Improving Quality and Patient Safety

Background

Hospitals engage in an array of collaborative activities designed to improve the quality and safety of the care they provide. The increasing amount of credible and actionable information that has become available through public reporting efforts has helped spur improvements. While it is worth celebrating the improvements in patient safety and quality, such as reductions in hospital-acquired infections and early elective deliveries, it also is imperative that hospitals continue to strive for better performance.

Public policies can further facilitate or impede hospitals' efforts to improve quality, which is why the AHA and its member hospitals work closely with the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), and The Joint Commission and other national accreditation bodies. However, the federal agencies' disparate responsibilities within the health care system prompt them to interact with and influence the work of hospitals in very different, and occasionally conflicting, ways.

Over the past several years, CMS has greatly expanded its pay-for-performance programs in accordance with provisions of the Affordable Care Act (ACA) and fostered experiments with new types of payment systems intended to promote more integrated care across the continuum. However, as CMS seeks changes in performance and improvements in integration across the care continuum, its own programs and initiatives can impede progress. For example, CMS is promoting more integrated care through bundled payment programs, various accountable care organization models and other initiatives, but its quality reporting require-ments are built along the siloed lines of its payment structures, and engaging in these new models of payment imposes another layer of quality reporting that may produce confusing and discordant measures. Additionally, changes that might be made to how a health system is organized, such as creating an integrated medical staff across hospitals in the same system, put the hospital or health system at risk of being cited for violating a Medicare Condition of Participation.

AHA View

Hospitals and health systems are working to achieve the Triple Aim – better health, better health care, and lower costs. They are integrating with other providers in a variety of ways to ensure more coordinated and patient-centered care and working to eliminate unneeded expenditures. At the same time, policy-makers need to continue to reform how they oversee, regulate and stimulate change in the health care delivery system. They need to understand how their rules, measures, and actions affect the activities of caregivers on the front line so they are not creating confusion or derailing successful improvement activities with discordant or outdated approaches to regulation. This is best achieved when there is open dialogue and opportunities for discussion among affected stakeholders.

Open discussions have been particularly effective in the ongoing work to share important and reliable quality performance data with the public. However, in too many instances, progress has been hampered by the overwhelming volume of measures hospitals are being asked to collect and report, the confusing and disparate assessments of a hospital's performance in different public report cards, and the fact that some of the data are too old or the measures are too unreliable. The sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and disparate incentives impeding efforts to enhance the coordination of care across the continuum. A strategically designed approach that promotes better health and better patient outcomes by appropriately involving all parts of the health care delivery system is urgently needed.

National Quality Strategy. The ACA calls for developing a National Quality Strategy. The law directs the Department of Health and Human Services (HHS) to create a strategic plan that identifies critically important areas for improvement, sets goals and selects measures to be used in the federal programs. This plan relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts.

The AHA strongly supports the premise of the National Quality Strategy. Alignment of quality reporting and payment across care settings and programs is critically important to the long-term success and sustainability of health care quality improvement efforts, and to helping patients and the general public find the information that is important, understandable and relevant to their care.

For the National Quality Strategy to be a success, it must align measures in various payment and public reporting programs using a consistent set of principles. At a time when health care resources are under intense scrutiny, the alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and unnecessary duplication of efforts among providers. Alignment also would help balance the allocation of limited resources between data collection and actual efforts to improve performance.

The AHA has actively participated in efforts to convene affected stakeholders and provide input to HHS on priorities, goals and measures. The National Priorities Partnership advises the HHS secretary on priorities and goals, and the Measure Applications Partnership advises the secretary on the selection of measures for various programs. We continue to urge both bodies to take additional steps to more concretely enhance the alignment of quality measurement reporting and payment efforts.

Linking Payment to Quality. The AHA supports the general concept of linking hospital payment to meeting performance targets on quality measures. However,

we are concerned that many of the quality measures upon which federal pay-for-performance programs are based do not produce accurate performance results, making them inappropriate to use for public reporting and accountability programs. Moreover, we believe the manner in which some of the payment penalties are calculated lacks fairness and equity.

A panel convened by the NQF recently invited public comment on its report, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," which recommends adjusting health care performance measures to account for sociodemographic factors, such as education, race/ethnicity and/or homelessness. The AHA is pleased that the recommendations recognize the importance of socioeconomic adjustment in public reporting and pay-for-performance programs. The recommendations in the report also are aligned with an AHA-supported bill, the Establishing Beneficiary Equity in the Hospital Readmission Program Act, H.R. 4188, which would require CMS to adjust hospital readmission penalties for socioeconomic factors. Such adjustment is intended to provide a more level "playing field," and ensure that hospitals caring for the most vulnerable patients are not unfairly penalized.

The AHA's efforts to improve quality measurement and its uses in public reporting and federal pay-for-performance programs are described in AHA's issue paper, "Quality Reporting and Pay-for-Performance Programs."

Conditions of Participation (CoP). Since 2011, CMS has been working to overhaul its CoPs for hospitals and critical access hospitals. This major overhaul is necessary because no major changes have been made to the CoPs since 1985, and the field has changed significantly. For example, many more patients are being treated in the ambulatory care setting than inpatient setting; new tools and treatment methods are being used, including electronic health records; there are more hospitalists, intensivists and surgeons working exclusively in hospitals or health systems, and many of them are employed by or under contract to the hospital or health system in which they work. Further, the fundamental roles of nurses, doctors, pharmacists and therapists have changed as we have learned more about how to provide team-based care.

All of these changes and more have altered the nature of hospital care and the relationship between hospitals and their medical staffs. Additionally, there is a new understanding of the tools and techniques for achieving higher quality, safer and more reliable care, a new expectation of the on-going responsibilities for patients post discharge from the hospital, and new knowledge about the vulnerabilities of our physical plants during normal operation and in the event of a disaster. CMS is striving to craft its requirements to recognize how care has changed, how requirements for buildings have evolved in response to experience and new knowledge, and to reflect new knowledge of quality and safety.

In early 2013, CMS proposed changes to the Medicare CoPs that were intended to reduce the burden on hospitals by eliminating outdated and outmoded requirements. For example, the agency proposed to rescind a CoP requirement that a member of the hospital's governing board be a member of the medical staff, and instead require periodic consultation between the governing body and the head of the medical staff. However, CMS also proposed a new requirement that prohibits hospitals in the same health care system from having a unified medical staff serving two or more of its hospitals, if the hospitals have different CMS certification numbers.

To ensure hospitals are prepared to deal with emergencies of all kinds, CMS also issued a proposed rule delineating emergency preparedness requirements in late 2013. The AHA urged CMS to align its proposals with existing standards from the fire marshals, the Hospital Preparedness Program and others; clarify who has the lead in emergency preparedness planning for the community and how the preparations of individual hospitals or health systems can be integrated with the plans of others serving the same communities; and improve their process for implementing these complex requirements. (Refer to the AHA issue paper, "Hospital Emergency Preparedness and Response," for more details.)

CMS also is working on revisions to the Life Safety Codes embedded in the CoPs, and recently proposed a rule delineating those changes.

The AHA applauds CMS for recognizing that its CoPs are out of date and supports many of the proposed changes; however, we remain concerned that CMS lacks a process for routinely and predictably updating the CoPs to ensure that they stay aligned with rules from other organizations overseeing the quality and safety work at hospitals. Further, we continue to work with CMS to ensure its CoPs do not impede progress toward more integrated care delivery. Since the CoPs were crafted on the premise that each hospital, as defined by having a unique CMS Certification Number (CCN), is an independent organization, efforts to be more integrated and standardized across systems have occasionally been thwarted by CMS and its surveyors insisting on strict adherence to the CoPs.

Drug Availability and Safety. Hospitals and health systems remain deeply concerned about chronic drug shortages. There were approximately 70 active drug shortages in the first quarter of 2014, including shortages of essential and broadly needed drugs, such as saline solutions. These drug shortages make delivering patient care more difficult and dangerous by causing delays in treatment and forcing the use of alternative drugs that come from sources not well regulated by the FDA or that are less familiar to the provider. Shortages also are costly to hospitals and health systems in terms of staff time and other resources to manage the shortages and the increased cost of buying alternative drugs "off contract."

As the saline shortage worsened in early 2014, the AHA urged the FDA to improve the availability of this critical supply to hospitals and consider importing saline from trusted sources abroad. The AHA also provided expert guidance to its members, urging them to take all appropriate steps to protect the dwindling supply of saline.

The AHA has been working closely with the office of the Assistant Secretary for Emergency Preparedness, and the FDA to better understand and seek solutions for drug shortages, which create a public health crisis. After advocacy by the AHA and a coalition of health care stakeholders, Congress passed the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA), which included provisions to help alleviate critical drug shortages. The law:

- Broadens and strengthens requirements for manufacturers to notify FDA, in advance of discontinuance or interruptions in drug production;

- Requires FDA to consider the impact on supply of drugs prior to taking enforcement actions against manufacturers;

- Permits expedited drug application reviews and site inspections to help mitigate or prevent shortages;

- Requires coordination between the FDA and the Drug Enforcement Administration for shortages involving controlled substances;

- Relaxes FDA requirements for hospitals that repackage shortage drugs for use within their own health system; and

- Requires FDA to establish a task force to develop and implement a strategic plan for enhancing the response to drug shortages and to submit an annual report to Congress on drug shortages and the agency's related actions.

While the enactment of FDASIA was an important achievement, additional efforts are underway. The AHA is engaged in an ongoing dialogue with FDA officials on the impact of shortages on hospitals and health systems and monitoring FDA's implementation of drug shortage provisions of FDASIA. We also continue to work with House and Senate committees, the Government Accountability Office and other national stakeholder organizations to explore causes and solutions for drug shortages.

PURSUING EXCELLENCE

Hospitals in Pursuit of Excellence. Through the AHA's strategic platform to accelerate performance improvement, *Hospitals in Pursuit of Excellence* (HPOE), the AHA provides field-tested practices, tools, education and other resources that support hospital efforts to meet the Institute of Medicine's Six Aims for Improvement – care that is safe, timely, effective, efficient, equitable and patient-centered. HPOE draws upon the resources of the entire association, including the

American Organization of Nurse Executives, AHA Solutions, the Center for Healthcare Governance, Health Research & Educational Trust (HRET), Institute for Diversity in Health Management, Physician Leadership Forum and the AHA's nine Personal Membership Groups.

HPOE, along with AHA and HRET, accelerates quality improvement in the health care field by:

- Sharing best practices through *www.hpoe.org*;

- Providing action guides on a variety of topics, including disparities, population health, variation and payment innovations; and

- Offering fellowship programs in patient safety and health care system reform.

National Improvement Projects. HRET and the AHA also are leading national improvement efforts that are changing the way hospitals provide care for patients. Through CMS's Partnership for Patients campaign and the Hospital Engagement Network (HEN) program, the AHA and HRET are assisting hospitals with the adoption of best practices with the goal of reducing inpatient harm by 40 percent and readmissions by 20 percent. HRET provides education and training for the nearly 1,600 hospitals recruited by its 31 state hospital association partners in support of their quality improvement efforts. Over the first two years of the program significant improvements in quality were made in key clinical areas:

- An 18 percent decrease in catheter-associated urinary tract infections (CAUTIs);

- A 23 percent decrease in central line blood stream infections (CLABSIs);

- A 57 percent decrease in early elective deliveries;

- A 25 percent decrease in pressure ulcers;

- A 6 percent decrease in all cause readmissions; and

- A 6 percent decrease in surgical sites infections.

Together these improvements resulted in better care for more than 69,000 patients with associated cost savings of $202 million. Equally important, the program has helped the hospital field develop the infrastructure, expertise and organizational culture that will support further improvements for years to come. In addition to accelerating improvement nationally, patients are benefiting every day from the spread and implementation of best practices.

Beyond HEN, HRET's work through funders like AHRQ is helping the field embrace and learn best practices in patient care. In particular the use of the Comprehensive Unit-based Safety Program (CUSP) has resulted in some prominent

successes. CUSP is a customizable program that helps hospital units address the foundation of how clinical teams care for patients. It combines clinical best practices with an understanding of the science of safety, improved safety culture, creating a learning culture and an increased focus on teamwork.

On the CUSP: Stop CAUTI (*www.onthecuspstophai.org*) has a primary goal of reducing the CAUTI rate in hospital units participating in the project by the completion of the four-year initiative. Secondarily, this project seeks to make decreased CAUTI rates sustainable by fostering a culture of safety in participating units. Since 2011, 79 percent of the units participating have reduced or maintained a rate of zero CAUTIs. The project continues to successfully expand by increasing its reach both to new geographic locations and to new areas of the health care system, as well as by broadening exposure of participating units to national experts, and does so in an inclusive manner involving hospitals of all types, including rural and urban, teaching and non-teaching. HRET also will be working to reduce CAUTIs and other health care-associated infections in long-term care facilities. The project seeks to implement CUSP in nursing homes and skilled nursing facilities nationwide.

HRET also is leading Team Strategies to Enhance Performance and Patient Safety (TeamSTEPPS), which was jointly developed by AHRQ and the Department of Defense Patient Safety Program as a system to train health care workers to function as a safe and effective team. TeamSTEPPS (*www.teamsteppsportal.org*) improves communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system.

In addition, AHRQ is funding a 12-month patient safety improvement collaborative (*www.ascsafetyprogram.org*) in which participating ambulatory surgery centers, hospital outpatient departments, endoscopy centers and primary care offices will effectively implement surgical safety checklists that integrate clinical and safety culture practices. With an aim of zero harm for patients undergoing care in ambulatory surgical settings, the goal is the reduction of surgical site infections and complications.

Achieving Equitable Care. The AHA has joined four leading health organizations in *Equity of Care*, a national call to action to eliminate health care disparities and improve quality of care for every patient. The Equity of Care initiative focuses on three areas:

- Increasing the collection and use of race, ethnicity, and language preference data;

- Increasing cultural competency training; and

- Increasing diversity in governance and leadership.

HRET is supporting AHA's work, which includes disseminating free resources and sharing best practices on the *Equity of Care* website, *www.equityofcare.org*. To help hospitals measure and thereby effectively address disparities, HRET developed a Disparities Toolkit that allows hospitals to collect race, ethnicity and primary language data in a uniform way. The toolkit is continually reviewed to reflect ACA requirements and The Joint Commission standards. In addition, the AHA's Center for Healthcare Governance and Institute for Diversity in Health Management developed a trustee training program to help hospitals expand the racial and ethnic diversity of their governing boards.