Critical Access Hospital Patient Safety Summit

The Flex Program Medicare Beneficiary Quality Improvement Project

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Florida's health
THE FLORIDA DEPARTMENT OF HEALTH

FMQAI
Information for Healthcare Improvement

UNIVERSITY OF FLORIDA

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Historical Perspective

- From 1980 to 1991 a total of 363 rural hospitals were closed, an average of 30 per year.
- The Inpatient Prospective Payment System (PPS) led to the decline in the numbers of rural hospitals.

Critical Access Hospitals Program

- Critical Access Hospitals (CAHs) were based on the experience of the Medical Assistance Facility (MAF) Demonstration Project in Montana and the EACH/RPCH Demonstration Project.

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The Rural Hospital Flexibility Program

- The Balanced Budget Act of 1997 (BBA) established the Medicare Rural Hospital Flexibility Program (Flex Program).

The Rural Hospital Flexibility Program

- The Flex Program consists of two separate but complementary components:
  - A State grant program administered by ORHP to support the development of community-based, rural, organized systems of care in the participating States.
  - Cost-based reimbursement for certified Critical Access Hospitals (CAH)

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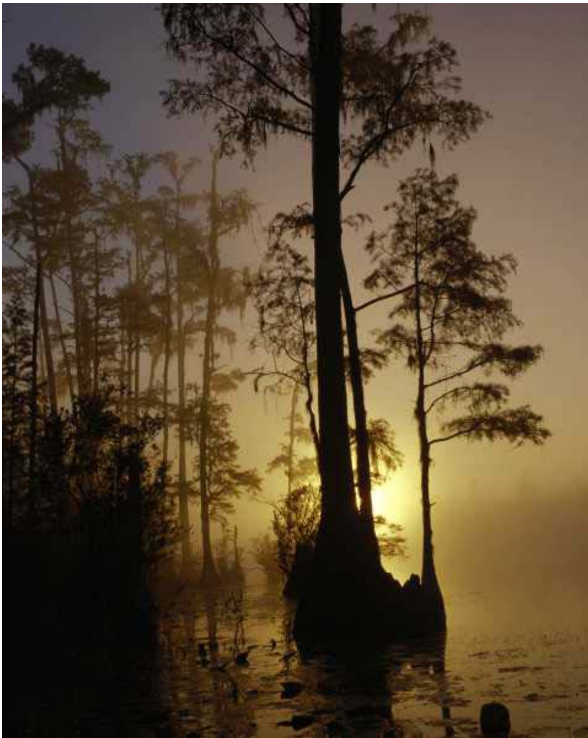
Original Flex Program Goals

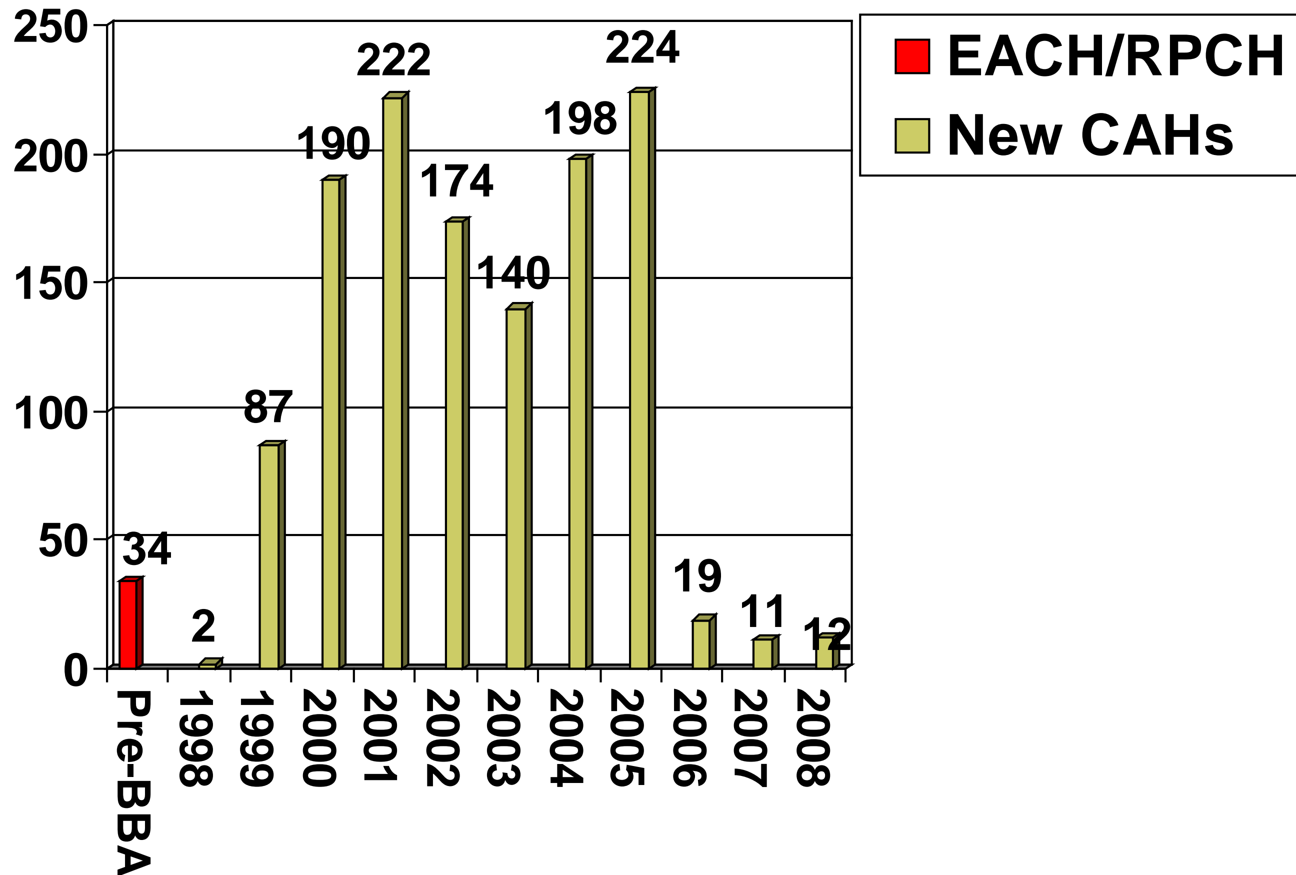
- Development of State Rural Health Plan (SRHP)
- Designation of CAHs in the State
- Development and Implementation of Rural Health Networks
- Improvement and Integration of EMS Services
- Improving Quality of Care

Sunset of Necessary Provider Waiver



A State may designate a facility as a critical access hospital if the facility… is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area.

CAHs Certified by Year



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The Future of Flex

- Virtual end of conversions.
- Where are we now?
- What comes next?

Where are CAHs?

- There are 1,320 CAHs currently
- The number of CAHs per State ranges from 3 to 83
- Five States (CT, DE, MD, NJ and RI) do not have certified CAHs

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How Big a Part?

- Total Community Hospitals = 5,010
- Number of Rural Community Hospitals = 1,998
- Total CAHs (July 2010) = 1,320
  - 26% of all Community Hospitals
  - 66% of all Rural Hospitals
  - 29% of rural Medicare hospital payments*

*Source: **Fast Facts on US Hospitals, American Hospital Assoc.***
Updated November 11, 2009

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MEDPAC Report

- Total Medicare Expenditures in 2007=$432.2 billion
- "Medicare's cost-based payments to CAHs were roughly $7 billion in 2007, representing 5 percent of all Medicare inpatient and outpatient payments to hospitals."
- *"Roughly <u>$1.5 billion more</u> than PPS payments would have been."*

Source: Critical Access Hospitals Payment System, Medpac, Revised October 2009

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Number of Florida CAHs Participating in Hospital Compare

Total CAHs	11	100%
AMI	0	0%
PNE	6	54%
HF	5	45%
SCIP	0	0%
Outpatient	1	9%

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Questions….

Are these rural-appropriate measures?

Do they represent the quality we provide in our CAHs?

Will they "drive" quality improvement in our hospitals?

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Ramp Up

(Next 5 months)

Getting the word out…

Getting "buy-in"….

Starting the process…

(innovators and early adopters)

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Phase 1

(Sept. 2011)

Reporting data…
Finding and using value…

(best practices / best methods)

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Pneumonia Process of Care Measures

Percent Pneumonia Patients:

- Assessed and Given Pneumococcal Vaccination
- Whose Initial Blood Culture Was Performed Prior to the Administration of the First Hospital Dose of Antibiotics
- Given Smoking Cessation Advice / Counseling
- Given Initial Antibiotic(s) within 6 Hours After Arrival
- Given the Most Appropriate Initial Antibiotic(s)
- Assessed and Given Influenza Vaccination

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Heart Failure Process of Care Measures

Percent Heart Failure Patients:

- Given Discharge Instructions
- Given an Evaluation of Left Ventricular Systolic Function
- Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)
- Given Smoking Cessation Advice / Counseling

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Hospital Outcome of Care Measures

- **30 Day Readmissions**:

  (Shows how often patients are readmitted within 30 days of discharge from a previous hospital stay for heart failure, or pneumonia.)

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Phase 2

(Sept. 2012)

Adding Out-Patient Measures

(Benchmarking IP Measures)

HCAHPS

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Out-Patient 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** Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision)
- **OP-7** Prophylactic Antibiotic Selection for Surgical Patients

Out Patient Chest Pain Measure

- Principal diagnosis or other diagnoses of chest pain
- Eligible for 2 OP Measures
  - OP-4: Aspirin on Arrival
  - OP-5: Median time to ECG

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Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- 34% of CAHs reported HCAHPS patient assessment of care survey data in 2008.
- On average, CAHs have significantly higher ratings on HCAHPS measures than all US hospitals.

Policy Brief #15 March 2010
Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results
Michelle Casey, MS, Michele Burlew, MS, Ira Moscovice, PhD
University of Minnesota Rural Health Research Center

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Phase 3

(Sept. 2013)

ED Patient Transfer Communication Measure

- NQF Endorsed…
- FR Notice for Public Comment
- Hopefully CMS Approved Measure by then!

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ED Patient Transfer Communication*

- Pre-Transfer Communication Information (0-2)
- Patient Identification (0-6)
- Vital Signs (0-6)
- Medication-Related Information (0-3)
- Physician or Practitioner Generated Information (0-2)
- Nurse Generated Information (0-6)
- Procedures and Tests (0-2)

* NFQ Endorsed

Are these rural-appropriate measures?

Do they represent the quality we provide in our CAHs?

Will they "drive" quality improvement in our hospitals?

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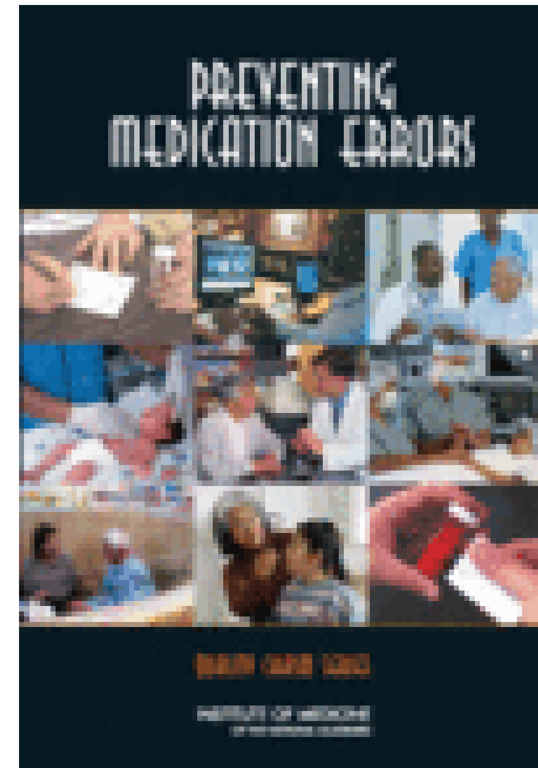
Measuring Quality vs Driving Quality

Where can the most improvement actually be made....

…then measured and reported?

“…a hospital patient can expect on average to be subjected to more than one medication error each day.”

July 20, 2006



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Pharmacist Staffing and the Use of Technology in Small Rural Hospitals: Implications for Medication Safety

Michelle M. Casey, M.S.

Ira Moscovice, Ph.D.

Gestur Davidson, Ph.D.

December 2005

A partnership of the University of Minnesota Rural Health Research Center and the University of North Dakota Center for Rural Health

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"The results of this study indicate that many small rural hospitals have limited hours of on site pharmacist coverage. Over one-third of the hospitals report having a pharmacist on site for less than 40 hours per week, including 31 hospitals where a pharmacist is on site for ***two hours or less per week."***

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RUPRI Center for Rural Health Policy Analysis

Rural Issue Brief

Prevalence of Evidenced-Based Safe Medication Practices in Small Rural Hospitals

Gary Cochran, PharmD

Katherine Jones, PhD

Liyan Xu, MS

Keith Mueller, PhD

April 2008

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Prevalence of Evidenced-Based Safe Medication Practices in Small Rural Hospitals

"Approximately one in five of the nation's smallest hospitals have… (1) a pharmacist review of orders within 24 hours…"

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ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090

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"One of every seven Medicare beneficiaries who is hospitalized is harmed…

…Added at least $4.4 billion a year to costs…

…Contributed to the deaths of about 180,000 patients a year…

…44 percent… preventable."

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“The most frequent problems….

…were those related to medication…

“the study highlighted the importance of improving procedures to prevent medication errors…”

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Phase 3

(Sept. 2013)

Pharmacist CPOE or Verification of Medication Orders within 24 hours

(meets EHR "Meaningful Use" criteria)

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MBQIP

- Across Multiple States
- Involving significant number of CAHs
- Aggregating the data – national benchmarking.
- Rural Appropriate Measures & Processes

  - Heart Failure, Pneumonia, (30 Day Re-admissions)
  - OP Measures , HCAHPS
  - Ed OP Transfer Measure, Med Orders Reviewed within 24 hours

Partners for Patients

1. *Reduce harm caused to patients in hospitals*. We will accelerate the reduction of preventable harms to inpatients starting now, so that by the end of 2013 we will observe a 40% reduction in preventable harm compared to 2010. Based on our calculations, this would mean almost two million fewer injuries to patients and more than 60,000 lives saved

2. *Reduce preventable hospital readmissions.* We will advance efforts to decrease preventable hospital readmissions within 30 days of discharge, so that by 2013 all readmissions would be reduced by 20% compared to 2010. This would mean prevention of more than 1,600,000 hospital readmissions.

Achieving these two goals will not only save lives and greatly reduce injuries to millions of Americans – it will also result in savings of billions of dollars that help put the nation on the path to having a more sustainable health care system.

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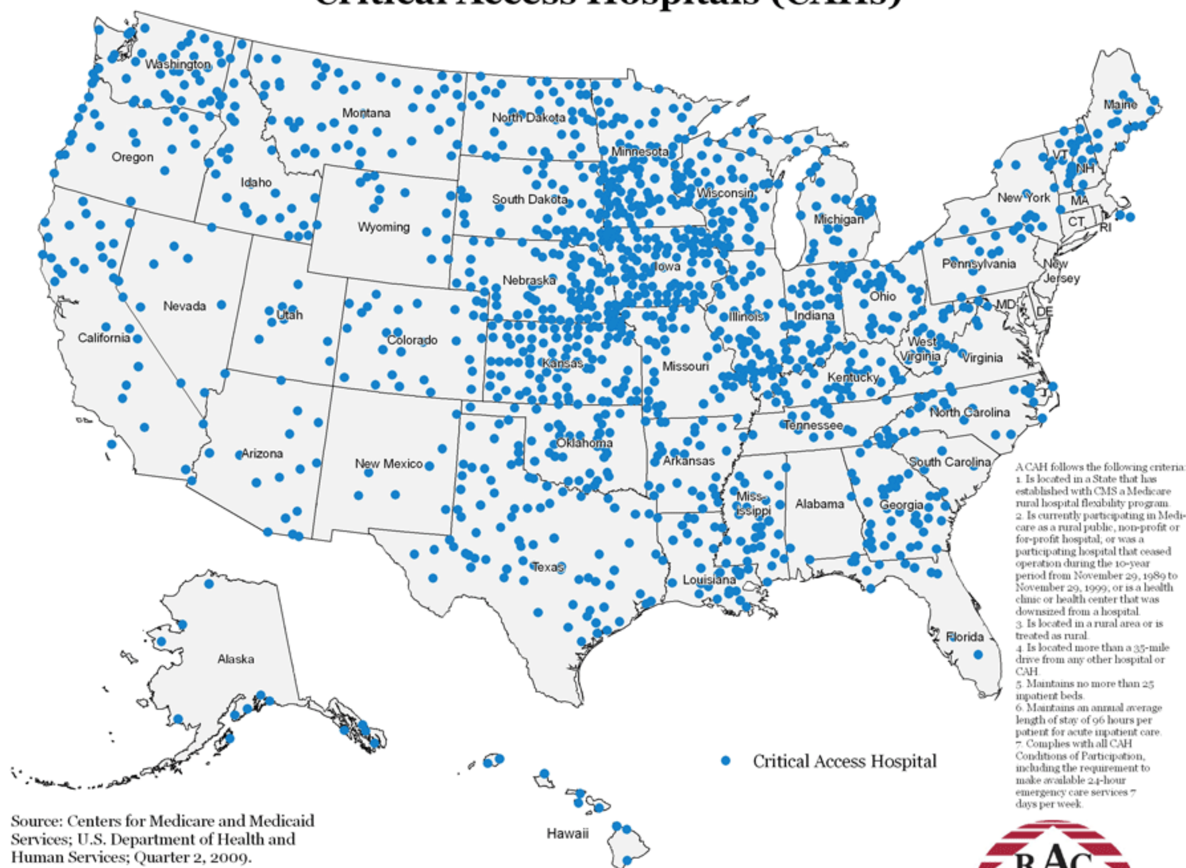
Hospital-Acquired Conditions: Some of the Many Opportunities for Improvement

Condition/Adverse Event (examples)	Total Cases (2010)	Preventable Cases (2010)
Central Line-Associated Blood Stream Infection	41,000	20,500
Pressure Ulcer	250,000	125,000
Surgical Site Infection	290,000	101,500
Adverse Drug Event	**1,900,000**	**950,000**
Injury from Fall	200,000	50,000
Ventilator-Associated Pneumonia	40,000	20,000
All Other Hospital Acquired Conditions For example: - Delay in administration of aspirin leads to hemorrhage - Misplacement of feeding tube leads to choking - Failure to manage diabetic symptoms leads to coma	2,240,589	985,859
Total ALL Hospital Acquired Conditions	**5,982,768**	**2,623,150**

The goal of the Initiative is to have a 40 percent reduction of preventable hospital acquired conditions in three years.

At the end of the day…



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