How the compliance department can support quality of care initiatives

HCCA
Las Vegas
April 29, 2012

Susan Moffatt-Bruce, MD, PhD
Chief Quality and Patient Safety Officer, Associate Professor of Surgery
Ohio State Medical Center

Catherine Wakefield, CPA, CIA, CHC, FHFMA
Vice President, Corporate Compliance and Internal Audit
MultiCare Health System

Christine Anusbigian, MBA, CHC
Senior Manager, Health Sciences, Governance, Risk and Regulatory Services
Deloitte & Touche LLP

Agenda

Background
Compliance officer’s role
Quality measure reporting — Value based purchasing
The Ohio State story
Auditing the quality data
Adverse event reporting
Physician and other quality measures to audit
Summary comments
Question and answers
Background

1999 — Institute of Medicine report, titled “To Err is Human: Building a Safer Health System”

• As many as 98,000 people die each year because of preventable medical harm, making medical error the fourth leading cause of death in the United States.
• Estimated the total annual cost of errors to be between $17 billion and $29 billion.

The report was a call to action for hospital leadership to take steps to improve patient safety and quality.

Pay for performance

• 2001 — Health and Human Services (HHS) announced quality initiatives
• 2003 — Financial incentives for reporting inpatient quality measures
  – Initially, the Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provided for a 0.4 percentage point reduction in the annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) update for hospitals that did not successfully report.
  – The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points.
• FY 2009 — 96% of hospitals participated successfully in the reporting program and received the full market basket update for FY 2010.
• July 1, 2011 — Hospital performance will impact Medicare inpatient payments in FY 2013.
Center for Medicare and Medicaid Services (CMS) quality measure goals

- **Safety**: Where care doesn’t harm patients.
- **Effectiveness**: Where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them.
- **Efficiency**: Where resources are used to maximize quality and minimize waste.
- **Transparency**: Where information is used by patients and providers to guide decision-making and quality improvement efforts, respectively.
- **Eliminating disparities**: Where quality care is reliably received regardless of geography, race, income, language, or diagnosis.

CMS quality measure focus areas

- Hospital inpatient
- Hospital outpatient
- Physician
- End-stage renal disease
- Home health
- Nursing home
- Hospice
- Post acute
- Inpatient rehabilitation facilities
Office of the Inspector General (OIG) work plan

Inpatient hospital quality related topics include:
• Reliability of hospital-reported quality measure data
  – OIG will conduct a review of hospitals’ controls for ensuring the accuracy and validity of
data related to quality of care that they submit to CMS for Medicare reimbursement
• Hospital reporting for adverse events
• Hospital admissions with conditions coded present on admission
• Accuracy of present-on-admission indicators submitted on Medicare claims
• Hospital same-day readmissions
• Payments for health care acquired conditions (Medicaid)

Implications

Health care organizations may be subject to a settlement or corporate integrity
agreement as well as other sanctions as a result of identified quality issues.

Sanctions may range from monetary penalties to exclusion from federal and state
health care programs and even incarceration for the most serious offenses. For
example, a health care provider can be subject to exclusion from the federal
health care programs if it provides medically unnecessary services, or services
that fail to meet professionally recognized standards of care.
The role of compliance

- Increased compliance and financial risk as payments linked to quality
- Potential for false claims and reduction in payments and payment denials
- Settlements and Corporate Integrity Agreements (CIAs) related to quality
- Potential for sanctions, monetary penalties or exclusion from state and federal health care programs
- More quality topics are being included in the OIG annual work plans
- Expectation that Medicare will be auditing the accuracy of quality measures reported

Quality measures reporting value-based purchasing
Pay for performance

Current health reform — Delivery system initiatives through implementation of value-based purchasing (VBP) which links payment to performance.

CMS uses the Inpatient Prospective Payment System (IPPS) to provide financial incentives to drive improvement in clinical quality, patient-centeredness, and efficiency.

Value Based Purchasing (VBP)

What is value based purchasing?

• Goal is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries
• VPP payment methodology rewards quality of care through payment incentives
• Beginning July 1, 2011 hospital performance on 12 measures in the clinical process of care domain and 1 Hospital Consumer Assessment of Health Plans Survey (HCAHPS) survey measure (across eight HCAHPS dimensions) will impact FY 2012 DRG payments
• Based on performance on certain quality measures or improvement in performance on each measure compared to performance on the measure during a baseline performance period
• In FY2013 1% of a hospital’s base operating DRG payments will be “at risk” based on its Total Performance Score (TPS)
• More quality measures will be added and increased “at risk” payment amounts in subsequent years

3 “Medicare Program; Hospital Inpatient Value-Based Purchasing Program,” Final Rule, Centers for Medicare & Medicaid Services (CMS), HHS, April 29, 2011.
The Ohio State University story

National Hospital value based purchasing (VBP) program: How does it impact our quality?

Susan Moffatt-Bruce, MD, PhD
## Leadership council for clinical quality, safety, and service goals FY 2012

| Quality and safety | Reduce quality and safety scorecard events by 50%
|                    | cDiff, SSI, CLA-BSI
|                    | Improve in risk adjusted inpatient mortality domain for UHC quality and accountability study to index of 0.62
|                    | Achieve top decile in all Value Based Purchasing clinical indicators
| Productivity and efficiency | Achieve 25% reduction in all cause readmission rate
| Service and reputation | Achieve top decile status for patient satisfaction HCAHPS score (76%)  

## System quality and safety scorecard

<table>
<thead>
<tr>
<th>Type of event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained foreign bodies</td>
</tr>
<tr>
<td>Wrong procedure/site/person events</td>
</tr>
<tr>
<td>Medication events with harm (Severity E-I)</td>
</tr>
<tr>
<td>Severe injury falls (Resulting in change in patient outcome)</td>
</tr>
<tr>
<td>Hospital acquired decubitus ulcer</td>
</tr>
<tr>
<td>Central line blood stream infections</td>
</tr>
<tr>
<td>Ventilator associated pneumonia</td>
</tr>
<tr>
<td>Hospital acquired surgical site infections</td>
</tr>
<tr>
<td>Hospital acquired clostridium difficile infection</td>
</tr>
<tr>
<td><strong>Total potentially avoidable events</strong></td>
</tr>
</tbody>
</table>

14

15
Quality oversight structure

Hospital boards

Leadership council for quality safety and service

Medical staff administrative committees

Clinical quality and patient safety committee

Clinical resource and utilization management evaluation committee

Medical staff administrative committees

Medical staff administrative committees

Process improvement teams

Hospital value based purchasing program

What does this mean?

• Move from pay-for-reporting to pay-for-performance beginning July 1, 2011
• Hospitals will receive incentive payments based on performance for certain clinical processes (core measure) and patient experience (HCAHPS measures)
• The incentive payments will be funded by a 1% reduction in hospitals’ base DRG payments.
• The Medical Center will have nearly $2 million at risk as part of this program (The James is excluded).
• Better performance = Higher reimbursement
Timeline: CMS publicly reported reporting program

0.4% point reduction in the annual market basket update for not reporting
2.0% point reduction in the annual market basket update for not reporting
1% reduction — incentive

Total performance score weighted

HCAHPS 35%
Hospital inpatient quality measures

<table>
<thead>
<tr>
<th>Acute myocardial infarction</th>
<th>Cardiac surgery</th>
<th>Heart Failure (HF)</th>
<th>Mortality measures</th>
<th>Pneumonia</th>
<th>Nursing sensitive care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aspirin at arrival</td>
<td>• Participation in a systematic database for cardiac surgery</td>
<td>• Discharge instructions</td>
<td>• AMI 30-day mortality</td>
<td>• Pneumococcal vaccination</td>
<td></td>
</tr>
<tr>
<td>• Aspirin at discharge</td>
<td>• ACEI/ARB for LVSD</td>
<td>• Evaluation of LVS function</td>
<td>• HF 30-day mortality</td>
<td>• Blood culture before antibiotics</td>
<td></td>
</tr>
<tr>
<td>• ACEI/ARB for LVSD</td>
<td>• Smoking cessation advice/counseling</td>
<td>• ACEI/ARB for LVSD</td>
<td>• PN 30-day mortality</td>
<td>• Timing of initial antibiotic</td>
<td></td>
</tr>
<tr>
<td>• Smoking cessation advice/counseling</td>
<td>• Beta-blocker at discharge</td>
<td>• Smoking cessation advice/counseling</td>
<td>• Participation in a systematic database registry for Nursing sensitive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fibrinolytic within 30 min. of arrival</td>
<td>• Fibrinolytic within 30 min. of arrival</td>
<td>• Timing of PCI</td>
<td>• AMI 30-day mortality</td>
<td>• Blood culture before antibiotics</td>
<td></td>
</tr>
<tr>
<td>• Timing of PCI</td>
<td>• Participation in a systematic database registry for Nursing sensitive care</td>
<td>• HF 30-day mortality</td>
<td>• HF 30-day mortality</td>
<td>• Timing of initial antibiotic</td>
<td></td>
</tr>
</tbody>
</table>

Hospital inpatient quality measures

<table>
<thead>
<tr>
<th>Surgical care improvement project</th>
<th>Patients' experience of care</th>
<th>Readmission measures</th>
<th>Stroke care</th>
<th>AHRQ patient safety indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prophylactic antibiotic received within one hour to incision</td>
<td>• Hospital consumer assessment of healthcare providers and systems survey</td>
<td>• HF 30-day readmission</td>
<td>• Participation in a systematic database registry for Stroke care</td>
<td></td>
</tr>
<tr>
<td>• Prophylactic antibiotic selection</td>
<td>• Prophylactic antibiotics discontinued within 24 hours after surgery</td>
<td>• AMI 30-day readmission</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
</tr>
<tr>
<td>• Prophylactic antibiotics discontinued within 24 hours after surgery</td>
<td>• Cardiac surgery patients with post-op glucose control</td>
<td>• PN 30-day readmission</td>
<td>• Iatrogenic pneumothorax</td>
<td></td>
</tr>
<tr>
<td>• Cardiac surgery patients with</td>
<td>• Surgery patients with</td>
<td>• Participation in a systematic database registry for Stroke care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urinary catheter removed on POD1 or POD2</td>
<td>appropriate hair removal</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgery patients with perioperative temperature management</td>
<td>• VTE prophylaxis ordered</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• VTE prophylaxis ordered</td>
<td>• VTE prophylaxis administered with 24 hours pre/post surgery</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period</td>
<td>• Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abdominal aortic aneurysm mortality rate</td>
<td>• Hip fracture mortality rate</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hip fracture mortality rate</td>
<td>• Mortality for selected surgical procedures</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mortality for selected surgical procedures</td>
<td>• Complication/patient safety for selected indicators</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complication/patient safety for selected indicators</td>
<td>• Mortality for selected medical conditions</td>
<td>• Death among surgical patients with treatable serious complications</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Hospital outpatient quality measures

| OP-1 | Median time to fibrinolysis |
| OP-2 | Fibrinolytic therapy received within 30 minutes of ED arrival |
| OP-3 | Median time to transfer to another facility for acute coronary intervention |
| OP-4 | Aspirin at arrival |
| OP-5 | Median time to ECG |
| OP-6 | Prophylactic antibiotic initiated within one hour prior to surgical incision |
| OP-7 | Prophylactic antibiotic selection for surgical patients |
| OP-8 | MRI lumbar spine for low back pain |
| OP-9 | Mammography follow-up rates |
| OP-10 | Abdomen CT use of contrast material |
| OP-11 | Thorax CT use of contrast material |

### Clinical process measures

#### Acute Myocardial Infarction (AMI)
- Aspirin at arrival
- Aspirin at discharge
- ACE/ARB for LVSD
- Smoking cessation advice/counseling
- Beta-blocker at discharge
- Fibrinolytic within 30 min of arrival
- PCI within 90 minutes of arrival

#### Heart Failure (HF)
- Discharge instructions
- Evaluation of LVS function
- ACE/ARB for LVSD
- Smoking cessation advice/counseling

#### Pneumonia (PN)
- Pneumococcal vaccination
- Blood culture before antibiotics
- Smoking cessation advice/counseling
- Timing of initial antibiotic
- Appropriate antibiotic selection
- Influenza vaccination

#### Surgical Care Improvement Project (SCIP)
- Prophylactic antibiotic received within one hour prior to incision
- Prophylactic antibiotic selection
- Prophylactic antibiotics discontinued within 24 hours after surgery
- Cardiac surgery patients with post-op glucose control
- Surgery patients with appropriate hair removal
- Urinary catheter removed on POD1 or POD2
- Surgery patients with peri-operative temperature management
- VTE prophylaxis ordered
- VTE prophylaxis administered within 24 hours pre/post surgery
- Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period
### HCAHPS measures

<table>
<thead>
<tr>
<th>Patients’ experience of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with nurses</td>
</tr>
<tr>
<td>Communication with doctors</td>
</tr>
<tr>
<td>Cleanliness and quietness</td>
</tr>
<tr>
<td>Responsiveness of hospital staff</td>
</tr>
<tr>
<td>Communication about Meds</td>
</tr>
<tr>
<td>Pain management</td>
</tr>
<tr>
<td>Discharge information</td>
</tr>
<tr>
<td>Overall hospital rating</td>
</tr>
<tr>
<td>Recommend hospital</td>
</tr>
</tbody>
</table>

### Additional measures

<table>
<thead>
<tr>
<th>AHRQ patient safety indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-op respiratory failure</td>
</tr>
<tr>
<td>Iatrogenic pneumothorax</td>
</tr>
<tr>
<td>Postoperative wound dehiscence</td>
</tr>
<tr>
<td>Accidental puncture or laceration</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm mortality rate</td>
</tr>
<tr>
<td>Hip fracture mortality rate</td>
</tr>
<tr>
<td>Post-op PE/DVT</td>
</tr>
<tr>
<td>Complication/patient safety for selected indicators</td>
</tr>
<tr>
<td>Mortality for selected medical conditions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmission measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF 30-day readmission</td>
</tr>
<tr>
<td>AMI 30-day readmission</td>
</tr>
<tr>
<td>PN 30-day readmission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mortality measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI 30-day mortality</td>
</tr>
<tr>
<td>HF 30-day mortality</td>
</tr>
<tr>
<td>PN-30-day mortality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital acquired conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign object retained after surgery</td>
</tr>
<tr>
<td>Air embolism</td>
</tr>
<tr>
<td>Blood incompatibility</td>
</tr>
<tr>
<td>Pressure Ulcer stage III/IV</td>
</tr>
<tr>
<td>Falls and trauma</td>
</tr>
<tr>
<td>Vascular catheter associated infections</td>
</tr>
<tr>
<td>Catheter associated UTI</td>
</tr>
<tr>
<td>Manifestations of poor glycemic control</td>
</tr>
</tbody>
</table>
### VBP — Clinical process measures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI AMI PCI ≤ 90 min</td>
<td>77.8%</td>
<td>88.9%</td>
<td>100.0%</td>
<td>91.9%</td>
<td></td>
</tr>
<tr>
<td>HF HF discharge instructions</td>
<td>100%</td>
<td>99.2%</td>
<td>100.0%</td>
<td>90.8%</td>
<td></td>
</tr>
<tr>
<td>PN Blood CX prior to antibiotics</td>
<td>91.4%</td>
<td>97.8%</td>
<td>100.0%</td>
<td>96.4%</td>
<td></td>
</tr>
<tr>
<td>PN Initial antibiotic selection</td>
<td>94.7%</td>
<td>91.1%</td>
<td>99.6%</td>
<td>92.8%</td>
<td></td>
</tr>
<tr>
<td>SCIP Pre-op antibiotics ≤ 1 hour</td>
<td>98.6%</td>
<td>99.2%</td>
<td>99.9%</td>
<td>97.4%</td>
<td></td>
</tr>
<tr>
<td>SCIP Pre-op antibiotic selection</td>
<td>98.0%</td>
<td>99.5%</td>
<td>100.0%</td>
<td>97.7%</td>
<td></td>
</tr>
<tr>
<td>SCIP Discontinue antibiotics within 24 hours post-op</td>
<td>97.5%</td>
<td>99.2%</td>
<td>99.7%</td>
<td>95.1%</td>
<td></td>
</tr>
<tr>
<td>SCIP Cardiac surgery glucose control</td>
<td>97.0%</td>
<td>100%</td>
<td>99.6%</td>
<td>94.3%</td>
<td></td>
</tr>
<tr>
<td>SCIP Pac-op beta blocker</td>
<td>89.6%</td>
<td>99.0%</td>
<td>100.0%</td>
<td>94.0%</td>
<td></td>
</tr>
<tr>
<td>SCIP VTE prophylaxis ordered</td>
<td>96.6%</td>
<td>94.7%</td>
<td>100.0%</td>
<td>95.0%</td>
<td></td>
</tr>
<tr>
<td>SCIP VTE prophylaxis received</td>
<td>95.9%</td>
<td>94.1%</td>
<td>99.9%</td>
<td>93.1%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date not available yet</th>
<th>Below threshold</th>
<th>Between benchmark and threshold</th>
<th>At or above benchmark</th>
</tr>
</thead>
</table>

### VBP — HCAHPS measures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rating</td>
<td>71.3%</td>
<td>72.4%</td>
<td>100.0%</td>
<td>91.9%</td>
<td></td>
</tr>
<tr>
<td>Communication with nurses</td>
<td>76.8%</td>
<td>77.7%</td>
<td>100.0%</td>
<td>90.8%</td>
<td></td>
</tr>
<tr>
<td>Communication with doctors</td>
<td>77.2%</td>
<td>79.0%</td>
<td>100.0%</td>
<td>96.4%</td>
<td></td>
</tr>
<tr>
<td>Responsiveness</td>
<td>59.9%</td>
<td>61.3%</td>
<td>99.6%</td>
<td>92.8%</td>
<td></td>
</tr>
<tr>
<td>Pain management</td>
<td>70.6%</td>
<td>71.1%</td>
<td>99.9%</td>
<td>97.4%</td>
<td></td>
</tr>
<tr>
<td>Cleanliness and quietness</td>
<td>59.4%</td>
<td>59.5%</td>
<td>100.0%</td>
<td>97.7%</td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td>86.0%</td>
<td>87.8%</td>
<td>99.7%</td>
<td>95.1%</td>
<td></td>
</tr>
<tr>
<td>Communication about medication</td>
<td>60.4%</td>
<td>63.2%</td>
<td>99.6%</td>
<td>94.3%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date not available yet</th>
<th>Below threshold</th>
<th>Between benchmark and threshold</th>
<th>At or above benchmark</th>
</tr>
</thead>
</table>
### VBP — Clinical process measures

<table>
<thead>
<tr>
<th>Pay for performance measure</th>
<th>Baseline period Jul 2009–Mar 2010</th>
<th>Current results Apr 2010–Mar 2011*</th>
<th>Benchmark (Top 10%)</th>
<th>Threshold (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI AMI PCI ≤ 90 min</td>
<td>77.8%</td>
<td>100%</td>
<td>100.0%</td>
<td>91.9%</td>
</tr>
<tr>
<td>HF HF discharge instructions</td>
<td>100%</td>
<td>98.3%</td>
<td>100.0%</td>
<td>90.8%</td>
</tr>
<tr>
<td>PN Blood CX prior to antibiotics</td>
<td>91.4%</td>
<td>100%</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
<tr>
<td>PN Initial antibiotic selection</td>
<td>94.7%</td>
<td>100%</td>
<td>99.6%</td>
<td>92.8%</td>
</tr>
<tr>
<td>SCIP Pre-op antibiotics ≤ 1 hour</td>
<td>98.6%</td>
<td>100%</td>
<td>100.0%</td>
<td>97.4%</td>
</tr>
<tr>
<td>SCIP Pre-op antibiotic selection</td>
<td>98.0%</td>
<td>100%</td>
<td>100.0%</td>
<td>97.7%</td>
</tr>
<tr>
<td>SCIP Discontinue antibiotics within 24 hours post-op</td>
<td>97.5%</td>
<td>97.9%</td>
<td>99.7%</td>
<td>95.1%</td>
</tr>
<tr>
<td>SCIP Cardiac surgery glucose control</td>
<td>97.0%</td>
<td>100%</td>
<td>99.6%</td>
<td>94.3%</td>
</tr>
<tr>
<td>SCIP Peri-op beta blocker</td>
<td>89.6%</td>
<td>100%</td>
<td>100.0%</td>
<td>94.0%</td>
</tr>
<tr>
<td>SCIP VTE prophylaxis ordered</td>
<td>96.6%</td>
<td>97.5%</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>SCIP VTE prophylaxis received</td>
<td>95.9%</td>
<td>97.5%</td>
<td>99.8%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

* Preliminary data includes encounters between July 2011–September 2011.

### Future VBP and quality measures

- Patient safety
- Structure
- Immunizations
- Emergency department throughput
- Healthcare-associated infections
- Cost efficiency
What is being measured?

Acute Myocardial Infarction (AMI)
• Aspirin at discharge
• Fibrinolytic within 30 minutes of arrival
• PCI within 90 minutes of arrival
• Statin at discharge
• 30-day mortality rate (Medicare patients)
• 30-day readmission (Medicare patients)

What is being measured? (cont.)

Heart Failure (HF)
• Discharge instructions
• Evaluation of LVS function
• ACEI/ARB for LVSD
• 30-day mortality rate (Medicare patients)
• 30-day readmission (Medicare patients)
What is being measured? (cont.)

Pneumonia (PN)
• Blood culture before antibiotics
• Appropriate antibiotic selection
• 30-day mortality rate (Medicare patients)
• 30-day readmission (Medicare patients)

What is being measured? (cont.)

Surgical Care Improvement Project (SCIP)
• Prophylactic antibiotic received within one hour prior to incision
• Prophylactic antibiotic selection
• Prophylactic antibiotics discontinued w/in 24 hours after surgery
• Cardiac surgery patients with post-op glucose control
• Urinary catheter removed on POD1 or POD2
• Surgery patients with peri-operative temperature management
• VTE prophylaxis ordered
• VTE prophylaxis administered within 24 hours pre/post surgery
• Surgery patients on beta blocker prior to arrival who received beta blocker during the peri-operative period
Which HCAHPS measures are affected?

- Communication with nurses
- Communication with doctors
- Clean and quiet room
- Responsiveness of hospital staff
- New medicines explained
- Pain management
- Discharge information
- Overall hospital rating
- Recommend hospital

Patient safety

Patient Safety Indicators (PSI)
- Iatrogenic pneumothorax
- Post-operative respiratory failure
- Post-operative PE or DVT
- Post-operative wound dehiscence
- Accidental puncture or laceration
- Abdominal aortic aneurysm (AAA) mortality rate
- Hip fracture mortality rate
  - Patient safety for selected indicators (composite)
  - Mortality for selected medical conditions (composite)
Patient safety (cont.)

Hospital Acquired Conditions (HACs)
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Falls and trauma
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection
- Manifestations of poor glycemic control

Structural measures

Participation in clinical database registries
- Cardiac surgery registry
- Stroke registry
- Nursing sensitive care registry
- General surgery registry
### Other new publicly reported measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global immunization measures</td>
<td>• Global flu immunization</td>
</tr>
<tr>
<td></td>
<td>• Global pneumonia immunization</td>
</tr>
<tr>
<td>Emergency department throughput</td>
<td>• Median time from ED arrival to departure from the ED for patients admitted to the hospital</td>
</tr>
<tr>
<td></td>
<td>• Median time from admit decision to time of departure from the ED for ED patients admitted to the inpatient status</td>
</tr>
<tr>
<td>Healthcare-associated infections</td>
<td>• Central line associated blood stream infections</td>
</tr>
<tr>
<td></td>
<td>• Surgical site infections</td>
</tr>
<tr>
<td></td>
<td>• Catheter-associated urinary tract infections</td>
</tr>
<tr>
<td>Cost efficiency</td>
<td>• Medicare spending per beneficiary</td>
</tr>
</tbody>
</table>

### Why are core measures important for our organization?

**Patient care**
- They represent evidence-based patient care guidelines
- Studies show patients recover more quickly and with fewer complications
- They assess our ability to provide the right care to the right patient at the right time

**National reputation**
- Since data is publicly reported, shared and used in national rankings, it influences public perception of the quality of care we provide

**Financial**
- Now our performance is tied to reimbursement and how we fund our mission
- The public can use performance data to make an informed decision about where to go for hospital care
Improving clinical process measures

- Feedback to Physicians on each “failed case”
- STEMI alert program
- IHIS solutions
  - “Healthy Living” section added to each patient’s After Visit Summary
  - VTE prophylaxis orders in all admission and post-op order sets
  - Electronic decision support to prompt physicians to use standard order sets based on diagnoses included on the problem list
Order set recommendations
Suggested admission order sets based upon problem list

Order Sets and Pathways

Search [Add] [Advanced]

Suggested admission order sets:
- MRT: Admission Read/Pressure Measurement
- MRT: Admission Head/Neck Management
- MRT: Admission Heart/Thorax Management
- MRT: Admission Lung/Diabetes Management

Suggested discharge order set based upon problem list

Discharge
1. Reconcile Orders for Discharge, 2. New Orders, 3. Review and Sign

Place New Orders

Search [Add] [Advanced]

Order Sets

Suggested discharge Core Measure CHF

Admission order set

Admission order set

Order Sets

Suggested admission order sets:
- MRT: Admission Head/Neck Management
- MRT: Admission Heart/Thorax Management
- MRT: Admission Lung/Diabetes Management

Additional Admission Orders
Best practice advisory
If CHF on problem list and admission set not selected

Discharge order set
Predicted impact of VBP

- OSUMC received three estimates of total impact of VBP (UHC, AAMC, Press Ganey)
- Results range from losing $1.5 million to profiting $900,000
- Bottom line: Until CMS releases the final performance of all hospitals, total impact is impossible to predict

Core measures video
How do we monitor compliance?

Meaningful use reporting homepage
Quality assurance dashboards

Clinical Graph Package

- Inpatient
  - Admission Medication Reconciliation Compliance
  - Encoding Near Miss
  - Central Line Associated Bloodstream Infections
  - CPOE Percentage by Department
  - Discharge Medication Reconciliation Compliance
  - Overdue Meds
  - PA-2
  - Transfer Medication Reconciliation Compliance
  - VTE-6

Meaningful use outputs

STK-2: Discharged on Antithrombotic Therapy

<table>
<thead>
<tr>
<th>Department Score</th>
<th>Facility Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>89%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>Discharged on Antithrombotic Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>99%</td>
</tr>
<tr>
<td>No</td>
<td>99%</td>
</tr>
<tr>
<td>Total</td>
<td>99%</td>
</tr>
</tbody>
</table>

Excluded from measure: 0
Medication reconciliation: Down to provider level

Admission Medication Reconciliation Compliance
For patients discharged between 06/30/2009 and 07/30/2009
Grouped by Hospital, then Admission Department, then Encounter

<table>
<thead>
<tr>
<th>Admission Department</th>
<th>PTA Miss</th>
<th>PTA Miss</th>
<th>PTA Miss</th>
<th>PTA Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMH EMERGENCY [102]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EMH MED SURG [12]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EMH MODEL HOSPITAL [10]</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Grand Total: 0 0 0 0

Physician report

Dashboard Launcher

Dashboard:
IP MD Reporting Homepage

Types:

Description:
MyEpic dashboard for inpatient physician users. This is to be used as a reporting homepage.
Physician quality and service data portal

Auditing the quality data
Why? (Objectives)

- Quality data is publically presented — Transparency
  - Comparative reporting
  - Patient choice for quality (and cost)
  - Risk to reputation
  - Marketing
- Tied to payment — False claims
- Tied to performance incentives — Accurate reporting
- Reliance on electronic record or abstracted data

What? (Scope)

- Inpatient data sets
  - Department specific submissions
- Adverse event reporting
- Physician quality reporting (PQRI)
- Organizational incentives — Focus on quality outcomes
- Other data reporting
How? (Methods)

- Abstracted data
- Extracted reports/data from clinical and financial systems
- Spreadsheets/end user computing
- Workflows — How does the data get reported?

Who? (Auditees/clients)

- Board/executive management
- Management
- Quality, finance, careline management
- Public data sites
When? (Audit plan)

• Prior to:
  – Results leaving organization
  – Public posting
  – Surprises to constituents

Auditing quality data

• Inpatient data sets
• Adverse event reporting
• PQRI and incentive plans
• Other data reporting
  – Meaningful use
  – Stories
  – Risks
  – Take-aways
    • Sources of data for Quality information
    • Audit templates
    • Lessons learned
Inpatient data sets

• Department specific submissions

Department specific submissions

• Used for benchmarking
• Contracted for and submitted by departments
• Concerns:
  – Data integrity
  – Management review and approval
  – Consistent application of definitions
Examples of dept. specific data

Description of the data/name
American College of Cardiology
CathPCI registry (diagnostic and interventional cardiac data)
COAP — Washington state registry — Clinical Outcomes Assessment Program
CathPCI data
ACC — ACTION registry—STEMI and NSTEMI data
ICD registry — Electrophysiology
STS/COAP; (adult surgery)
Society of Thoracic Surgeons (STS) congenital heart surgery database
TJC stroke measures (Disease specific certification for primary stroke center)
CMS reporting of elective Carotid Artery Stent cases
Diabetic outcomes for Premier Quality Scorecard
Qualis health EMR project, Breast Ca screening, Colorectal Ca screening, Pneumococcal immunization, Influenza immunization
CMS core measures — Clinical data (TG/AH, GSH)
LEAPFROG survey
TG/AH — CALNOC
CHARS
PQRI

Major risk areas

• Clinical documentation insufficient
• Timing and accuracy of coding
• Abstracting errors
• System extract errors for discrete data elements
• Determining population and sample size accurately
• Meeting submission schedule
• Follow-up on quality variances identified
• Reconciliation, review, and approval for submission
Conducting an internal assessment

• Who is involved in reporting?
• What systems are involved?
• What tools are used?
  – Abstraction tools
  – Checklists
  – Calendars with timeframes to report
• Are there policies and procedures?
• What are the results of the CMS quarterly validation audits?

Internal controls

• Written policies
• Tools to capture data points for abstracted data
• Calendars to meet timeframes
• Inter-rater reliability testing
• Meetings to discuss results of CMS audits and abstraction questions
• IT controls
• Quality meetings to review results as a team
• Reports to the board
• Root Cause Analysis (RCA)
Internal controls (cont.)

Written policies and procedures may include:
• Organization chart
• Flowcharts of the reporting process
• Timetables/calendar around reporting
• Listing of resources and documents available to guide personnel
• Procedures
• Checklists

Scoping and planning an audit

Planning — Determining relevant controls
• Internal controls — Internal Controls are guidelines and actions that attempt to address risk and help ensure that management’s objectives are achieved.
• They are the process designed to help ensure:
  – reliable financial reporting
  – effective and efficient operations
  – compliance with applicable laws and regulations
• Safeguarding assets against theft and unauthorized use, acquisition, or disposal is also part of an effective internal control structure.
Performing the internal audit

Types of testing techniques:

**Corroborative inquiry:** Inquiries on how the activity is performed and obtain evidence that corroborates such responses.

**Inspection:** If performance of an activity is documented, we may obtain evidence of its performance by inspecting such documentation.

**Re-performance:** Re-performance involves reconstructing the activity/process to determine whether the activity functioned correctly and whether errors were prevented or detected.

**Observation:** Observation involves watching the activity being performed in practice.

Performing the internal audit (cont.)

**Additional testing techniques**

- Confirmation
- Physical examination
- Data Analysis
- Analytical Procedures
- Vouching (recorded entry to support)
- Trace (support to recorded entry)
IT testing

Confirm that the transfer of patient data into such a tool is accurate and complete.
• Automatic alerts that indicate data transfers are not complete
• Comparisons of record counts in the systems the data is transferred from to the number of records within the system that the data has been transferred to
• Controls that limit access to data
• Audit trails to monitor who has accessed data and/or manipulated data
• Password parameters that reduce the risk a password may be guessed or obtained by an unauthorized individual and used to gain access to the system
• Procedures to test and obtain approval when system changes are implemented, which could potentially result in data transfer errors.

Finalizing the compliance audit

• Identify gaps
• Develop corrective action plan
• Identify responsible party
• Define timeline to complete
Leading practices

• Concurrent review to identify gaps real time
• Electronic capture of data points
• Involvement of:
  – Board
  – Executive team
  – Quality committee
  – Physicians and clinical leaders
• Share leading practices identified from process improvement efforts across the health system
• Provide continual feedback and training to physicians and nursing personnel
• Collect and monitor quality performance relative to benchmarks
• Identify and prioritize the most important quality improvement opportunities
  – Perform root cause analysis to identify causes and develop solutions
• Integrate quality of care into your compliance program

Adverse event reporting
Adverse event background

OIG estimate of adverse events
• 13.5% of hospitalized Medicare beneficiaries discharged during October 2008 experienced adverse events during their hospital stays,
• An additional 13.5% experienced events that resulted in temporary harm.
• These events are estimated to have cost Medicare $324 million in October 2008 alone.
• Physician reviewers determined that 44% of these events were clearly or likely preventable


Adverse event background (cont.)

What is an adverse event?
• Harm to a patient as a result of medical care
• Not always errors
• Not always preventable
Adverse events

Adverse events are underreported

The OIG published a report in January 2012 titled: “Hospital Incident Reporting Systems Do Not Capture Most Patient Harm”.

The report indicates that all of the 189 hospitals surveyed use incident reporting systems, but the administrators acknowledged that the systems provided incomplete information about how often incidents occur. In the OIG survey, hospital staff did not report 86 percent of events to incident reporting systems, partly because of misperceptions on what constitutes patient harm.

Potential reasons for underreporting

• Lack of understanding of what constitutes a reportable event
• Event was a “near miss” where there was no harm to the patient
• Staff are accustomed to common occurrences
• Lack of time
• The belief that reporting an event is “tattling” on a coworker
• Fear of retribution
• The incident reporting system is not user friendly
Adverse events

Roles — and where does the compliance officer fit in?

- Patient safety officer — Usually responsible for reporting, tracking, training and root cause analysis
- Internal audit or compliance may conduct audits of the process to evaluate internal controls, completeness, timeliness, and accuracy of reporting.
  - Reporting implications, internal and external
  - 2012 OIG report — 86% of events were not reported in a survey of 189 hospitals
- Support coordination of reporting and proper billing as an interface between Patient Safety, HIM, and Billing.
  - Payment implications

OSUMC sentinel event process

1. Event is reported or discovered
2. Quality and risk management perform an initial investigation
3. If a potential Sentinel Event (SE), notification is sent to Senior Administration
4. Event is taken to Sentinel Event Determination Group (SEDG) for determination of a SE
5. Sentinel event workgroup established
6. Presentation of an action plan for approval to the sentinel event team
Sentinel Event Determination Group (SEDG)

- Meets weekly
- Three (3) voting members — Chief Quality and Patient Safety Officer, Risk Management, Quality Director
- Makes determination:
  - Near miss
    - A workgroup assigned may be assigned (or)
    - Referred to appropriate department or committee
  - Not a sentinel event or a near miss
    - May refer to appropriate department or committee
  - Sentinel event
    - Workgroup assigned

Sentinel event workgroup

Members:
- Executive sponsor
- Physician leader
- Facilitator members (front line faculty and staff involved in event)

Tasks:
- Meet within five business days
- Develop a root cause analysis and action plan within 45 calendar days
- Present findings to the sentinel event team
Audit program objectives:
1. Adverse events are properly identified and timely reported.
2. Root-cause analysis are performed and action plans are created in a timely manner.
3. Appropriate process changes and control measures are implemented and functioning as intended to reduce risk of future events.

Auditing adverse event reporting (cont.)

1. Timely identification and reporting
   a. Organizational policies and procedures
   b. Staff awareness and training
   c. “Comfort” in reporting — fear of consequences
   d. Logging and evaluating of events
   e. Comparison of events log against patient claims
   f. Compliance with external reporting requirements
Auditing adverse event reporting (cont.)

2. Root Cause Analysis (RCA) and action plans
   a. Standard template and procedures
   b. Competency and training of those responsible for RCA
   c. Authority given and access provided to the RCA team
   d. Communication of the RCA results and action plan across the organization
   e. Monitoring implementation of the action plan

Auditing adverse event reporting (cont.)

3. Process change implementation
   a. Authority to implement process changes and controls
   b. Timely implementation of process changes
   c. Monitoring of compliance with new processes
   d. Reporting on compliance
   e. Post implementation review — did the action plan reduce the risk of reoccurrence?
Adverse events

Conducting an audit of adverse event reporting

- Interviews — individual or focus groups
- Gain an understanding of systems used to report
  - Electronic system
  - Paper
  - Hotline
  - Other
- Obtain reports of incidents by type of personnel, shift and department to identify potential underreporting
- Compare claims data to patient safety reports
- Evaluate training programs
- Confirm root cause analyses are conducted when trends are noted
- Confirm that actions are taken based on RCA results
- Confirm reporting to the Board
- Confirm that there is an active Patient Safety Committee
- Confirm for compliance with state reporting requirements

Adverse events (cont.)

Internal controls

- Policies and procedures
- Training and retraining
- Monitoring of who is reporting, shifts, and locations to identify underreporting
- Comparison of HIM coding/claims data to patient safety reports
Billing requirements

- Present on Admission (POA) — POA indicator is assigned to principal and secondary diagnoses on a UB-04 claim form for inpatient claims.
- The POA is a flag to Medicare to reduce payment for certain conditions that were not present on admission.
- Never event billing — see National Coverage Determination (NCD) Pub 100-3 sections 140.6, 140.7 and 140.8 effective January 15, 2009:
  - For inpatients the following diagnoses should be on the claim:
    - E876.5 — Performance of wrong operation (procedure) on correct patient (existing code)
    - E876.6 — Performance of operation (procedure) on patient not scheduled for surgery
    - E876.7 — Performance of correct operation (procedure) on wrong side/body part
  - For Outpatients the following modifiers should be applied to applicable procedure codes:
    - PA: Surgery Wrong Body Part
    - PB: Surgery Wrong Patient
    - PC: Wrong Surgery on Patient

Other quality measures to audit
Quality and performance/incentive comp plans

- Quality objectives must be actionable, measurable, and auditable
- Each measure should include only one metric
- The methodology must be clear and easy to understand or recipients might not know what to do to earn incentive
- Periodic reporting on progress throughout year

Data collection and management

- Manual?
- Spreadsheet? (audit for spreadsheet errors, design errors and hidden worksheets, rows, and columns)
- Electronic downloads? (accuracy of data download, subsequent manipulation)
- Reporting — timely, audited
Summary comments

Quality initiatives — What should hospitals be doing now?

• Collect and analyze indicators and scores
• Execute solutions to improve performance
• Perform assessment around quality and coding
• Establish mechanisms for on-going advancement
Discussion and questions

Contact Information

Susan Moffatt-Bruce, MD, PhD
Chief Quality and Patient Safety Officer, Associate Professor of Surgery
Ohio State Medical Center
Susan.Moffatt-Bruce@osumc.edu

Catherine Wakefield, CPA, CIA, CHC, FHFMA
Vice President, Corporate Compliance and Internal Audit
MultiCare Health System
Catherine.Wakefield@multicare.org

Christine Anusbigian, MBA, CHC
Senior Manager, Health Sciences, Governance, Risk and Regulatory Services
Deloitte & Touche LLP
canusbigian@deloitte.com
The Deloitte portion of this presentation contains general information only and Deloitte is not, by means of this presentation, rendering accounting, business, financial, investment, legal, tax, or other professional advice or services. This presentation is not a substitute for such professional advice or services, nor should it be used as a basis for any decision or action that may affect your business. Before making any decision or taking any action that may affect your business, you should consult a qualified professional advisor.

Deloitte, its affiliates, and related entities shall not be responsible for any loss sustained by any person who relies on this presentation.