going to be asked in these 3 important areas
- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment
- Hospitals should consider attaching the documentation and P&P to the worksheet
This would impress the surveyor when they came to the hospital

The worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited who are suppose to have a CMS survey every three or so years

- The Joint Commission (TJC), AAAHC Healthcare Facility Accreditation Program, CIHQ, (Center for Improvement in Healthcare Quality) or DNV Healthcare are the 4 AOs with deemed status

It would also be used for hospitals undergoing a validation survey by CMS
Centers for Medicare & Medicaid Services

Hospital Quality Assessment Performance Improvement (QAPI) Worksheet

State Agency Name

Instructions: The following is a list of items, broken down into separate Parts, which must be assessed during the on-site survey in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital’s QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate. The separate Parts can be assessed in any order. Within each Part there may also be flexibility to change the order in which the various items are assessed.

The interviews should be performed with the most appropriate staff person(s) for the items of interest (e.g., unit/department staff should be asked how they participate in the hospital-wide QAPI program).

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name

1.2 Address, State and Zip Code

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.3 CMS Certification Number (CCN)

1.4 Date of survey site visit:

<table>
<thead>
<tr>
<th>mm/mm/dd/yyyy to mm/mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
First two pages included identification information

Name of the state survey agency which in most states is the department of health under contract by CMS

- In Kentucky it is the OIG or Office of Inspector General

It will ask for the name and address of the hospital, CCN number (certification number), number of surveyors, date of survey, number of surveyors, time spent on performing the PSI surveys, is hospital accredited and if so date of last survey
CMS QAPI Hospital Worksheet

- CMS uses the term “tracers” for the first time
- The first worksheet is on QAPI which stands for Quality Assessment Performance Improvement
  - CMS previously called it Quality Assurance Performance Improvement
- The worksheet is a document that the surveyor will sit down with the hospital and fill out
- The first column includes the elements to be assessed and there are boxes to fill in
## Quality Indicator Tracers

### PART 2: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS

**Instructions for Part #2 Questions:**
Select 3 distinct quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Indicator #1</th>
<th>Indicator #2</th>
<th>Indicator #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write in indicator selected:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)</td>
<td>○ YES</td>
<td>○ YES</td>
<td>○ YES</td>
</tr>
<tr>
<td></td>
<td>○ NO</td>
<td>○ NO</td>
<td>○ NO</td>
</tr>
<tr>
<td>2.1.b Is the scope of data collection appropriate to the indicator, e.g., an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would require data from multiple parts of the hospital.</td>
<td>○ YES</td>
<td>○ YES</td>
<td>○ YES</td>
</tr>
<tr>
<td></td>
<td>○ NO</td>
<td>○ NO</td>
<td>○ NO</td>
</tr>
<tr>
<td>2.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?</td>
<td>○ YES</td>
<td>○ YES</td>
<td>○ YES</td>
</tr>
<tr>
<td></td>
<td>○ NO</td>
<td>○ NO</td>
<td>○ NO</td>
</tr>
</tbody>
</table>
This section is 15 pages long

First select three quality indicators related to PI activities or projects

- An example might be the timing of medications and PI data to show medication was given on time and number of medication errors or missed or omitted doses or the number of falls

- Number of catheter associated UTIs

- Write the quality indicator at the top and answer the following questions for each one
Hospitals collect all kind of data

TJC requires data to be collected in a number of areas

- Data on medication management (ADR, medication errors), FMEA, patient flow, staff compliance with employee health screening requirements, patient satisfaction, pediatric asthma, ED measures, infection control surveillance data

- Data on R&S use, patient perception of care, organ donation, blood transfusion reactions, ORYX data, medical record deficiency data, staffing, data on how patient communication needs are met, race and ethnicity etc.
QAPI Tracer  Data Collection & Analysis

- CMS has hospital compare with data on number of MI patients who are readmitted or pneumonia patients who get their antibiotics timely
- Measure patient experience or patient satisfaction data
- Measure some or all of the AHRQ patient safety indicators
- National Quality Forum includes lists of quality indicators that are evidence based that hospital may measure
QAPI Tracer  Data Collection & Analysis

- Can you show evidence that each quality indicator is related to improved health outcomes? (Tag 273)
  - Based on QIO, national guidelines, evidence based studies, peer reviewed etc.

- Is the scope of data collection appropriate to the indicator (273)
  - Hand hygiene would require data from multiple parts of the hospital
  - ED or L&D might be specific to date from that area such as the average LOS in the ED or the number of elective C-sections performed with premature infants
PI Tracer  Data Collection & Analysis

- Is the method and frequency of data collection specified? (Tag 273)
  - Such as chart reviews or monthly observations
  - Is the data collected in the manner specified and it is done as often as specified such as will do 30 charts per month for ED triage documentation criteria
- If unit staff play a role in data collection then is the data collection consistent with the specifications (273)
  - Example OR staff complete a data collection tool with number of cases time out is taken and documented, H&P and consent on chart before surgery, etc.
Are data collected aggregated in accordance with hospital methodology specified for this indicators

- Is the data analyzed? (Tag 273)

If indicator is type that measures rate are the rates calculated for points in time and compared to benchmark data set out by national organizations when available? (273)

- Pneumonia patients should get their first dose of antibiotics within 6 hours or MI patients thrombolytics in 30 minutes or PCI within 90 minutes or falls per 1,000 patient bed days
PI Tracer  Data Collection & Analysis

- Is data broken down into subsets that allow for comparison among hospital units (Tag 273)
  - Such as hand hygiene or the fall rate
- If data identified area that needs improvement then is there evidence the issue was addressed (283)
  - Such as an infant abduction risk, high fall rate, high medication error rate, injury from restraints
- Are the interventions evaluated for success?
  - If successful did hospital monitor to ensure success was sustained
- If not, what did the hospital do?
QAPI Tracer  Data Collection & Analysis

- Does PI focus on high risk, high volume, or problem prone areas? (Tag 283)
  - Orthopedic hospital performs lots of Orthopedic surgeries and another CABG and each does QAPI on these

- Can hospital prove it conducts distinct PI projects?
  - Should be reflected in the PI minutes (297)
  - Every department should participate in PI process

- Is number of projects proportional to the scope and complexity of the hospital’s service and operations
  - Larger hospital expected to do more projects
If NICU is there QAPI related to that area such as the percentage of babies who do not survive the first 28 days of life (297)

- Or quality measures for low birth weight babies including HAI, intraventricular hemorrhage, hearing loss, retinopathy, or chronic lung disease

If the hospital has an open heart surgery unit

- Part of SCIP or surgical care improvement project such as antibiotics within one hour of incision, antibiotics discontinued within 24 to 48 hours, appropriate hair removal (razors are out and clippers are in), normothermia, DVT prophylaxis, and control post-op glucose
PI Tracer  Data Collection & Analysis

- Can the hospital show evidence of why each project was selected? (297)
  - Unless QIO project or IT project such as CPOE

- CMS then has a section on patient safety that discusses adverse events (AE) and medical error

- This part is to evaluate the hospital’s leadership expectation for patient safety

- Is there staff training or communications related to expectation for patient safety to all staff?

- Is there a P&P on non-punitive approach to staff reporting medical errors which includes near misses?
Can staff on each unit explain hospital’s expectation for their role in promoting patient safety? (286)

Is there widespread staff training related to expectation for patient safety?

Training related to what steps to take in situation that feels unsafe

Is there a systematic process to identify medical errors which include near misses and AEs?

On every unit, can the staff describe what is a medical error or near miss?
### Patient Safety LD, AE and Medical Error

#### PART 4 – PATIENT SAFETY – ADVERSE EVENTS AND MEDICAL ERRORS

<table>
<thead>
<tr>
<th>Elements to Be Assessed</th>
<th>Space for Surveyor Notes (if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1 Evaluation regarding whether the hospital’s leadership sets expectations for patient safety:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 4.1.a Is there evidence of widespread staff training or communication to convey expectations for patient safety to all staff? (e.g. training related to steps to take in a situation that feels unsafe, how to report adverse patient events, medical errors, near misses/close calls, etc. that they are expected to report internally) | ○ YES  
○ NO |
| 4.1.b Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of adverse patient events, medical errors, near misses/close calls, etc., and situations they consider unsafe? | ○ YES  
○ NO |
| 4.1.c On each unit surveyed, can staff explain what the hospital’s expectations are for their role in promoting patient safety? | ○ YES  
○ NO |

*If no to 4.1.a, 4.1.b, or 4.1.c, cite at 42 CFR 482.21(e)(3) (Tag A-286)*

**4.2 Evaluation regarding hospital processes to identify adverse patient events, medical errors, near misses/close calls, etc.:**

| **4.2.a On each unit/program surveyed, can staff describe the types of adverse patient events, medical errors, near misses/close calls, etc. they are expected to report internally?** | ○ YES  
○ NO |
| **4.2.b On each unit/program surveyed, can staff** | ○ YES |
Can they explain how to report? (286)

- How do they report?
  - Phone report, incident report, communicate to supervisor etc.

- Who do they report it to?
  - Manager, risk manager, physician, pharmacist etc.

Does the staff know what needs to be reported internally?

- ADEs, medical errors, near misses and unsafe situations

Does hospital employ other methods to find medical errors such as trigger tools, chart reviews, review of claims, patient grievances, interview patients etc.
Can the hospital provide evidence of medical errors and AEs identified through staff reports? (286)

Is there a PI program with the infection preventionist (IP) to track avoidable HAI?
- IC section requires this and starts at tag 747

Are problems identified by the IP addressed through QAPI activities? (756 or 286)

Does the PI program track medication errors and ADE and drug incompatibilities
- Pharmacy tag 508 requires this
Is there a process to report blood transfusion reaction and determine if due to medical error? (286 and 410)

- Must be reviewed to identify if an medical error

Did the survey team have prior knowledge of any serious AE that the hospital failed to identify? (286)

- Were any identified by the surveyors?

Has a RCA (systematic analysis) or QAPI review been done on all serious preventable AEs? (286)

- Sample all serious preventable events identified in the past 12 months
The next question discusses the causal analysis tracers (RCAs) or patient safety tracers

- Causal analysis searches for the cause and effect or causes of the particular event or adverse outcome
- More commonly referred to as a RCA or root cause analysis (RCA_2 or systematic analysis)
- CMS calls it QAPI reviews

The surveyor (not the hospital) will select three causal analysis done for single event or near miss during the last 12 to 24 months (286)

Were underlying causes identified?
## Causal Analysis Tracers

**Part 4: Patient Safety Tracers**

Instructions for Questions #4.9 and 4.10: If the answer to Question #4.9 is “yes”, the Surveyor should select up to three significant adverse events or close calls/near misses the hospital reviewed for QAPI purposes during the last 12 - 24 months (“cases”). Do not let the hospital select the adverse events/close call reviews to be used for the Tracer.

The reviews may be of single events/close calls (e.g., a wrong site surgery that actually occurred or that came close to occurring on a particular patient), groups of similar kinds of events/close calls (e.g., all inpatient falls with injury during the first quarter), or a combination of both types of review.

Answer all of the questions in #4.10 for each “case” selected. (For at least one, there should be sufficient time after implementation of preventive measures for the hospital to have evaluated the impact of those measures.)

### 4.9 Has the hospital conducted any QAPI reviews of adverse patient events/close calls in the 12 – 24 months prior to the survey date?

- **Yes** - IF YES, CONTINUE.
- **No** - IF NO, SKIP ALL 4.10 SUB-QUESTIONS.

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Case #1</th>
<th>Case #2</th>
<th>Case #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.10 Select the number of hospital conducted QAPI reviews of adverse events/close calls that were reviewed for this survey.</td>
<td>□ One “case” reviewed.</td>
<td>□ Two “cases” reviewed.</td>
<td>□ Three “cases” reviewed.</td>
</tr>
<tr>
<td>Write in a general description of each case. Avoid using any identifiable information on this worksheet.</td>
<td>Case #1 General Description:</td>
<td>Case #2 General Description:</td>
<td>Case #3 General Description:</td>
</tr>
<tr>
<td>Answer all of the questions below for each “case.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.10a Has the hospital identified potential underlying causes or contributing factors?</td>
<td>□ Yes</td>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>
QAPI Patient Safety Tracers

- Was preventive actions developed based on the RCA? (286)

- TJC has a matrix which contains elements that must be included in a reviewable sentinel event
  - Removed from July 1, 2015 P&P but still good tool to use

- Did the hospital identify any other departments utilizing similar processes that are at a similar risk? (286)
  - Alarm fatigue issue in ED, CCU, ICU, and telemetry

- Were preventive actions implemented in at least one area of the hospital? (286)
QAPI Patient Safety Tracers

- Has the hospital evaluated the impact of the preventable actions including tracking a reoccurrences or near misses? (286)

- If the goals were not met did the hospital go back to the drawing board?
  - New patient fall tool used in the ED but staff did not have a culture of safety and not implementing actions

- Has the hospital implemented the preventable actions found to be effective unless there is a documented reason for not doing so? (286)
TJC Framework for Conducting RCA

www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/
**Event Description**

When did the event occur?

<table>
<thead>
<tr>
<th>Date:</th>
<th>Day of the week:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**Detailed Event Description Including Timeline:**


**Diagnosis:**


**Medications:**


**Autopsy Results:**


**Past Medical/Psychiatric History:**
Sentinel Event Policy and Procedures

February 17, 2017

The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of Patient Safety Events (events not primarily related to the natural course of the patient’s illness or underlying condition), as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with health care organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.

A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. See list below.
Table 3. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

<table>
<thead>
<tr>
<th>Areas of Potential Root Causes</th>
<th>Suicide (24-Hour Care)</th>
<th>Medication Error</th>
<th>Procedural Complication</th>
<th>Wrong-Site Surgery</th>
<th>Treatment Delay</th>
<th>Restraint Death</th>
<th>Elopement Death</th>
<th>Assault/Rape/Homicide</th>
<th>Transfusion Death</th>
<th>Unanticipated Death of Full-Term Infant</th>
<th>Unintended Retention of Foreign Body</th>
<th>Fail Related</th>
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</thead>
<tbody>
<tr>
<td>Behavioral assessment process **</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Physical assessment process ***</td>
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<td>Individual identification process</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Individual observation procedures</td>
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<td>Care planning process</td>
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<td>X</td>
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</tr>
<tr>
<td>Continuum of care</td>
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<td></td>
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<td></td>
<td>X</td>
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<td>Staffing levels</td>
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<td>X</td>
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<tr>
<td>Orientation and training of staff</td>
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<td>X</td>
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<td></td>
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</tbody>
</table>

continued on next page
RCA2: Improving Root Cause Analyses and Actions to Prevent Harm

Report issued by the National Patient Safety Foundation

Root cause analysis (RCA) is a process widely used by health professionals to learn how and why errors occurred, but there have been inconsistencies in the success of these initiatives. With a grant from The Doctors Company Foundation, NPSF convened a panel of subject matter experts and stakeholders to examine best practices around RCAs and develop guidelines to help health professionals standardize the process and improve the way they investigate medical errors, adverse events, and near misses.

Download the full report here. [PDF]
This report or parts of it may be printed for individual use or distributed for training purposes within your organization.
No one may alter the content in any way, or use the report in any commercial context, without written permission from the National Patient Safety Foundation. Inquiries should be addressed to info@npsf.org.
Part 5 addresses broad QAPI requirements and leadership responsibilities (309)

Does the hospital have a formal PI program?
- Most hospitals have a PI plan that discusses the PI program
- Is there a written P&P on the PI program?
- Is there budgeted resources so staff can attend education programs and data can be collected?
- Is there responsible staff to do PI
- Is the PI program approved by MS, CEO, and the board?
## Broad PI Requirements and Leadership

### PART 5 – BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Space for Surveyor Notes (if needed)</th>
</tr>
</thead>
</table>
| 5.1 Is there evidence that the hospital has a formal QAPI program - including written policies and procedures, budgeted resources, and clearly identified responsible staff - approved by the governing body after input from the CEO and medical staff leadership? | □ YES  
□ NO |
| If no to 5.1, cite at 42 CFR 482.21(e)(1) & (2) (Tag A-309)                                                                                                                                                                    |                                     |
| 5.1.a Has the hospital maintained and made available for surveyor review sufficient evidence of its QAPI program to allow compliance assessment?                                                                               | □ YES  
□ NO |
| If no to 5.1.a, cite at 42 CFR 482.21 (Tag A-263)                                                                                                                                                                           |                                     |
| 5.2 Evaluation regarding whether the QAPI program is hospital-wide:                                                                                                                                                        |                                     |
| 5.2.a Using information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?                                                       | □ YES  
□ NO |
| If no to 5.2.a, cite at 42 CFR 482.21 (Tag A-263 or A-306)                                                                                                                                                                   |                                     |
| 5.2.b Using information from the hospital identifying services provided under arrangement (contract), can the QAPI manager provide evidence of QAPI monitoring for each service related to clinical care provided under contract or arrangement? (Exclusively administrative contractual services, e.g., payroll preparation, are not required to be included in the QAPI program.) | □ YES  
□ NO  
□ N/A |
Broad PI Requirements and Leadership

- Has the hospital maintained and made available to the surveyor sufficient evidence of its QAPI program to allow compliance assessment? (263)

- Is the QAPI hospital-wide?

- Can the QAPI manager provide evidence of QAPI monitoring related to each service? (263 or 308)
  - Surveyor to use information in the data base worksheet to determine what services are offered by the hospital
  - Every department should be involved in the QAPI process

- Is there evidence of PI review for contracted services for clinical care? (83, 263, or 308)
Broad PI Requirements and Leadership

- Is there evidence that the board, CEO, MS leadership and senior leaders, including the CNO, have a role in PI planning and implementation? (309)

- Is there evidence of PI review in the board minutes? (273)

- Does the board approve the PI program quality indicators and how often the data is collected?
  - Determine how many projects for next year?
  - Does the board hold the CEO accountable for the effectiveness of PI program? (309 and 57)

- CMS Board section starts at tag 38
Resource Allocation

- Is there evidence of funding and personnel dedicated to the QAPI program? (315)

- If condition level deficiencies, is there evidence that the lack of resources contributed to this? (315)

- Did the hospital at any time refuse to provide the requested material claiming it was protected by the Patient Safety Work Product under the federal PSO law?
  - This is for information only and no citation risk
CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS)

What PPS Hospitals Need to Know About the QAPI Section
§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital’s governing body must ensure that the program reflects the complexity of the hospital’s organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

§§482.21(a), 482.21(b)(1), 482.21(b)(2)(i), & 482.21(b)(3)

§482.21(a) Standard: Program Scope

(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes....

(2) The hospital must measure, analyze, and track quality indicators...and other aspects of performance that assess processes of care, hospital service, and operations.
Changes to the Tag Numbers

- Old Tag Numbers:
  - 34 tag numbers and 7 pages

- Tag Numbers after March 21, 2014:
  - 263, 273, 283, 286, 297, 308, 309 and 315
  - 8 tag numbers and 7 completely rewritten and 4 pages
  - 34 tags to 8 standards
QAPI stands for quality assessment and performance improvement

- Use to stand for Quality Assurance and Performance Improvement (QAPI) but changed to Quality Assessment

- Referred to in short as PI

- In each section, such as nursing and pharmacy, CMS says every department has a role in QAPI

- Also CMS Compare is important and has information about the hospital’s quality of care
Hospital Compare Measures

www.medicare.gov/hospitalcompare/search.html
Measures Displayed on Hospital Compare

What information can I get about hospitals?

You can get a “snapshot” of the quality of the hospitals in your area and across the nation by looking at:

- **Hospital Compare overall rating**: Summarizes up to 57 quality measures shown on Hospital Compare into a single star rating, making it easier to compare hospitals side by side.

- **General information**: Name, address, telephone number, type of hospital, and other general information about the hospital.

- **Survey of patients’ experiences**: How patients recently discharged from the hospital responded to a survey about their hospital experience. The survey asked questions such as how well a hospital’s doctors and nurses communicated with the patient.

- **Timely & effective care**: How often a hospital gives recommended treatments for certain conditions, such as heart attack, influenza, cancer, and blood clots, how quickly recommended treatments are administered, and how often a hospital follows best practices to prevent surgical complications.

- **Complications & deaths**: How likely it is that patients will suffer from complications while in the hospital or after having certain inpatient surgical procedures, and how often patients died within 30 days of being in the hospital for a specific condition.

- **Unplanned hospital visits**: Whether patients return to a hospital after an initial hospital stay or outpatient procedure, and how much time they spent back in the hospital.

- **Use of medical imaging**: How a hospital uses outpatient medical imaging tests (like CT scans and MRIs).

- **Payment & value of care**: Whether the payments made for patients treated at a particular hospital are less than, no different than, or greater than the national average payment.
Measures and current data collection periods

- Update frequencies and data collection periods for individual measures are subject to change. View data updates for changes.
- Get the data collection periods for the measures included in the Hospital Compare overall rating.
- Download the data (Note: Beginning in July 2017, the downloadable database will be provided in CSV format only.)
- Send general questions regarding Hospital Compare and the data to HospitalCompare@hsag.com.

# Measures and current data collection periods on Hospital Compare

<table>
<thead>
<tr>
<th>Measure identifier</th>
<th>Technical measure title</th>
<th>Measure as posted on Hospital Compare</th>
<th>Update frequency</th>
<th>Current data collection period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>From</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Through</td>
</tr>
<tr>
<td><strong>General information- Structural measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SM-PART-NURSE</td>
<td>Participation in a systematic database for nursing sensitive care</td>
<td>Nursing Care Registry</td>
<td>Annually December</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>ACS-REGISTRY</td>
<td>Participation in a multispecialty surgical registry</td>
<td>Multispecialty Surgical Registry</td>
<td>Quarterly (April, July, October, December)</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>OP-12</td>
<td>The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified</td>
<td>Able to receive lab results electronically</td>
<td>Annually December</td>
<td>1/1/2016</td>
</tr>
</tbody>
</table>
Hospital Value-Based Purchasing

The Fiscal Year 2018 Hospital VBP Program adjusts hospitals’ payments based on their performance on four domains that reflect hospital quality: (1) the clinical care domain, (2) the patient- and caregiver-centered experience of care/care coordination domain, (3) the safety domain, and (4) the efficiency and cost reduction domain. Each domain is weighted at 25% of the Total Performance Score (TPS).

Each data set includes the following data points:

A measure/dimension score
This represents the higher of either the achievement or improvement points.

An achievement score
Scores awarded to hospitals that achieve certain levels of performance compared to other hospitals.

An improvement score
Scores awarded to hospitals that improved over its own baseline period performance.

To learn more about the scoring of the Hospital VBP Program, please visit the QualityNet Website.

Go to the clinical care domain
Go to the patient- and caregiver centered experience of care/care coordination domain
Go to the safety domain
Go to the efficiency and cost reduction domain
Go to the total performance scores
Go to the payment adjustments

www.medicare.gov/hospitalcompare/Data/hospital-vbp.html
FY 2018 program results for three Value-Based Purchasing programs updated on Hospital Compare site
December 21, 2017

The Centers for Medicare & Medicaid Services (CMS) has updated the Hospital Compare website to include fiscal year (FY) 2018 measure results for the Hospital Readmissions Reduction Program (HRRP); the Hospital Value-Based Purchasing (VBP) Program; and the Hospital-Acquired Condition (HAC) Reduction Program. Data for all three programs may be accessed under the Additional Information section of the Hospital Compare home page by selecting the following link: "Get data from Medicare programs that link quality to payment".

Hospital Readmissions Reduction Program (HRRP)

Updates posted to Hospital Compare for the HRRP include data for the following readmission measures:

- Acute myocardial infarction (AMI)
- Heart failure (HF)
- Pneumonia
- Chronic obstructive pulmonary disease (COPD)
- Elective primary total hip and/or total knee arthroplasty (THA/TKA)
- Coronary artery bypass graft (CABG) surgery

For applicable hospitals with at least 25 eligible discharges, CMS reports the following data elements for each 30-day risk-standardized readmission measure:

- Number of eligible discharges
- Number of readmissions (if the hospital has 11 or more readmissions)
- Predicted readmissions (i.e., the adjusted actual readmissions)
- Expected readmissions
- Excess readmission ratio

For information and resources on HRRP, refer to the HRRP page of the CMS.gov website or the HRRP page on QualityNet.org.
Clinical Care Domain

Clinical care domain

The Centers for Medicare & Medicaid Services’ (CMS) clinical care domain measures assess estimates of deaths in the 30 days after entering the hospital for a specific condition (reported as the “survival” rate; therefore, higher percentage rates are favorable). Patients who received high-quality care during their hospitalizations and their transition to the outpatient setting will likely have improved outcomes, like survival rate.

Acute myocardial infarction (AMI) 30-day mortality rate

The death (mortality) rate indicates whether a patient with an AMI diagnosis died within 30 days of their hospitalization.

Heart failure (HF) 30-day mortality rate

The death (mortality) rate shows whether a patient with a HF diagnosis died within 30 days of their hospitalization.

Pneumonia (PN) 30-day mortality rate

The death (mortality) rate shows whether a patient with a PN diagnosis died within 30 days of their hospitalization.

www.medicare.gov/hospitalcompare/data/clinical-care-outcomes-subdomain.html
Patient- and caregiver-centered experience of care/care coordination domain

The patient- and caregiver-centered experience of care/care coordination domain in Hospital VBP is based on the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey. HCAHPS is a national, standardized survey that asks adult patients about their experiences during a recent hospital stay. The domain score encompasses eight important dimensions of hospital quality:

Communication with nurses

Shown as percentage of patients who reported that their nurses "Always" communicated well. This means nurses explained things clearly, listened carefully, and treated the patient with courtesy and respect.

Communication with doctors

Shown as percentage of patients who reported that their doctors "Always" communicated well. This means doctors explained things clearly, listened carefully, and treated the patient with courtesy and respect.

Responsiveness of hospital staff

Shown as percentage of patients who reported that hospital staff were "Always" responsive to their needs. This means the patient was helped quickly when he or she used the call button or needed help in getting to the bathroom or using a bedpan.

Cleanliness and quietness of hospital environment

Shown as percentage of patients who reported that the hospital environment was "Always" clean and quiet. This means the patient’s hospital room and bathroom were kept clean and the area around the patient’s room was quiet at night.

Communication about medicines
Hospital CoPs for QAPI 263

- Standard: Must have PI program that is ongoing, data driven, and effective
- Board must make sure that PI program reflects the complexity of the hospital’s organization and services
- Must involve all departments including contracted services
- Focus on indicators to improve health outcomes
Hospital CoPs for PI

- Includes all departments even if contracted services
- Must focus on indicators related to improve health outcomes
  - How do you improve outcomes in the patient with hyponatremia, sepsis, or delirium?
  - How to improve outcomes in the diabetic patient admitted with hyperosmolar syndrome?
- Must focus on the prevention and reduction of medical errors
  - What do you do to prevent medical errors such as medication errors which is the most common type?
Program Scope

- Standard: PI program needs to be ongoing and show measurable improvements to improve health outcomes
- Must measure, analyze and track the quality indicators
- Must track other areas of performance that assess processes of care, hospital service and operations
- MI patients get their thrombolytics timely which helps to dissolve the clot to increase blood though the coronary artery which increases their survival
Ongoing Program

- Hospitals has improved patient flow and admitted patients now get to their bed in four hours or less
- Patients get their antibiotics timely in the OR now
- Patients with pneumonia now get their antibiotics within the six hour window
- Use of the sepsis bundle has improved survival rate
Track Quality Indicators

- The hospital must measure, analyze, and track quality indicators which would include adverse events.
- Want to focus on aspects and processes that relate to the health and safety of patient care services.
- Look at what could result in a sentinel event if not properly managed.
  - TJC has a sentinel event policy and lists reviewable SE.
Sentinel Events (SE)

I. Sentinel Events
In support of its mission to continuously improve the safety and quality of health care provided to the public, The Joint Commission in its accreditation process reviews hospitals’ activities in response to sentinel events. The accreditation process includes all full accreditation surveys and, as appropriate, for-cause surveys, and random validation surveys specific to Evidence of Standards Compliance (ESC).

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events are called “sentinel” because they signal the need for immediate investigation and response.
- The terms “sentinel event” and “error” are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

II. Goals of the Sentinel Event Policy
The policy has four goals:
1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To focus the attention of a hospital that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organizational culture), and on changing the hospital’s culture, systems, and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention
4. To maintain the confidence of the public and accredited hospitals in the accreditation process
Reviewable Sentinel Events

- The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition.

- The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition):
  - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
  - Unanticipated death of a full-term infant
  - Abduction of any patient receiving care, treatment, and services
  - Discharge of an infant to the wrong family
  - Sexual abuse/assault (including rape)
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
Table 1. Examples of Sentinel Events That Are Reviewable Under The Joint Commission’s Sentinel Event Policy

Note: This list may not apply to all settings.

Examples include the following:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient’s body, on the wrong site on the patient’s body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery
Program Scope 273

- So what is the scope of activities of your PI program?
  - Is the scope your PI program to include an overall assessment of the efficacy of the PI activities with a focus on continually improving the care provided at your hospital?
  - Does it look at indicators for both process and outcome?
  - Are the indicators objective, measurable, and based on current knowledge and experience?
<table>
<thead>
<tr>
<th>STK</th>
<th>STROKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>STK-1</td>
<td>Venous Thromboembolism (VTE) Prophylaxis</td>
</tr>
<tr>
<td>STK-2</td>
<td>Discharged on Antithrombotic Therapy</td>
</tr>
<tr>
<td>STK-3</td>
<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
</tr>
<tr>
<td>STK-4</td>
<td>Thrombolytic Therapy</td>
</tr>
<tr>
<td>STK-5</td>
<td>Antithrombotic Therapy by End of Hospital Day 2</td>
</tr>
<tr>
<td>STK-6</td>
<td>Discharged on Statin Medication</td>
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<td>STK-8</td>
<td>Stroke Education</td>
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<td>STK-10</td>
<td>Assessed for Rehabilitation</td>
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<th>VENOUS THROMBOEMBOLISM</th>
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<td>VTE-2</td>
<td>Intensive Care Unit Venous Thromboembolism Prophylaxis</td>
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<td>VTE-3</td>
<td>Venous Thromboembolism Patients with Anticoagulation Overlap Therapy</td>
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<td>VTE-4</td>
<td>Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol</td>
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<td>VTE-5</td>
<td>Venous Thromboembolism Discharge Instructions</td>
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<tr>
<td>VTE-6</td>
<td>Incidence of Potentially-Preventable Venous Thromboembolism</td>
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<table>
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<th>OUTPATIENT Core Measure GROUP</th>
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<td>SURGICAL CARE IMPROVEMENT PROJECT</td>
</tr>
<tr>
<td>OP-6</td>
<td>Timing of Antibiotic Prophylaxis (Prophylactic ABX initiated within 1 Hr. prior to Surgical Incision)</td>
</tr>
<tr>
<td>OP-7</td>
<td>Antibiotic Selection</td>
</tr>
<tr>
<td>ED</td>
<td>ED - THROUGHPUT</td>
</tr>
<tr>
<td>OP-18</td>
<td>Median time from ED arrival to ED departure for discharged ED patients</td>
</tr>
<tr>
<td>OP-19</td>
<td>Transition record with specified elements received by discharged patients</td>
</tr>
</tbody>
</table>
What is the Scope of Your PI Program?

- Medication therapy/medication use
  - Includes medication reconciliation
  - Includes the use of dangerous abbreviations
- Threats to patient safety
  - Such as falls, patient identification, trauma
- Infection control system, including healthcare associated infections (HAI)
- Utilization Management System
- Patient experience or patient satisfaction
What is the Scope of Your PI Program?

- Discrepant pathology reports
- Unanticipated deaths, adverse and/or sentinel events
- Adverse event/near miss
- Physical Environment Management Systems
- Operative and invasive procedures
  - Including wrong site/wrong patient/wrong procedure surgery
- Anesthesia/moderate sedation, Complaints
- Blood and blood components, blood incompatibility
- Restraint use/seclusion use and injury
What is the Scope of Your PI Program?

- Effectiveness of pain management system
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of four hours
- ED throughput with median time from ED arrival to ED departure for discharged patients
- ED door to door diagnostic evaluation by QMP
- Patients who are AMA or LWBS
- Median time to pain management for long bone fractures
Pediatric Quality Measures ED

Sample Emergency Department Pediatric Quality Improvement Markers/Indicators

**Asthma**
- Prior ICU admission
- Onset of wheezing, prior treatments
- $O_2$ sat, BP, HR and RR documented
- Peak Flow pre and post treatment
- Reassessment/documentation identifying progress

**Child Maltreatment**
- Screening mechanisms
- Social work evaluation
- DCFS reporting documentation

**Diabetic Ketoacidosis (DKA)**
- Time to VBG and BS
- IV fluid bolus appropriate
- $K^+$, $Na^+$, $Ca$ and $Phos$ documented
- $HCO_3^-$ administered? Indication?
- Mental status documented
- Serial examinations documented
- Hourly glucose documented
- Documentation of total fluids administered on the child that is transferred out
- Reassessment/documentation identifying progress

**Hematology/Oncology**
- Time to antibiotic administration (fever/neutropenia)
- Reassessment/documentation identifying progress
Head Trauma
- Timely airway management when GCS < 8
- Child maltreatment assessment completed
- Reassessment/documentation identifying progress
- Documentation of indicator if a head CT is obtained.

Length of Stay in the ED
- Time to interfacility transfer
- Reassessment/documentation identifying progress

Mock Codes
- Evaluate dosing calculations and procedures
- Reassessment/documentation identifying progress

Moderate Sedation
- Reassessment/documentation identifying progress
- Appropriate monitoring

Developed by the Illinois EMSC Facility Recognition Committee 3/2010

Neonatal Fever
- Time to antibiotics
- Lumbar puncture
- Reassessment/documentation identifying progress

Pain Management
- Door to first pain medication
- Documentation of relief
- Pulse oximetry
- Reassessment/documentation identifying progress

Patient Safety/Monitoring
- Obtaining accurate weight (using kg)
- Was weight obtained upon ED admission or was verbal weight conveyed by parent
- Vital signs routinely documented on kids, i.e. temp
- Reassessment/documentation identifying progress
- Abnormal VS reassessed/addressed prior to discharge
- Monitoring medication error rates
- Assuring compliance with EDAP/SEDAP equipment guidelines

Pneumonia
- Complete VS documented: Temperature, BP, HR, RR and Pulse oximetry
- Time to first antibiotic
- Reassessment/documentation identifying progress

Rapid Response Team
- Assess pediatric preparedness
- Reassessment/documentation identifying progress

Seizures
- Airway management
- Medication delivery
- Reassessment/documentation identifying progress
- Current medications documented
What is the Scope of Your PI Program?

- Timing of antibiotics within 1 hour of surgical incision and antibiotic selection
- Other adverse events, CaUTI, SSI, air embolism
- Critical and/or pertinent processes, both clinical and supportive
- Medical record delinquency
- Other aspects of performance that assess process of care, hospital service and operation
- Contract reviews, immunizations, SCIP, Hospital based inpatient psych services, VTE, stroke, etc.
Data Collection and Analysis

- **Program Data**: The PI program must incorporate quality data.
- This must include patient care data and other relevant data.
- For example, information submitted to or received from the hospital’s QIO.
  - Hospital works with QIO on quality project to reduce falls, readmissions, and to reduce SSI, CaUTI, CDI and CLABSI.
The hospital must use data collected to monitor the effectiveness and safety of services and quality of care.

- Data shows that hospital reduced their fall rate by 25% after new initiatives were implemented.
- Hospital reduced their CaUTI rate by 40%.

The frequency and detail of data must be specified by the board.

- Some data may be collected quarterly while some may be collected monthly.
What’s in Your PI Plan?

**General Hospital PI Plan**

<table>
<thead>
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<th>POLICY NUMBER: 114.104</th>
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**PURPOSE:**

The purpose of the Organizational Performance Improvement Plan at General Hospital is to ensure that the Board of Directors, medical staff and professional service staff demonstrate a consistent endeavor to deliver care that is optimal in an environment of minimal risk.

In keeping with General Hospital’s mission:

To be dedicated to providing a healing environment for maintaining and improving the health of residents of the district as well as providing quality healthcare services to those persons visiting or traveling through the district. In carrying out this mission, the DISTRICT will provide a coordinated range of services including acute inpatient and outpatient services, long-term care, education, referral services and recruitment of healthcare personnel to the area.

In support of this Mission, the hospital is pledged to:

- Foster a trust relationship with the communities served which includes broad-based community involvement in the development of services and programs.
- Promote a commonality of goals, objectives, and expectations within the community of
General Hospital Core Values:

- **UNDERSTANDING**: Exhibited by the presence of receptivity, assessable and generosity. Creating an environment for fruitful communication.
- **TRUST**: Our behavior is composed of sincerity, mutual respect and genuineness leading to honest communication.
- **LEADERSHIP**: We each take responsibility in creating a positive organization in which our values can flourish. We lead by modeling "we go there first".
- **QUALITY**: Is our constant commitment as evidenced by positive customer outcomes, financial performance, and continuous operational improvement.
- **ACCOUNTABILITY**: Taking ownership of our responsibilities and actions and following through to contribute to the success of our organization.

The Organizational Performance Improvement Plan allows for a systematic, coordinated and continuous approach to process design and performance measure analysis and improvement, focusing upon the aspects and dimensions that address this mission and values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the Performance Improvement activities at General Hospital. The Organizational Performance Improvement Program, established by the medical staff and interdisciplinary Performance Improvement Committee, with support and approval from the Board of Directors, has the responsibility for monitoring every aspect of patient care, from the time the patient enters the hospital through diagnosis, treatment, recovery and discharge in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

GOALS OF Performance Improvement:

The primary goal of the Organizational Performance Improvement Plan is to continually and
systematically plan, design, measure, assess and improve performance of hospital-wide key functions and processes relative to patient care. To achieve the primary goal, the plan strives to:

- Incorporate quality planning throughout the facility: Provide a systematic mechanism for the facility's appropriate individuals, departments and professions to function collaboratively in their efforts toward Performance Improvement.

- Provide for a hospital-wide program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others.

- Assure that the improvement process is organization-wide, monitoring, assessing and evaluating the quality and appropriateness of patient care and clinical performance to identify changes that will lead to improved performance and reduce the risk of sentinel events.

- Achieve and sustain improvements made in performance throughout the organization.

- To demonstrate our ability to consistently provide services that meets customer and applicable statutory and regulatory requirements.

- To enhance customer satisfaction through the effective application of the system, including processes for continual improvement of the system and the assurance of conformity to customer.

- Appropriate reporting of information to the Board of Directors to provide it with the information it needs in fulfilling its responsibility for the quality of patient care and safety is a required mandate of this plan.
Scope of Activities of the PI Plan

- Necessary information is to be communicated among department/services when problems or opportunities to improve patient care involve more than one department/service.
- The status of identified problems is tracked to assure improvement or problem resolution.
- Information from departments/services and the findings of discreet Performance Improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.

The objectives, scope, organization and mechanisms for overseeing the effectiveness of planning, designing, measuring, analyzing and improving performance via the Performance Improvement Program are evaluated annually and revised as necessary. Important key aspects and processes of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, those tending to produce problems for patients, their families or staff, and those that may lead to sentinel events.

SCOPE OF ACTIVITIES:

The scope of the Organizational Performance Improvement Program includes an overall assessment of the efficacy of Performance Improvement activities with a focus on continually improving care provided throughout General Hospital. The program consists of three focus components:

Performance Improvement, quality assessment/improvement and quality control activities. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by all appropriate departments/services and disciplines of the facility in an effort to improve organizational performance. These indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid performance
measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time.

The X trending reports are tools to be utilized by the facility to identify problems and assure improvement. X documents and reports shall remain confidential and protected. Reports and documents shall be transmitted to the Medical Staff Performance Improvement Committee through the Performance Improvement Coordinator.

The scope of the Organizational Performance Improvement Program includes performance of the following medical staff functions:

The monitoring, assessment, and of performance of patient care and the clinical performance of all individuals with clinical privileges. At monthly/bimonthly meetings of medical staff service committees, findings of the continuous Performance Improvement activities of the medical staff and all appropriate departments/services and disciplines that impact patient care and medical staff services within the medical staff service committee will be reviewed, assessed, and evaluated.

The functions to be measured at a minimum will include the following (as applicable):

- Evaluation of all patient care services and other services provided affecting patient health and safety, quality and appropriateness of the diagnosis and treatment (including outcomes) provided by the PA, NP and nursing staff. This evaluation must be performed by a staff or contract Physician; (485.616(b), 485.641(b)(1); 485.641(b)(3)
- Credentialing and quality and appropriateness of the diagnosis and treatment (including outcomes) provided by Physicians. This credentialing and clinical review must be performed by: (485.616(b), 485.641(b)(4),485.603(c)
- Participation in QualityNet (QIO) measures (485.616(b)(2); 485.641(b)(4)(ii), 485.603(c)(2)
- Annual credentialing and quality review by California Critical Access Hospital Network (CCAHN) or other qualified entity (another CAH or any licensed firms, businesses, or agencies
Scope of PI Plan and Program

that provide credentialing and QA services, an entity qualified by the state rural health care plan. 485.616(b)(3); 485.641(b)(4)(iii), 485.603(c)(3)

- Threats to patient safety; 485.641(b)(1), (i.e. falls, patient identification, injuries)
- Medication therapy/medication use; (this may include medication reconciliation and the use of dangerous abbreviations; 485.641(b)(2), 485.635(a)(3)(v)
- Infection control system, including hospital acquired infections (HAI); 485.641(b)(2); 485.635(a)(3)(vi)
- Utilization Management System; 485.641(a)(1)(i)
- Customer satisfaction, both clinical and support areas;
- Discrepant pathology reports;
- Unanticipated deaths, adverse and/or sentinel events;
- Adverse event/near miss; and,
- Physical Environment Management Systems
- Operative and invasive procedures; (including wrong site/wrong patient/wrong procedure surgery)
- Anesthesia/moderate sedation;
- Blood and blood components
- Restraint use/seclusion;
- Effectiveness of pain management system;
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of eight hours.
- Other adverse events;
- Critical and/or pertinent processes, both clinical and supportive;
- Medical record delinquency;
- Other aspects of performance that assess process of care, hospital service and operation

Internal Audits (8.2.2) shall be conducted taking into consideration the status and importance of the processes and areas to be audited, as well as the results of previous audits. For a list of internal audits conducted refer to the “Hospital-Wide Quality Assessment and Performance Improvement
Board is Responsible for Quality of Care

Relevant findings from Performance Improvement activities performed are considered part of:
- Reappraisal/reappointment of medical staff members;
- The renewal or revision of the clinical privileges of individuals who practice independently;
- The mechanism used to appraise the competence of all those individuals not permitted by the hospital to practice independently.

ORGANIZATION:

To achieve fulfillment of the objectives, goals and scope of the Organizational Performance Improvement Plan, the organizational structure of the program is designed to facilitate an effective system of measuring, analyzing and improving the care and services provided throughout General Hospital. The Performance Improvement Director is responsible to ensure the effectiveness of the Performance Improvement Program for the District.

The Board of Directors is responsible for the quality of patient care provided.

The Board of Directors requires the medical staff to implement and report on the activities and the mechanisms for process design and performance measurement, analysis and improvement; monitoring, assessing and evaluating the quality of patient care, for identifying and reducing the risk of sentinel events; for resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect effect on patient care, including management and administrative functions.

The Board of Directors provides for resources and support systems for the Performance Improvement
functions and risk management functions related to patient care and safety.

The Board of Directors has a responsibility to evaluate the effectiveness of the Performance Improvement activities performed throughout the hospital and the Organizational Performance Improvement Program as a whole to assure that improved performance is achieved and sustained.

With authority delegated by the Board of Directors, the medical staff strives to improve and assure the provision of quality patient care through the monitoring, assessment, and evaluation of performance measurement and outcome.

The medical staff provides effective mechanisms to monitor, assess, and improve the quality and appropriateness of patient care and the clinical performance and competency of all individuals with delineated clinical privileges. Performance Improvement opportunities are addressed, with improvement strategies and actions implemented, to assure improved performance is achieved and sustained.

The Medical Executive Committee delegates the oversight responsibility for performance activity monitoring, assessment, and improvement of patient care services provided throughout the facility to the Performance Improvement Committee and Medical Staff Performance Improvement Committee.

With designated responsibility from the Performance Improvement Committee, Performance Improvement (PI) Teams will operate as functional groupings of individuals in the organization who meet to evaluate and improve a specific process, system, or function within the hospital. Performance Improvement Teams are comprised of departmental leaders, medical staff on an as needed basis, and those individuals designated from each department, as appropriate, who may have the highest degree of knowledge regarding a given Performance Improvement topic.

Performance Improvement teams meet as necessary and are defined by the team, to perform the Performance Improvement processes required for improving processes involved in patient care and organizational function. Team reporting is performed at the organizational Performance Improvement
Hospital Uses PDCA and FOCUS

team level, through the Organizational Performance Improvement Committee and medical staff committees, as appropriate. Performance Improvement team activity may also be incorporated into individual departmental Performance Improvement programs as the activity relates to that department.

METHODOLOGY:

FOCUS - PDCA process is utilized to plan, design, measure, assess and improve functions and processes related to patient care and service throughout the organization:

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>PDCA</th>
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<tr>
<td>Find the process to improve</td>
<td>Plan the improvement</td>
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<tr>
<td>Organize to improve the process</td>
<td>Do the improvement</td>
</tr>
<tr>
<td>Clarify current knowledge of the process</td>
<td>Check the results</td>
</tr>
<tr>
<td>Understand the process improvement</td>
<td>Act to hold the improvement</td>
</tr>
<tr>
<td>Select the process improvement</td>
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Responsibility
Assign responsibility for monitoring, assessing and improving performance.

Scope
Delineate the scope of care and services provided;

Important Aspects/Processes
Identify important key aspects of care, focusing on those aspects and processes that relate to the health and safety of the patients services, or that may result in a sentinel event if not optimally managed.

Measurement
Identify objective and statistically valid performance measures for monitoring and improving performance aspects/processes of care. Performance measures include processes performance
Focus on High Risk and High Volume

measures and outcome performance measures that affect a large percentage of patients; and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or are likely to be problem prone; and/or may result in sentinel events.

Performance measures are structured to focus on high risk, high volume, high cost, or problem prone areas; are based on current knowledge and clinical experience; and are structured to reflect cross-departmental, interdisciplinary processes, as appropriate. Measures will be further categorized whether the focus is to evaluate:
- Health Outcome
- Patient Safety
- Quality Care
- Medical Error/Adverse Events
- Satisfaction
- Quality Control and
- Compliance

The following criteria are utilized when determining appropriate performance measures to utilize to improve performance:

- The measure can identify the events it was intended to identify;
- The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;
- The measure has defined data elements and allowable values;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities;
- The data intended for collection are available and accessible;
- Results can be reported in a manner that is useful to the organization and other interested healthcare participants.
Collect Data and Monitor

Data Collection: Monitor, assess and improve the important aspects/processes of care by assessment of data collected. Collected data allows the hospital to:

- Monitor its performance;
- Monitor performance of areas targeted for further study;
- Monitor the performance of processes that involve risks or may result in sentinel events (i.e. Quantros Report);
- Make informed judgments about the stability of existing processes; Identify opportunities for incrementally improving processes;
- Identify the need to redesign processes;
- Decide whether improvements or redesign of processes meet objectives. Data collection focuses upon:

Processes, particularly those that are high-risk, high-volume, problem-prone and/or may result in sentinel events; Outcomes; Comprehensive performance measures; Other gauges of performance; Evaluate/Analyze; Aggregating, analyzing and evaluating data allows the hospital to draw conclusions about its performance in relation to a process or the nature of an outcome. The following criteria are considered during data analysis and evaluation:

- Were the design specifications for new processes met?
- What is the current level of performance? How stable are current processes?
- What are the priorities for possible improvement of existing processes or implementation of
Identify Change and Implement

new processes?

- Is the data displayed utilizing appropriate statistical techniques to allow for optimal analysis?
- Does analysis include internal (historical) and external data comparison? Is internal and external data displayed in a format that allows for comparison over time?
- Does the data include information that will lead to the reduction of sentinel events?
- Was a strategy to stabilize or improve performance effective (as appropriate)?

Identify Change
Changes required to improve performance and reduce the risk of sentinel events are identified based on the analysis of data, either from ongoing monitoring or targeted study results.

Improve
Implement actions to improve the performance of new or existing processes, systems and/or functions, as well as to reduce or eliminate sentinel events.

Evaluate
Evaluate whether the change(s) implemented and actions taken to improve have been effective, documenting the achievement of improved performance, monitoring the aspect/process until there is documented proof that the improvement is (or can be) sustained.

Report
Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services, the Hospital Performance Improvement Committee, Medical Staff Performance Improvement Committee and to the Governing Body.

Any variation, or deficiency identified shall be addressed by appropriate corrective or preventive
Quality Improvement Activities

- **Standard**: The hospital must collect data to identify opportunities for improvement.

- **Standard**: Hospital must set priorities that focus on high risk, high volume, or problem prone areas.

- Must consider the incidence, prevalence, and severity of problems in those areas.

- Look at issues that affect health outcomes, patient safety and quality of care.

- Track performance to ensure improvements are sustained.
- **Standard**: PI program must include indicators to identify and reduce medical errors
  - Track medical errors and ADE

- Analyze their causes and implement preventive actions
  - Example would be a RCA or root cause analysis

- Board is responsible for the operations of the hospital

- Medical staff and administrative staff are accountable to make sure clear expectations for safety
Need a system that includes feedback and learning throughout the hospital

First, the hospital need to identify that there is a medical error

- It needs to be reported into the PI system
- Risk management and hospital staff cannot fix a problem they do not know exists

Second, the hospital evaluates it to determine what processes can be put in place to prevent it from occurring

RCA and FMEA are two tools that can be used
Medical errors may be difficult to detect in hospitals and are under reported

Make sure incident reports are filled out for errors and near misses and remember non-punitive approach

Are there any diagnostic errors, equipment failures, blood transfusion injuries, or medication errors

Trigger tools by IHI can assist in finding medical errors and opportunities for improvement

Trigger Tool for Measuring Adverse Drug Events

The use of “triggers,” or clues, to identify adverse drug events (ADEs) is an effective method for measuring the overall level of harm from medications in a health care organization. The Trigger Tool for Measuring Adverse Drug Events provides instructions for conducting a retrospective review of patient records using triggers to identify possible ADEs. This tool includes a list of known ADE triggers and instructions for collecting the data you need to measure the number of ADEs per 1,000 doses and the percentage of admissions with an ADE.

NOTE: You can use this tool in conjunction with the interactive Trigger Tool for Measuring ADEs in the Workspace area on IHI.org. Enter your detailed data from all of your ADE Patient Record Review Sheets into the interactive Trigger Tool for Measuring ADEs. The Tool will automatically calculate and graph two measures: ADEs per 1,000 Doses and Percent of Admissions with an ADE.

This tool contains:
- Background
- List of ADE Triggers
- General Instructions
Resources


- **Standard:** Hospital must conduct PI projects
- How many the hospital does depends on how big they are and what types of services are provided
- May develop and use information technology system to improve patient safety and quality
- Document the projects and reasons for doing
- Can participate in a QIO project or do one that is of comparable effort
QIO to advance quality of care for Medicare patients

Every state has a QIO or Quality Improvement Organization under contract by CMS

- Also 2 BFCC QIOs Livanta and KePro

Sign up with your state QIO to get newsletters and other information

CMS has a website on information about QIOs

CMS has the mission to improve services provided to Medicare patients
Quality Improvement Organizations

What are QIOs?

CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction’s Quality Improvement Organization (QIO) contractor. QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care. QIO contracts are 3 years in length, with each 3-year cycle referenced as an ordinal “SOW.”

What do QIOs do?

By law, the mission of QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Based on this statutory charge, and CMS’ Program experience, CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Why does CMS have QIOs?

CMS relies on QIOs to improve the quality of health care for all Medicare beneficiaries. Furthermore, QIOs are required under Sections 1152-1154 of the Social Security Act. CMS views the QIO Program as an important resource in its effort to improve quality and efficiency of care for Medicare beneficiaries. Throughout its history, the Program has been instrumental in advancing national efforts to motivate providers in improving quality and in measuring and
List of QIOs

Medicare Quality Improvement Organizations (QIOs) work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations.

QIOs safeguard the integrity of the Medicare program by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

Under the direction of the Centers for Medicare & Medicaid Services (CMS), the Medicare QIO program consists of a national network of 53 QIOs responsible for each U.S. state, territory, and the District of Columbia. To locate a QIO, select the state below.

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<tr>
<th>State</th>
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<td>AQAF</td>
<td>205-970-1600</td>
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<tr>
<td>Alaska</td>
<td>Mountain-Pacific Quality Health</td>
<td>800-497-6232</td>
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<tr>
<td>Arizona</td>
<td>Health Services Advisory Group, Inc.</td>
<td>602-264-6382</td>
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<tr>
<td>Arkansas</td>
<td>Arkansas Foundation for Medical Care</td>
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<tr>
<td>California</td>
<td>Health Services Advisory Group of California, Inc.</td>
<td>818-265-4650</td>
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<tr>
<td>Colorado</td>
<td>Colorado Foundation for Medical Care</td>
<td>303-695-3300</td>
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<td>Connecticut</td>
<td>Qualidigm</td>
<td>860-632-2008</td>
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<tr>
<td>Delaware</td>
<td>Quality Insights of Delaware</td>
<td>302-478-3600</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Delmarva Foundation of the District of Columbia</td>
<td>202-293-9650</td>
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<tr>
<td>Florida</td>
<td>FMQAI</td>
<td>800-564-7490</td>
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http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/QnetTier2&cid=1144767874793
Outpatient Data Collection

QualityNet News

Hospital VBP FY 2020 Baseline Measures Report Now Available
The Hospital Value-Based Purchasing (VBP) Program Fiscal Year 2020 Baseline Measures Reports are now available from the Centers for Medicare & Medicaid Services (CMS). This report allows hospitals to monitor their baseline period performance for all domains and measures required for the Hospital VBP Program. Hospitals can access their Baseline Measures Report through the QualityNet Secure Portal.

Full Article »

Headlines
- New CMS HSR tutorial video released
- CMS releases April 2018 Hospital Compare preview reports
- FY 2018 program results for three Value-Based Purchasing programs updated on Hospital Compare site
- Hospitals selected for FY 2020 inpatient quality reporting chart-abstracted data validation
- CY 2018 OPPS/ASC final rule with comment period
- CY 2018 OPPS/ASC Final Rule displayed
- CMS grants exemptions for Quality Program participants in FEMA disaster areas affected by Northern California Wildfires
- CY 2017 eCOM Reporting Updates and Resources for the Hospital IQR and Medicare EHR Incentive Programs Issued
- CMS releases December 2017 Hospital Compare preview reports

About QualityNet
Measures
Hospital Outpatient Quality Reporting Program

The Centers for Medicare & Medicaid Services (CMS) uses a variety of data sources to determine the quality of care that Medicare beneficiaries receive.

For the measure sets listed below, CMS uses Medicare Outpatient claims data submitted by hospitals for Medicare fee-for-service patients. Each measure set is calculated using a separate, distinct methodology and, in some cases, separate discharge periods.

- **Hospital Outpatient Quality Reporting (OQR) Quality Measures** - Includes process of care, imaging efficiency patterns, care transitions, ED-throughput efficiency, use of health information technology (HIT), care coordination, patient safety, and volume measures.

- **Colonoscopy Measure** – This outcome measure for the Outpatient setting is meant to provide facilities with information on patient outcomes that will allow them to improve quality of care for patients undergoing low-risk colonoscopy.

- **Imaging Efficiency Measures** – Includes six publicly reported measures calculated using data from hospital Outpatient claims: MRI lumbar spine for low back pain, mammography follow-up rates, abdomen computed tomography – use of contrast material, thorax CT – use of contrast material, cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery, and simultaneous use of brain CT and sinus CT.

- **Chemotherapy Measure** – This claims-based outcome measure provides facilities with information on patients undergoing chemotherapy treatment in the outpatient setting and is intended to facilitate quality improvement efforts. A dry run of this measure will begin in August 2017.

- **Surgery Measure** – This claims-based outcome measure provides facilities with information on hospital visits within seven days of hospital outpatient surgery that will allow them to improve the quality of care at their facility. A dry run of this measure will be held in September 2017.
<table>
<thead>
<tr>
<th>#</th>
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<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
<td>Eligible Hospitals</td>
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<td>Antithrombotic Therapy By End of Hospital Day 2</td>
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<td>VTE3</td>
<td>Venous Thromboembolism Patients with Anticoagulation Overlap Therapy</td>
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<td>Discharged on Antithrombotic Therapy</td>
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<td>Clinical Processes/Effectiveness</td>
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<td>Stroke Education</td>
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<td>Patient and Family Engagement</td>
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<td>VTE1</td>
<td>Venous Thromboembolism Prophylaxis</td>
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<td>VTE4</td>
<td>Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram</td>
<td>Eligible Hospitals</td>
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<td>VTE5</td>
<td>Venous Thromboembolism Discharge Instructions</td>
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<td>ED2</td>
<td>Median Admit Decision Time to ED Departure Time for Admitted Patients</td>
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<td>VTE5</td>
<td>Incidence of Potentially-Preventable Venous Thromboembolism</td>
<td>Eligible Hospitals</td>
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<td>April 2014 EH</td>
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<td>SCIPIn1</td>
<td>Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision</td>
<td>Eligible Hospitals</td>
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<td>April 2014 EH</td>
<td>Patient Safety</td>
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<tr>
<td>SCIPIn2</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>Eligible Hospitals</td>
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<td>April 2014 EH</td>
<td>Efficient Use of Healthcare Resources</td>
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<tr>
<td>SCIPIn9</td>
<td>Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero</td>
<td>Eligible Hospitals</td>
<td>4</td>
<td>April 2014 EH</td>
<td>Patient Safety</td>
</tr>
</tbody>
</table>
AHRQ Quality Measure Tools & Resources

- AHRQ has many resources on quality measurement and patient safety


- Has toolbox, child health measures, pediatric quality measures, emerging measures, patient safety indicators

Sign Up for Quality Measure Tools


Quality Measure Tools & Resources

Sign up: email Quality Measure Tools Email updates

Quality improvement measurement, tools, and information, including AHRQ Quality Indicators Hospital Toolkit, ambulatory clinical performance measures, the National Quality Measures Clearinghouse, and TalkingQuality.

Tools & Resources

Quality measures tools and resources

- AHRQ Quality and Safety Review System
- All-Payer Claims Databases
- All-Payer Claims Databases Measurement of Care
- Building the Science of Public Reporting
- Challenge and Potential for Assuring Quality Health Care for the 21st Century
- Child Health Care Quality Toolbox
- Delivery System Research Initiative
- Health Literacy Measurement Tools
- Improving the Quality of Asthma Care
- MEDNET Resource Guide
- Public Reports on Provider Performance for Consumers
- Selecting Quality and Resource Use Measures
Sign Up for Patient Safety Email Updates

Executive Responsibilities 309

- **Standard**: Board assumes full legal authority and responsibility for the operations of the hospital

- Medical Staff and Administrative officials are responsible and accountable for the following:
  - Ongoing PI program that includes patient safety including reducing medical errors
  - Hospital wide PI and patient safety program
  - A determination of the number of PI projects that is conducted annually
Adequate Resources  315

- **Standard:** The board, Medical Staff, and Administrative Officials are accountable for measuring, assessing, improving and sustaining the hospital’s performance
- This also requires reducing risk to patients
- Example: hospitals created a process to ensure MI patients got their thrombolytics timely, that PCI was done before 90 minutes and pneumonia patients got their antibiotics and blood culture timely
- Process to make sure the improvements continue
QAPI Patient Safety

- This means people who can attend meetings, data so analysis can be made and other resources

- Safer IV pumps, anticoagulant program, implement central line bundle, sepsis and VAP bundle, preventing inpatient suicides, wrong site surgery, retained FB, revised processes for neuromuscular blocker agents, implement policy on Phenergan administration and Fentanyl patches

- So what’s in your PI and Safety Plans?
National Quality Forum  NQF

- NQF is an excellent resource
- Has the ABCs of measurement
- A list of NQF endorsed standards
- A list of consensus projects
- Resources

- Can do a search of measures such as AAA repair mortality rate, accidental puncture or laceration rate, 30 day post hospital MI discharge care transition rate, stroke mortality rate, adherence to medication for diabetic patients, etc.
AHRQ Has Excellent Resources

Quality and Patient Safety

Sign up: Patient Safety Email updates
Sign up: Quality Improvement Email updates
Sign up: National Health Care Quality and Disparities Email updates

Tips for preventing medical errors and promoting patient safety, measuring health care quality, consumer assessment of health plans, evaluation software, report tools, and case studies.

AHRQ's Healthcare-Associated Infections Program

Comprehensive Unit-based Safety Program (CUSP)

- CUSP Toolkit
- Eliminating CLABSI, Companion Guide
- High-Performance Work Practices in CLABSI Prevention Interventions
- Eliminating CLABSI, A National Patient Safety Imperative
- Eliminating CLABSI, Neonatal CLABSI Prevention
- CUSP Success Stories

AHRQ and Patient Safety

Bruce Siegel on AHRQ and Patient Safety

RESOURCE LINKS
Toolkit for Using the AHRQ Quality Indicators - A “How to” Guide for Improving Hospital Quality and Safety

Slide presentation of the webinar held on August 1, 2016

The Agency for Healthcare Research and Quality (AHRQ) held a Webinar on August 1, 2016, to provide an overview of the AHRQ Quality Indicators (QIs) and the updated QI toolkit.

Slide 1

Need Help?

- Audio is provided through your computer; don’t forget to turn on your speakers! Closed captioning is also available.
- For technical help, please type your question in the Q&A box on your screen.
Patient Safety Indicators

Quality Indicator User Guide: Patient Safety Indicators (PSI) Composite Measures
Version 4.4

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
http://www.qualityindicators.ahrq.gov

Contract No. HHSA290201200001C

Prepared by:
Battelle
505 King Avenue
Columbus, OH 43201
Types of Indicators; Inpatient, PS, Peds,

INTRODUCTION

The Agency for Healthcare Research and Quality (AHRQ) has developed an array of health care decision making and research tools that can be used by program managers, researchers, and others at the Federal, State and local levels. The Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The current AHRQ QI modules expand HCUP QIs. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- **Prevention Quality Indicators** identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care. (first released November 2000, last updated March 2012)

- **Inpatient Quality Indicators** reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. (first released May 2002, last updated March 2012)

- **Patient Safety Indicators** reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. (first released March 2003, last updated March 2012)

- **Pediatric Quality Indicators** use indicators from the other three modules with adaptations for use among children and neonates to reflect quality of care inside hospitals, as well as geographic areas, and identify potentially avoidable hospitalizations. (first released April 2006, last updated March 2012)

The AHRQ QIs are used in free software distributed by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

NEWS

2013

- **February 8, 2013 — Federal Register Notice for a time-limited workgroup and a standing workgroup**

- **February 4, 2013 — AHRQ QI Newsletter Issue 1**

- **January 4, 2013 — AHRQ QI User Survey Available (Click here to participate)**
## List of NQF Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>NQF#</th>
<th>Steward</th>
<th>Updated</th>
</tr>
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<tbody>
<tr>
<td>(Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level &lt; 10g/dL</td>
<td>1667</td>
<td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)</td>
<td>Jul 10, 2012</td>
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<tr>
<td>30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock</td>
<td>0536</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Jan 03, 2013</td>
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<tr>
<td>30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock</td>
<td>0535</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Jan 03, 2013</td>
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<tr>
<td>30-Day Post-Hospital AMI Discharge Care Transition Composite Measure (Composite Measure)</td>
<td>0698</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Sep 11, 2012</td>
</tr>
<tr>
<td>30-Day Post-Hospital HF Discharge Care Transition Composite Measure (Composite Measure)</td>
<td>0699</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Sep 11, 2012</td>
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<tr>
<td>30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure (Composite Measure)</td>
<td>0707</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Jan 17, 2011</td>
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<td>3-Item Care Transition Measure (CTM-3) (Composite Measure)</td>
<td>0228</td>
<td>University of Colorado Health Sciences Center</td>
<td>May 05, 2010</td>
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<td>Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)</td>
<td>0359</td>
<td>Agency for Healthcare Research and Quality</td>
<td>May 01, 2012</td>
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<tr>
<td>Abdominal Aortic Aneurysm (AAA) Repair Volume (IQI 4)</td>
<td>0357</td>
<td>Agency for Healthcare Research and Quality</td>
<td>May 01, 2012</td>
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<tr>
<td>Accidental Puncture or Laceration Rate (PSI 15)</td>
<td>0345</td>
<td>Agency for Healthcare Research and Quality</td>
<td>Aug 09, 2012</td>
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</table>
COMMENT: Gastrointestinal / Genitourinary Stage 2 - through May 24
COMMENT: Common Formats for Patient Safety Data: Version 1.2 – open comment period

www.qualityforum.org/Home.aspx
Performance Measurement

Venous Thromboembolism

The Joint Commission Response to the Annals of Internal Medicine Editorial Regarding VTE: Learn More
Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. Payment implications began October 1, 2008, for these Hospital Acquired Conditions. The IPPS FY 2009 Final Rule is available in the Statute/Regulations/Program Instructions section, accessible through the navigation menu at left.

These 14 categories of HACs listed below include the new HACs from the IPPS FY 2013 Final Rule which are Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization. For FY 2014 and FY 2015, there are no additional HACs added:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
In Summary

- Make sure you use the QAPI worksheet
- Consider going a gap analysis on the QAPI standards
- Make sure every department and service is reporting data
  - This includes inpatient and outpatient departments
  - Both clinical and non-clinical areas like maintenance
- Make sure you review services provided under contracts and ensure board reviews same
  - Include the performance indicators for each contract
In Summary

- Board must make sure you are implementing an effective QAPI program
  - Consider providing the board a report demonstrating this
- Need to show measurable improvements
  - Indicators that show you are improving health outcomes and making a difference
  - That you are reducing and identifying medical errors and adverse events
  - That you are tracking adverse patient events
  - Focus on patient safety and ensure adequate resources
- Review your QAPI plan and policy annually
In Summary

- The data that you collect should be relevant, aggregated, analyzed, and acted upon to identify opportunities for improvement
- Train your staff that collect data so it done correctly
- Focus on high volume, high risk, and problem prone areas
- Clearly document the actions you take to improve performance
- Document how you will make sure these actions to improve are sustained
The End!  Questions??

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- Dublin, Ohio 43017
- 614 791-1468
- sdill1@columbus.rr.com
- Call with questions, No emails, Thanks