Quality Indicators that Hospitals are Working on Through QIO Programs

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Consequences of Failure

• Billing/UR
  – Temporary harm
  – Fix by paying back
  – Temporary bad publicly
    • Little public interest

• Quality
  – May cause permanent harm or death
  – May not be fixable
  – Undermines public trust in the institution
Major Hurdles

- Documentation
- Lack of independence/objectivity
  - Peer review
- Physicians
- Enforcement
Key Elements of a Compliance Program

- Oversight
- Standards and Procedures
- Education and Training
- Monitoring and Auditing
- Reporting
- Enforcement and Discipline
- Response and Prevention
UR/Quality Program Elements

Oversight

Quality/UR

Standards and Procedures

Education and Training

Monitoring and Auditing
Missing Elements

- Reporting
- Enforcement and Discipline
- Response and Prevention
Addressing Missing Elements

- Add UR/Quality as risk areas to existing compliance program
- Develop mini compliance program to address UR/QI
- Other
• Oversight:
  – Governing Body
  – Governing Body Committees
  – Medical Staff
  – Management
  – Compliance Steering Committee
  – Quality Committee
• Standards and Procedures:
  – Set standards of conduct
  – Outline processes and systems designed to prevent errors or address risk
  – Define documentation requirements
  – Establish protocols/standards of care
  – Identify internal controls
  – Assign responsibility and accountability
  – Ensure consistency throughout the
• Education and Training:
  – Risk areas
  – Performance improvement tools
  – Documentation
  – Reporting
  – Safety
  – Local medical review policies
  – Regulatory/standard changes
• Monitoring and Auditing:
  – Concurrent review
  – Adverse outcomes (patient and/or financial)
  – Risk areas
  – Trends and data analysis
  – Independence in review
  – Identification of areas for improvement
  – Ensure compliance with standards and protocols
• Reporting:
  – Defines reportable events
  – Communication
  – Early identification of errors/issues
  – Responsiveness
  – Builds confidence in organizations commitment
  – Non-retaliation/retribution
• Enforcement and Discipline:
  – Demonstrates commitment
  – Documents:
    • Additional education and training needs,
    • Competencies (or lack)
  – Consistent application
  – Evidence of effectiveness
Response and Prevention:
  – Self management
  – Getting it right the first time
  – Forward thinking
  – Risk avoidance
  – Heighten awareness
Collaborators

- Compliance
- Quality Improvement
- Quality Assurance
- Utilization Review
- Performance Improvement
- Infection Control
- Case Management
- Peer Review
- Patient Safety
- JCAHO
- Coding
- Education
- Administration
Why Collaborate?

- Need of one clear voice
- Accountability
- Responsiveness
- Effective/efficient use of resources
Benefits of Collaboration

- Access senior management
- Improve responsiveness
- Address physician issues
- Continuous improvement
- Education and training
- Reduce medical errors
- Infection control and prevention
- Teamwork
- Resource allocation
Potential Collaborative Projects

- Medical necessity
- Coding (up or down)
- QIO initiatives
- Discharge destination
- Admission criteria
- Observation
- Cardiac rehab
- 3-day window
- Treatment protocols
  - Coronary Event Orders
  - Cardiology Discharge Orders
- Re-admission review
- Error reduction
- Surgical infection
Collaboration Example #1
Step One

- Establish Work Group
- Determine the following:
  - Scope
  - Work group type
  - Name
- Define work group purpose
- Identify key departments
- Recommend team members and assign (UR, Case Management, Medical Records, Compliance)
- How will this issue impact:
  - Cost
  - Quality
  - Service
- Frequency of meetings
- Target date for completion
- Identify method for measuring results
- Reporting process
- Required resources
Step Two

- **First Group Meeting:**
  - Collect all related policies and procedures both house-wide and department specific
  - Gather all pertinent regulations
  - Set scope of audit
  - Define criteria of audit
  - Develop audit worksheet
- **Work assignments:**
  - Probe sample size
  - Selection of sample

- **Second Group Meeting**
  - Review audit results
  - Determine if additional audit work is required
  - Identify process changes
  - Identify employee/physician issues

- **Work assignments:**
  - Policy and procedure changes
  - Education/discipline
  - Report development
Medicare Regulations

- 230.6(A) CMS Hospital Manual
- 230.6(E) CMS Hospital Manual
- LMRP
Observation Audit Findings/Categories

1. The documentation in the record supported observation services.
2. The order for the observation service was not available within the medical record.
3. There was not an order for observation services. In addition, the patient underwent a surgical procedure during the same hospital stay.
4. Observation services were not medically necessary because the patient underwent a surgical procedure without complications or inordinate reaction, or observation ordered prior to surgical procedure.
Observation Audit Findings/Categories

5. Physician ordering the services did not specify that the admission was observation

6. The documentation in the record did not demonstrate medical necessity for observation services or documentation did not reveal the reasoning for observation services, i.e. could have been for patient or family convenience

7. Patient was reverted from an inpatient admission to an outpatient observation service
Summary Report Format

- Patient Name
- Acct. # or Medical Record #
- Total Charges
- OBS order in record? (yes/no)
- Was OBS justified? (yes/no)
- Physician
- Category (1-7)
Potential Outcomes

- All observations billings were accurate
- High error rate, requiring further audit work
- Repayment to Medicare
- Minor errors requiring only remedial education (documentation, coding, etc.)
Collaboration Example #2
Step One

- Formed team to work on improving surgical site infections
- Established composition (nursing, anesthesia, PACU, pharmacy, compliance, etc.)
- Defined aim statement
- Defined pilot population
- Defined impact (reduced infections and costs, reduced readmissions, greater patient satisfaction, etc.)
- Assigned member roles and responsibilities
- Defined measures and reporting (CMS abstraction and reporting tool – CART; look at 50 cases/quarter/surgical procedure group and provide reports to each surgical group and compliance)
Pilot Population

- CABG
- Colon Surgery
- Hip/Knee Arthroplasty
Medicare Regulations

- Medicare conditions of participation (quality of care)
- Evidence-based clinical protocols
- CMS/JCAHO measure requirements
Next Steps

- Short cycles of testing process changes:
  - Place of administration (unit, pre-op holding, OR suite, etc.)
  - Who administers antibiotic (nurse or anesthesiologist)
  - Revised anesthesia form
  - When discontinued

- Refined change
  - Revised care pathway and physician order set for hip and knee arthroplasty

- Later implemented formal policies
Barriers

- Quarterly data collection
- Measures
  - “The data must be wrong” theory
  - “Perceived Risk” of stopping antibiotics
  - MRSA Fears (Vancomycin/Clindamycin)
  - Resistance to change
Outcomes

• Anesthesiologists accepted responsibility for administering prophylactic dose
  – 98% of pilot population had a timed prophylactic antibiotic documented by the anesthesiologist

• Variances from 1 hour prior to incision measure decreased
  – Exceeded the 90% goal
  – Cases that did not meet the goal had minimal variation
Outcomes/Successes

• Choice of antibiotic improved
  – Exceeded the goal for choice of antibiotic for Hip/Knee Arthroplasty

• Discontinuance of prophylactic antibiotic
  – Exceeded the goal for discontinuing the prophylactic antibiotic