

Connecting with the Positive

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CMS

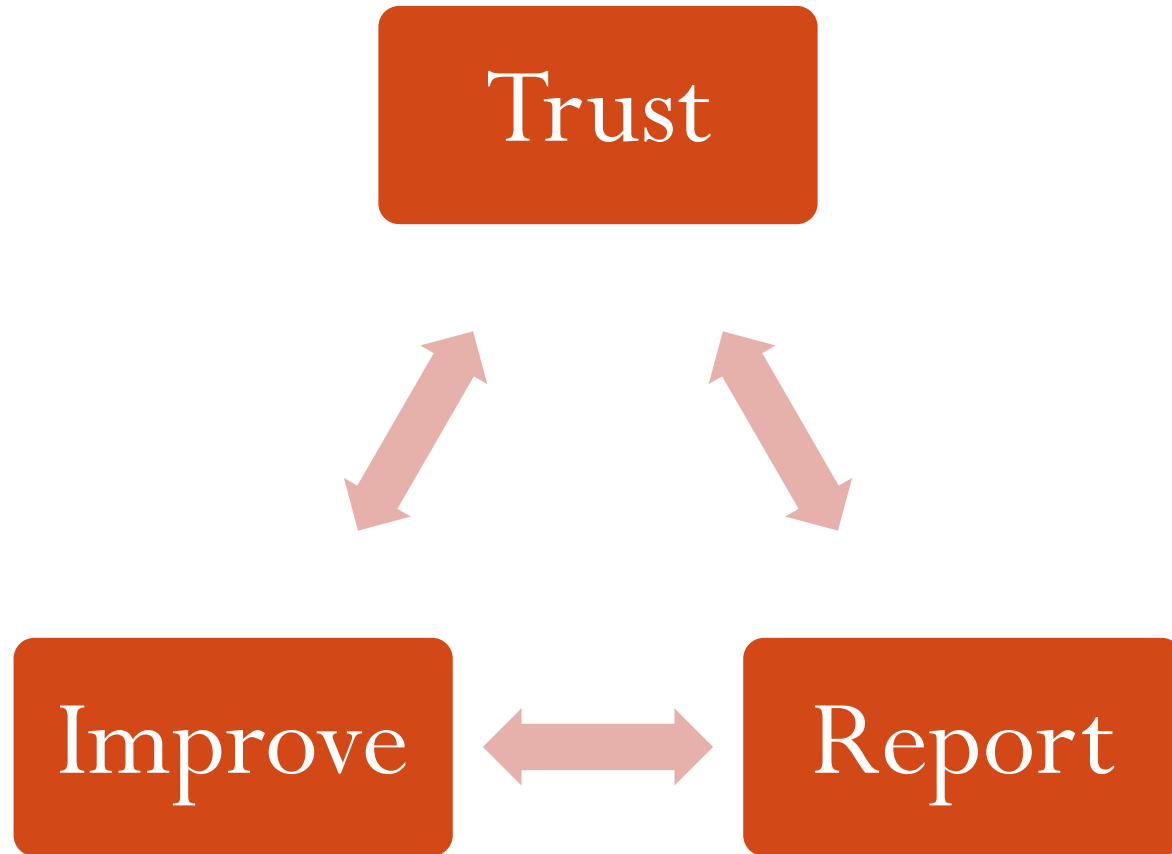
Division of Quality Improvement/Division of Survey &
Certification

Institute of Medicine- 6 Quality Aims

- SAFETY
- PATIENT-CENTEREDNESS
- EFFECTIVENESS
- EFFICIENCY
- TIMELINESS
- EQUITY
- All as an overarching ceiling within the healthcare arena



The 3 Imperatives of a Safety Culture



Statistics

- 1999 IOM report stated 98,000 Americans die every year from preventable medical errors
- *Heath Affairs*- study published in April 2011 noted 1 in 3 patients admitted to a hospital suffer a medical error or adverse event
- Any point in time- about 1 in every 20 patients has an infection r/t their care
- Estimated cost \$4.3 billion
- Nearly 1 in 5 Medicare patients d/c from hospital is re-admitted within 30 days; approximately 2.6 million seniors at a cost over \$26 billion yearly

New National Partnership

- Help to save 60,000 lives
- Stopping millions of preventable injuries & complications over next 3 years
- Potential to save up to \$35 billion in health care costs
- Including \$10 billion for Medicare
- Over next 10 years could reduce Medicare cost by about \$50 billion
- HHS pledged to invest \$1 billion under Affordable Care Act

Innovations Center

- New within CMS - Authorized through Section 3026 of Affordable Care Act
- Up to \$500 million more through CMS Innovation Center
- \$500 million available through Community Based Transitions Program
- Money to be used to test different models
- Started by asking hospitals to focus on 9 types of medical errors- preventable harm

Innovation Center

- CMS also announced opportunity to apply for Medicare Community Based Care Transitions Program
- Funding provided to organizations and eligible hospitals
- Services that include competent post-discharge education, medication review and patient-centered self-management within 24 hours of discharge
- Centers on reducing complications during transitions from one care setting to another
- Prevention of hospital readmissions

About Care Transitions

- Patients are being readmitted within weeks after discharge due to an adverse event from medical management and not the underlying disease process
- Most common adverse event- medication related
- Causal factors are actual medication errors, **poor communication and poor coordination between providers** along the continuum

Partnership for Patients

Better Care, Lower Costs

- Committed to addressing all forms of **harm**
- Can it be done
- Office of Inspector General report 12/10* stated 1 in 4 Medicare beneficiaries is harmed during hospital stay
- 5000 patients/month suffer a never event
- 180,00 die from adverse events each year
- How can it be done
- Need to tackle safety and quality in every care setting
- Embed a new philosophy into the system

Harm- All Forms of Harm (Preventable)

- Harm occurring where
- Everywhere
- How do we prevent it from happening again
- **Pressure Ulcers**
- Falls & Immobility
- Surgical Complications/Infections
- HAI
- Adverse Drug Events
- Catheter Associated UTI (CAUTI)
- Central Line Associated Bloodstream Infections (CLABSI)
- OB Adverse Events
- Venous Thromboembolism (VTE)
- Ventilator Associated Pneumonia (VAP)

Pressure Ulcers

- **Pressure ulcers**
- Among Medicare patients between 8% and 28% of all documented hospital acquired conditions are pressure ulcers
- Partnership for Patients (PfP) estimates 50% of the most dangerous pressure ulcers in an acute care setting are preventable
- Reduce by 50% over next 3 years prevents nearly 110,000 pressure ulcers

Partnership for Patients- PfP

- Intended to improve the quality, **safety** and affordability of health care
- 2 goals of the partnership
- Keep patients from getting sicker
- Help patients heal without complications



PfP- By End of 2013

Keep Those From Getting Sicker

- Decrease **preventable** healthcare acquired conditions by 40 %

Help Patients Heal without complications

- Preventable complications during a transition of care would be reduced
- All hospital readmissions would be reduced by 20%

- We plan to.....
- We hope to find.....
- Mostly these are promises- not reality
- Prior initiatives focused on lives and access (not money)
- Or money (more important than lives and access)
- PfP gives equal focus to lives AND money
- It is a win for patients
- It is a win for providers
- It is a win for payers

Lessons Learned

- Sustaining improvement is difficult
- Improvement will end when the project is over without people sustaining the change and measuring the results
- Must have monitoring and feedback- feedback is both ways
- Communication is a pillar of Quality Improvement efforts

Quality Improvement

- Finding better ways to do something
- Finding faster ways to do something
- Finding easier ways to do something
- Your systems are creating your outcomes
- Variation comes in different types
 - variability in process
 - variability in people
 - variability in practice

Sustaining Quality Care

- Need to routinely use data collected- don't resist the data
- Provide feedback in a multiple of forums
- Share outcomes & processes to remind folks of guidelines
- Use patient database close to bedside
- Need to retain interdepartmental & interdisciplinary approach and not silo style
- Change needs to be not only accepted but expected

The Art Of Communication

- Need to be effective at it
- Need to be accountable for it
- Need to be clear about it
- Need a system for it
- Need to use it
- Need to adapt it



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- How do we communicate and use data to drive improved performance
- What could be clearer than a yardstick to measure pressure ulcers
- Prevalence and incidence- across the continuum of care
- Sharing for continuity of services & care

