New CMS QAPI Standards and Revised QAPI Worksheet

Tuesday, January 13th, 2015
Speaker

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- Board Member Emergency Medicine Patient Safety Foundation
- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com
Learning Objectives

1. Review the CMS Worksheet on QAPI.

2. Explain why the Board is ultimately responsible for the QAPI program.

3. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.

4. Evaluate compliance requirements and penalties.
You Don’t Want One of These
The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Manual updated more frequently now
  - Tag number 0001 through 1164 and PI starts at tag 263
  - Questions to CMS at hospitalscg@cms.hhs.gov

- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **Survey Procedures**
  - Hospitals should check this website once a month for changes

1[www.gpoaccess.gov/fr/index.html](http://www.gpoaccess.gov/fr/index.html)  
Location of CMS Hospital CoP Manuals

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

CMS Hospital CoP Manuals new address

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State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents

(Rev. 122, 09-26-14)

Transmittals for Appendix A

Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

- Show all items
- Show only (select one or more options):
  - Show only items whose is within the past
  - Show only items whose Fiscal Year is
  - Show only items containing the following word

Show Items

There are 455 items in this list.

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
# Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov
Number of Deficiencies for QAPI

- CMS deficiency reports show many deficiencies in QAPI
- CMS is updating quarterly and issued report in November 2014
- PI standards were rewritten March 21, 2014 and many changed tag numbers
- Reports lists the name and address of all hospitals receiving deficiencies
- Can read the deficiencies for each one to get an idea of what surveyors are hitting hard
Access to Hospital Complaint Data

MEMORANDUM

December 22, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group


DATE: March 22, 2013

Ref: S&C: 13-21-ALL

Memorandum Summary

- **Survey Findings Posted on [http://www.cms.gov](http://www.cms.gov)**: In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.

- **Other Web-based Tools Based on These Data**: At least two additional websites, provided by private parties (ProPublica and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.

- **Plans of Correction (POC)**: The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.

- **Questions & Answers**: We plan to issue an update to this memorandum that will include an attachment of frequently asked questions, in order to provide answers to other queries that may arise.

Background — Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Federal Long Term Care Survey.
# Updated Deficiency Data Reports

Updated deficiency data reports are available on the CMS.gov website. Click on the provided link to access the latest reports.

**Links:**
- [CMS.gov](https://www.cms.gov)
- [Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html)

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## Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules, it is possible for one hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice. Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments.

**Accredited Hospitals:** A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas, and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

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*Note: The above text is a simplified and abridged version for demonstration purposes.*
Can Count the Deficiencies by Tag Number

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<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>
## Deficiency Data

<table>
<thead>
<tr>
<th>Tag</th>
<th>Section</th>
<th>Nov 2014</th>
<th>April 21, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>280</td>
<td>Patient Care Policies</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>281-282</td>
<td>Patient Services</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>283</td>
<td>QI Activities</td>
<td>180</td>
<td>160</td>
</tr>
<tr>
<td>284</td>
<td>Patient Services</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>286</td>
<td>Patient Safety</td>
<td>258</td>
<td>224</td>
</tr>
</tbody>
</table>
Hospital CoPs for QAPI

- CMS issued new hospital COPs memo for QA and Performance Improvement (QAPI)
- CMS issues Memo March 15, 2013 on AHRQ Common Formats
  - Hospitals are required to track adverse events for PI
- Starts with tag number 0263
- Short section because the hospital compare program is not part of the CMS CoP
  - Hospital compare is the indicators that must be sent to CMS to receive full reimbursement rates
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: March 15, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats

Memorandum Summary

**Hospitals are Required to Track Adverse Events:** The Condition of Participation (CoP) for Quality Assessment and Performance Improvement (QAPI) at 42 CFR 482.21(a)(2) requires hospitals to track adverse patient events. However, several recent reports completed by the Department of Health and Human Services Office of the Inspector General (OIG) indicated that hospitals fail to identify most adverse events.

**Use of the Common Formats May Help Hospitals Improve Tracking.** The OIG suggested staff failure to understand what events need to be reported to the hospital’s QAPI program contributes to the problems with internal tracking systems. The OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) could help hospitals improve their ability to track adverse patient safety events by disseminating information on AHRQ’s Common Formats. The Common Formats define a systematic process for reporting adverse events, near misses, and unsafe conditions, and allow a hospital to report harm from all causes. Hospital use of the AHRQ Common Formats is voluntary, but a hospital that uses them and is adept at the analysis that they permit will be in a better position...
Adverse Event Reporting

- Hospitals are required to track AE (adverse events)
- Several reports show that nurses and others were not reporting adverse events and not getting into the PI system
- OIG recommends using the AHRQ common formats to help with the tracking
- States could help hospitals improve the reporting process
- Encouraged all surveyors to develop an understanding of this tool
Adverse Event Reporting

- IOM report discussed the need for comprehensive patient safety reporting to address the alarming high incidence of AE occurring in hospitals (Pg. 2)

- OIG report November, 2010 “AE in Hospitals: National Incidence Among Medicare Beneficiaries” encouraged internal reporting of all AE, whether preventable or not

- OIG issues report in January 2012 “Hospital Incident Reporting Systems Do Not Capture Most Patient Harm”
  - 86% of AE are never reported to the PI program
  - 44% are considered preventable
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

HOSPITAL INCIDENT REPORTING SYSTEMS DO NOT CAPTURE MOST PATIENT HARM

http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp

Daniel R. Levinson
Inspector General

January 2012
OEI-06-09-00091
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries

http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090
**Adverse Event Reporting**

- CMS PI section requires hospital to track AEs and analyze the causes and implement actions to prevent in the future

- Need to include near misses

- The internal hospital reporting system represents a foundational capability to determine if the hospital can maintain compliance with the CoPs

- The AHRQ Common Formats are evidenced based

- Common Formats allow for identification and reporting of any AE even if rare and includes NQF 29 never events such as falls and medication errors
## Events That Should be Reported

<table>
<thead>
<tr>
<th>Event Category</th>
<th>Examples of event occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event was an expected outcome or side effect</td>
<td>Thrush</td>
</tr>
<tr>
<td>Event caused little harm and/or harm was ameliorated</td>
<td>Hypoglycemia treated with orange juice (glucose)</td>
</tr>
<tr>
<td>Event was not on the hospital mandatory reporting list</td>
<td>Patient given wrong medication, but no harm; Reporting of Stage 2 pressure ulcers is not mandated in some states.</td>
</tr>
<tr>
<td>Event occurs frequently in hospitals</td>
<td>Medication given late; falls</td>
</tr>
<tr>
<td>Event symptoms became apparent after discharge</td>
<td>VTE diagnosed 10 days after discharge; Surgical Site infection 3 weeks after pacemaker implant.</td>
</tr>
<tr>
<td>Event occurred in a patient with a history of similar events</td>
<td>Falls, Stage 1 or 2 pressure ulcers</td>
</tr>
<tr>
<td>Events not caused by a perceptible error</td>
<td>Postoperative ileus (severe, lasting more than six days)</td>
</tr>
<tr>
<td></td>
<td>Constipation after narcotics</td>
</tr>
<tr>
<td></td>
<td>Adverse reaction (rash) to a medication the patient was not known to be allergic to</td>
</tr>
</tbody>
</table>
9 Modules in the Common Formats

1. Blood or Blood Product
2. Device or Medical/Surgical Supply, including Health Information Technology (HIT)
3. Fall
4. Healthcare-associated Infection
5. Medication or Other Substance
6. Perinatal
7. Pressure Ulcer
8. Surgery or Anesthesia
9. Venous Thromboembolism
10. Other (allows collection of information on all other types of events)
Welcome to the PSO Privacy Protection Center

The Patient Safety Organization Privacy Protection Center (PSOPPC) was created by the Agency for Healthcare Research and Quality (AHRQ) to support the implementation of the Patient Safety and Quality Improvement Act (PL-109-41), passed by the United States Congress in July, 2005. The PPC provides technical assistance to PSOs by ensuring patient safety event data is nonidentifiable for data submission and reporting to the NPSD, and provides technical assistance on use of Common Formats. Read more about the PPC.

https://psoppc.org/web/patientsafety
Hospital Common Formats

Through a contract with the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF) solicited feedback on the formats from private sector organizations and individuals. The NQF, a nonprofit organization that focuses on healthcare quality, then convened an expert panel to review the comments received, and provide feedback to AHRQ. Based on the expert panel’s feedback, AHRQ further revised and refined the Common Formats that are now available as Hospital Common Formats Version 1.2 & 1.1.

The following Hospital Common Formats are active for reporting are available for implementation and use by healthcare providers and Patient Safety Organizations (PSOs). These versions of the Common Formats are also accepted by the PSCOPPC for national reporting.

Hospital Common Formats - Version 1.2
- Event Descriptions, Sample Reports & Forms
- Technical Specifications
- Users Guide

Hospital Common Formats - Version 1.1
- Event Descriptions, Sample Reports & Forms
- Technical Specifications
- Users Guide

https://www.pscoppc.org/web/patientsafety/version-1.1_documents
The Conditions of Participation (CoPs)

- The manual is known as the conditions of participation or the CoPs for short.
- The CoP sections are called tag numbers and go from 1 to 1164.
- When interpretive guidelines (IG) are final they are printed in a transmittal and then placed in the manual.
- All the sections contain a tag number so it is easy to go back and look up that section if you want to read more about it.
- There are currently 470 pages in the current manual.
Transmittals

The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that we will incorporate into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The transmittals for 2000 through 2003 have been archived. The archived transmittals can be accessed using the following URLs:

2003 Transmittals

2002 Transmittals

2001 Transmittals

2000 Transmittals
CMS Worksheets
Infection Control, Discharge Planning and QAPI
CMS Hospital Worksheets History

- October 14, 2011 CMS issues a 137 page memo in the survey and certification section and it was pilot tested in hospitals in 11 states

- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey

- Addresses discharge planning, infection control, and QAPI (performance improvement)

  - May 18, 2012 CMS published a second revised edition and pilot tested each of the 3 in every state over summer 2012
  - November 9, 2012 CMS issued the third revised worksheet
  - Final ones issued November 26, 2014
Final 3 Worksheets  QAPI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland  21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE:  November 26, 2014
TO:  State Survey Agency Directors
FROM:  Director
Survey and Certification Group
SUBJECT:  Public Release of Three Hospital Surveyor Worksheets

REF:  S&C: 15-12-Hospital

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- **Three Hospital Surveyor Worksheets Finalized:** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.

- **Final Worksheets Made Public:** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.
CMS Hospital Worksheets

- Hospitals should be familiar with the three worksheets and QAPI one is 15 pages

- Will use whenever a validation survey or certification survey is done at a hospital by CMS

- CMS says worksheets are used by State and federal surveyors on all survey activity in assessing compliance with any of the three CoPs

- Hospitals are encouraged by CMS to use the worksheet as part of their self assessment tools which can help promote quality and patient safety
And of course completing the forms helps the hospital to comply with those three CoPs

Citation instructions are provided on each of the worksheets

The surveyors will follow standard procedures when non-compliance is identified in hospitals

This includes documentation on the Form CMS 2567

Not used in CAH but good tool for CAH to use

Questions to: hospitalscg@cms.hhs.gov
Form 2567 Statement of Deficiency/POC

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. BUILDING</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CMS Hospital Worksheets

- Some of the questions asked might not be apparent from a reading of the CoPs

- So the worksheets are a good communication device

- It helps to clearly communicate to hospitals what is going to be asked in these 3 important areas

- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment

- Hospitals should consider attaching the documentation and P&P to the worksheet
CMS Hospital Worksheets

- This would impress the surveyor when they came to the hospital

- The worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited who are suppose to have a CMS survey every three or so years
  - The Joint Commission (TJC), American Osteopathic Association (AOA) Healthcare Facility Accreditation Program, CIHQ, (Center for Improvement in Healthcare Quality) or DNV Healthcare are the 4 AOs with deemed status

- It would also be used for hospitals undergoing a validation survey by CMS
CMS Hospital QAPI Worksheet

- First two pages included identification information

- Name of the state survey agency which in most states is the department of health under contract by CMS
  - In Kentucky it is the OIG or Office of Inspector General

- It will ask for the name and address of the hospital, CCN number (certification number), number of surveyors, date of survey, number of surveyors, time spent on performing the PSI surveys, is hospital accredited and if so date of last survey
State Agency Name

Instructions: The following is a list of items, broken down into separate parts, which must be assessed during the on-site survey in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital’s QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate. The separate Parts can be assessed in any order. Within each Part there may also be flexibility to change the order in which the various items are assessed.

The interviews should be performed with the most appropriate staff person(s) for the item of interest (e.g., unit/department staff should be asked how they participate in the hospital-wide QAPI program).

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on the Form CMS-2567 when deficient practices are observed.

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name (please print)

1.2 Address, State and Zip Code (please print)

1.3 CMS Certification Number (CCN)
CMS QAPI Hospital Worksheet

- CMS uses the term “tracers” for the first time
- The first worksheet is on QAPI which stands for Quality Assessment Performance Improvement
  - CMS previously called it Quality Assurance Performance Improvement and changed June 7, 2013
- The worksheet is a document that the surveyor will sit down with the hospital and fill out
- The first column includes the elements to be assessed and there are boxes to fill in
### Quality Indicator Tracers

**PART 2: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS**

Instructions for Part #2 Questions:
Select 3 distinct quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Indicator #1</th>
<th>Indicator #2</th>
<th>Indicator #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write in indicator selected:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g., based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
</tr>
<tr>
<td>2.1.b Is the scope of data collection appropriate to the indicator, e.g., an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would require data from multiple parts of the hospital.</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
</tr>
<tr>
<td>2.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
<td>○ YES ○ NO</td>
</tr>
</tbody>
</table>
This section is 15 pages long

First select three quality indicators related to PI activities or projects

- An example might be the timing of medications and PI data to show medication was given on time and number of medication errors or missed or omitted doses
  - Number of catheter associated UTIs

- Write the quality indicator at the top and answer the following questions for each one
Hospitals collect all kind of data

TJC requires data to be collected in a number of areas

- Data on medication management (ADR, medication errors), FMEA, patient flow, staff compliance with employee health screening requirements, patient satisfaction, pediatric asthma, ED measures, infection control surveillance data

- Data on R&S use, patient perception of care, organ donation, blood transfusion reactions, ORYX data, medical record deficiency data, staffing, data on how patient communication needs are met, race and ethnicity etc.
QAPI Tracer  Data Collection & Analysis

- CMS has hospital compare with data on number of MI patients who get thrombolytics timely or pneumonia patients who get their antibiotics timely.

- Measure patient experience or patient satisfaction data.

- Measure some or all of the AHRQ patient safety indicators.

- National Quality Forum includes lists of quality indicators that are evidence based that hospital may measure.
QAPI Tracer  Data Collection & Analysis

- Can you show evidence that each quality indicator is related to improved health outcomes? (Tag 273)
  - Based on QIO, national guidelines, evidence based studies, peer reviewed etc.
- Is the scope of data collection appropriate to the indicator (273)
  - Hand hygiene would require data from multiple parts of the hospital
  - ED or L&D might be specific to date from that area such as the average LOS in the ED or the number of elective C-sections performed with premature infants
PI Tracer  Data Collection & Analysis

- Is the method and frequency of data collection specified? (Tag 273)
  - Such as chart reviews or monthly observations
  - Is the data collected in the manner specified and it is done as often as specified such as will do 30 charts per month for ED documentation criteria

- If unit staff play a role in data collection then is the data collection consistent with the specifications (273)
  - Example OR staff complete a data collection tool with number of cases time out is taken and documented, H&P and consent on chart before surgery, etc.
PI Tracer  Data Collection & Analysis

- Are data collected aggregated in accordance with hospital methodology specified for this indicators
  - Is the data analyzed? (Tag 273)

- If indicator is type that measures rate are the rates calculated for points in time and compared to benchmark data set out by national organizations when available? (273)
  - Pneumonia patients should get their first dose of antibiotics within 6 hours or MI patients thrombolytics in 30 minutes or PCI within 90 minutes
PI Tracer Data Collection & Analysis

- Is data broken down into subsets that allow for comparison among hospital units (Tag 273)
  - Such as hand hygiene or the fall rate
- If data identified area that needs improvement then is there evidence the issue was addressed (283)
  - Such as an infant abduction risk, high fall rate, high medication error rate, injury from restraints
- Are the interventions evaluated for success?
  - If successful did hospital monitor to ensure success was sustained
- If not, what did the hospital do?
QAPI Tracer  Data Collection & Analysis

- Does PI focus on high risk, high volume, or problem prone areas? (Tag 283)
  - Orthopedic hospital does lots of Orthopedic projects or hospital that does CABG do QAPI on these?
- Can hospital prove it conducts distinct PI projects?
  - Should be reflected in the PI minutes (297)
  - Every department should participate in PI process
- Is number of projects proportional to the scope and complexity of the hospital’s service and operations
  - Larger hospital expected to do more projects
QAPI Tracer  Data Collection & Analysis

- If NICU is there QAPI related to that area such as the percentage of babies who do not survive the first 28 days of life (297)
  - Or quality measures for low birth weight babies including HAI, intraventricular hemorrhage, hearing loss, retinopathy, or chronic lung disease

- If the hospital has an open heart surgery unit
  - Part of SCIP or surgical care improvement project such as antibiotics within one hour of incision, antibiotics discontinued within 24 to 48 hours, appropriate hair removal (razors are out and clippers are in), normothermia, perioperative beta blocker, DVT prophylaxis, and control post-op glucose
PI Tracer  Data Collection & Analysis

- Can hospital show evidence of why each project was selected? (297)
  - Unless QIO project or IT project such as CPOE
- CMS then has a section on patient safety that discusses adverse events (AE) and medical error
- This part is to evaluate the hospital’s leadership expectation for patient safety
- Is there staff training or communications related to expectation for patient safety to all staff?
- Is there a P&P on non-punitive approach to staff reporting medical errors which includes near misses?
QAPI Patient Safety AE and Medical Errors

- Can staff on each unit explain hospital’s expectation for their role in promoting patient safety? (286)
- Is there widespread staff training related to expectation for patient safety?
- Training related to what steps to take in situation that feels unsafe
- Is there a systematic process to identify medical errors which include near misses and AEs?
- On every unit, can the staff describe what is a medical error or near miss?
### Patient Safety LD, AE and Medical Error

#### PART 4 – PATIENT SAFETY – ADVERSE EVENTS AND MEDICAL ERRORS

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Space for Surveyor Notes (if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1</strong> Evaluation regarding whether the hospital’s leadership sets expectations for patient safety:</td>
<td></td>
</tr>
</tbody>
</table>
| **4.1.a** Is there evidence of widespread staff training or communication to convey expectations for patient safety to all staff? (e.g. training related to steps to take in a situation that feels unsafe, how to report adverse patient events, medical errors, near misses/close calls, etc. that they are expected to report internally) | ○ YES  
○ NO |
| **4.1.b** Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of adverse patient events, medical errors, near misses/close calls, etc. and situations they consider unsafe? | ○ YES  
○ NO |
| **4.1.c** On each unit surveyed, can staff explain what the hospital’s expectations are for their role in promoting patient safety? | ○ YES  
○ NO |

**If no to 4.1.a, 4.1.b, or 4.1.c, cite at 42 CFR 482.21(e)(3) (Tag A-286)**

**4.2.** Evaluation regarding hospital processes to identify adverse patient events, medical errors, near misses/close calls, etc.:

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Space for Surveyor Notes (if needed)</th>
</tr>
</thead>
</table>
| **4.2.a** On each unit/program surveyed, can staff describe the types of adverse patient events, medical errors, near misses/close calls, etc. they are expected to report internally? | ○ YES  
○ NO |
| **4.2.b** On each unit/program surveyed, can staff | ○ YES |
Can they explain how to report? (286)

How do they report?
- Phone report, incident report, communicate to supervisor etc.

Who do they report it to?
- Manager, risk manager, physician, pharmacist etc.

Does the staff know what needs to be reported internally?
- ADEs, medical errors, near misses and unsafe situations

Does hospital employ other methods to find medical errors such as trigger tools, chart reviews, review of claims, patient grievances, interview patients etc.
QAPI  Patient Safety AE and Medical Errors

- Can hospital provide evidence of medical errors and AEs identified through staff reports? (286)
- Is there a PI program with the infection preventionist (IP) to track avoidable HAI?
  - IC section requires this and starts at tag 747
- Are problems identified by the IP addressed through QAPI activities? (756 or 286)
- Does the PI program track medication errors and ADE and drug incompatibilities
  - Tag 508 requires this
QAPI Patient Safety AE and Medical Errors

- Is there a process to report blood transfusion reaction and determine if due to medical error? (286 and 410)
  - Must be reviewed to identify if an medical error

- Did the survey team have prior knowledge of any serious AE that the hospital failed to identify? (286)
  - Were any identified by the surveyors?

- Has a RCA or QAPI review been done on all serious preventable AEs? (286)
  - Sample all serious preventable events identified in the past 12 months
The next question discusses the causal analysis tracers (RCAs) or patient safety tracers. Causal analysis searches for the cause and effect or causes of the particular event or adverse outcome. More commonly referred to as a RCA or root cause analysis. CMS calls it QAPI reviews.

The surveyor (not the hospital) will select three causal analysis done for single event or near miss during the last 12 to 24 months (286). Were underlying causes identified?
### Causal Analysis Tracers

#### PART 4: PATIENT SAFETY TRACERS

Instructions for Questions #4.9 and 4.10: If the answer to Question #4.9 is “yes”, the Surveyor should select up to three significant adverse events or close calls/near misses the hospital reviewed for QAPI purposes during the last 12 - 24 months (“cases”). Do not let the hospital select the adverse events/close call reviews to be used for the Tracer.

The reviews may be of single events/close calls (e.g., a wrong site surgery that actually occurred or that came close to occurring on a particular patient), groups of similar kinds of events/close calls (e.g., all inpatient falls with injury during the first quarter), or a combination of both types of review.

Answer all of the questions in #4.10 for each “case” selected. (For at least one, there should be sufficient time after implementation of preventive measures for the hospital to have evaluated the impact of those measures.)

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Case #1</th>
<th>Case #2</th>
<th>Case #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.10 Select the number of hospital conducted QAPI reviews of adverse events/close calls that were reviewed for this survey.</td>
<td>One “case” reviewed.</td>
<td>Two “cases” reviewed.</td>
<td>Three “cases” reviewed.</td>
</tr>
<tr>
<td>Write in a general description of each case. Avoid using any identifiable information on this worksheet.</td>
<td>Case #1 General Description:</td>
<td>Case #2 General Description:</td>
<td>Case #3 General Description:</td>
</tr>
<tr>
<td>Answer all of the questions below for each “case.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.10a Has the hospital identified potential underlying causes or contributing factors?</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

- IF YES, CONTINUE.
- IF NO, SKIP ALL 4.10 SUB-QUESTIONS.
QAPI Patient Safety Tracers

- Was preventive actions developed based on the RCA? (286)
- TJC has a matrix which contains elements that must be included in a reviewable sentinel event
- Did the hospital identify any other departments utilizing similar processes that are at a similar risk? (286)
  - Alarm fatigue issue in ED, CCU, ICU, and telemetry
- Were preventive actions implemented in at least one area of the hospital? (286)
QAPI Patient Safety Tracers

- Has the hospital evaluated the impact of the preventable actions including tracking a reoccurrences or near misses? (286)

- If the goals were not met did the hospital go back to the drawing board?
  - New patient fall tool used in the ED but staff did not have a culture of safety and not implementing actions

- Has the hospital implemented the preventable actions found to be effective unless there is a documented reason for not doing so? (286)
TJC Framework for Conducting RCA

www.jointcommission.org/sentinel_event.aspx
TJC Sentinel Event Policy

Sentinel Event Policy and Procedures

June 10, 2013

In support of its mission to continuously improve the safety and quality of health care provided to the public, The Joint Commission reviews organizations’ activities in response to sentinel events in its accreditation process, including all full accreditation surveys and random unannounced surveys and, as appropriate, for-cause surveys.

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events are called “sentinel” because they signal the need for immediate investigation and response.
- The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

View Sentinel Event Policy and Procedures by Accreditation and/or Certification Program:
- Ambulatory Health Care
- Behavioral Health Care
- Critical Access Hospital
- Home Care
- Hospital
- Laboratory Services
- Long Term Care
- Office Based Surgery
- Disease-Specific Care

www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/
Table 3. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

<table>
<thead>
<tr>
<th>Areas of Potential Root Causes</th>
<th>Suicide (24-Hour Care)</th>
<th>Medication Error</th>
<th>Procedural Complication</th>
<th>Wrong-Site Surgery</th>
<th>Treatment Delay</th>
<th>Restraint Death</th>
<th>Elopement Death</th>
<th>Assault/Rape/Homicide</th>
<th>Transfusion Death</th>
<th>Patient Abduction</th>
<th>Unanticipated Death of Full-Term Infant</th>
<th>Unintended Retention of Foreign Body</th>
<th>Fall Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral assessment process**</td>
<td>X</td>
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<tr>
<td>Physical assessment process***</td>
<td>X X X X X X</td>
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<tr>
<td>Individual identification process</td>
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<td>X</td>
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<tr>
<td>Individual observation procedures</td>
<td>X</td>
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<tr>
<td>Care planning process</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Continuum of care</td>
<td>X X</td>
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<tr>
<td>Staffing levels</td>
<td>X X X X X X X X X X X X X X X</td>
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<tr>
<td>Orientation and training of staff</td>
<td>X X X X X X X X X</td>
<td></td>
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</tr>
</tbody>
</table>

*continued on next page*
Part 5 addresses broad QAPI requirements and leadership responsibilities (309)

Does the hospital have a formal PI program?

- Most hospitals have a PI plan that discusses the PI program
- Is there a written P&P on the PI program?
- Is there budgeted resources so staff can attend education programs and data can be collected?
- Is there responsible staff to do PI
- Is the PI program approved by MS, CEO, and the board?
# Broad PI Requirements and Leadership

## PART 5 – BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Elements to be Assessed</th>
<th>Space for Surveyor Notes (if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Is there evidence that the hospital has a formal QAPI program - including written</td>
<td>O YES</td>
</tr>
<tr>
<td>policies and procedures, budgeted resources, and clearly identified responsible staff</td>
<td>O NO</td>
</tr>
<tr>
<td>- approved by the governing body after input from the CEO and medical staff leadership?</td>
<td></td>
</tr>
</tbody>
</table>

**If no to 5.1, cite at 42 CFR 482.21(e)(1) & (2) (Tag A-309)**

| 5.1.a Has the hospital maintained and made available for surveyor review sufficient   | O YES                                |
| evidence of its QAPI program to allow compliance assessment?                         | O NO                                 |

**If no to 5.1.a, cite at 42 CFR 482.21 (Tag A-263)**

<table>
<thead>
<tr>
<th>5.2 Evaluation regarding whether the QAPI program is hospital-wide:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.a Using Information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?</td>
<td>O YES</td>
</tr>
<tr>
<td></td>
<td>O NO</td>
</tr>
</tbody>
</table>

**If no to 5.2.a, cite at 42 CFR 482.21 (Tag A-263 or A-308)**

| 5.2.b Using information from the hospital identifying services provided under       | O YES                                |
| arrangement (contract), can the QAPI manager provide evidence of QAPI monitoring    | O NO                                 |
| for each service related to clinical care provided under contract or arrangement?  | O N/A                                |
| (Exclusively administrative contractual services, e.g., payroll preparation, are    |                                      |
| not required to be included in the QAPI program.)                                  |                                      |
Broad PI Requirements and Leadership

- Has the hospital maintained and made available to the surveyor sufficient evidence of its QAPI program to allow compliance assessment? (263)
- Is the QAPI hospital-wide?
- Can the QAPI manager provide evidence of QAPI monitoring related to each service? (263 or 308)
  -Surveyor to use information in the data base worksheet to determine what services are offered by the hospital
  -Every department should be involved in the QAPI process
- Is there evidence of PI review for contracted services for clinical care? (83, 263, or 308)
Broad PI Requirements and Leadership

- Is there evidence that the board, CEO, MS leadership and senior leaders, including the CNO, have a role in PI planning and implementation? (309)

- Is there evidence of PI review in the board minutes? (273)

- Does the board approve the PI program quality indicators and how often the data is collected?
  - Determine how many projects for next year?
  - Does board hold CEO accountable for effectiveness of PI program? (309 and 57)

- CMS Board section starts at tag 38
Resource Allocation

- Is there evidence of funding and personnel dedicated to the QAPI program? (315)

- If condition level deficiencies, is there evidence that the lack of resources contributed to this? (315)

- Did the hospital at any time refuse to provide the requested material claiming it was protected by the Patient Safety Work Product under the federal PSO law?
  - This is for information only and no citation risk
What PPS Hospitals Need to Know About the QAPI Section
CMS CoP PI Section Starts at Tag 263

A-0263
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital’s governing body must ensure that the program reflects the complexity of the hospital’s organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

A-0273
(Rev. 105, Issued: 03-21-14, Effective: 03-21-14, Implementation: 03-21-14)

Data Collection & Analysis

§§482.21(a), 482.21(b)(1), 482.21(b)(2)(i), & 482.21(b)(3)

§482.21(a) Standard: Program Scope

(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes....

(2) The hospital must measure, analyze, and track quality indicators...and other aspects of performance that assess processes of care, hospital service and operations.
Changes to the Tag Numbers

- Old Tag Numbers:
  - 34 tag numbers and 7 pages

- New Tag Numbers after March 21, 2014:
  - 263, 273, 283, 286, 297, 308, 309 and 315
  - 8 tag numbers and 7 completely rewritten and 4 pages
  - 34 tags to 8 standards
QAPI stands for quality assessment and performance improvement

Use to stand for Quality Assurance and Performance Improvement (QAPI) but changed June 7, 2013 to Quality Assessment

Referred to in short as PI

In each section, such as nursing and pharmacy, CMS states every department has a role in QAPI

Also CMS Compare is an important and has information about the hospital’s quality of care
Find a hospital

A field with an asterisk (*) is required.

* Location
Example: 45802 or Lima, OH or Ohio

ZIP Code or City, State or State

Hospital Name (optional)

Full or Partial Hospital Name

Search

Spotlight

- **NEW** Inpatient psychiatric facility measures are now available
- American College of Surgeons (ACS) surgical outcomes

Additional information

- Hospital Compare data last updated: April 17, 2014. Go to updates
- Download the Hospital Compare

Tools and Tips

- Learn how Medicare covers inpatient and outpatient hospital services.
- Get tips for printing hospital
Measures Displayed on Hospital Compare

www.medicare.gov/hospitalcompare/Data/Measures-Displayed.html

Measures displayed on Hospital Compare

- Send general questions regarding Hospital Compare and the data to HospitalCompare@hsag.com.
- Get information on when the data was last revised - from data.medicare.gov

<table>
<thead>
<tr>
<th>Measure category</th>
<th>Measure identifier</th>
<th>Technical measure title</th>
<th>Measure as posted on Hospital Compare</th>
<th>Update frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Information</td>
<td>SM-PART-CARD</td>
<td>Participation in a systematic database for cardiac surgery</td>
<td>Cardiac Surgery Registry</td>
<td>Annually July</td>
</tr>
<tr>
<td></td>
<td>SM-PART-STROKE</td>
<td>Participation in a systematic database for stroke care</td>
<td>Stroke Care Registry</td>
<td>Annually July</td>
</tr>
<tr>
<td></td>
<td>SM-PART-NURSE</td>
<td>Participation in a systematic database for nursing sensitive care</td>
<td>Nursing Care Registry</td>
<td>Annually July</td>
</tr>
<tr>
<td></td>
<td>ACS-REGISTRY</td>
<td>Participation in a multispecialty surgical registry</td>
<td>Multispecialty Surgical Registry</td>
<td>Semi-Annually July, December</td>
</tr>
<tr>
<td>Structural measures</td>
<td>SM-PART-GEN-SURG</td>
<td>Participation in general surgery registry</td>
<td>General Surgery Registry</td>
<td>Quarterly (April, July, October, December)</td>
</tr>
</tbody>
</table>
2015 Hospital Compare Measures

- Patient experience, use of medical imaging
- Timely and effective care; time to transfer for acute coronary intervention, time to EKG, MI got thrombolytics within 30 minutes, ASA on arrival, PCI within 90 minutes, etc
- Heart failure, pneumonia, SCIP measures including timely removal of foley within 1 or 2 PODs,
- ED throughput, children’s asthma care, preventive care with immunizations for flu, stroke, blood clot prevention, readmission rates, surgical complications, HAIs,
CMS VBP Website

Hospital Value-Based Purchasing

The Official Website for the Medicare Hospital Value-based Purchasing Program

This website will be CMS’ official source of information about the Hospital Value-based Purchasing (HVBP) Program for hospitals, clinicians, and other stakeholders who share CMS’ commitment to transforming the quality of hospital care by realigning hospitals’ financial incentives to do so.

Check back often for more resources to help your organization launch this ground-breaking new program.

To learn more about what the HVBP Program is, and how it can impact you, please read the links within and outside CMS, below.

HVBP News

Members Named to HVBP Monitoring and Evaluation Strategies Technical Expert Panel (01-15-13)

Fifteen healthcare professionals from across the country have been named to participate in the Hospital Value-based Program (HVBP) Monitoring and Evaluation Strategies Technical Expert Panel. For more details, see Downloads below.

Payment Adjustments

CMS Publishes HVBP-based Incentive Payment Adjustment Factors for FY 2013 (12-20-12)

CMS continues implementation of the HVBP Program in the Fiscal Year 2013 Inpatient Prospective Payment System (IPPS) rule. In that final rule, CMS finalized the methodology to calculate the value-based incentive payment adjustment factor and what portion of the IPPS payment will be subject to the adjustment factor (see 77 FR 53573; 76). For more information on these payment-related policies, please refer to the FY 2013 IPPS Final Rule in the “Related Links” section below.
Hospital Value-Based Purchasing

The Fiscal Year 2015 Hospital Value-Based Purchasing (Hospital VBP) Program adjusts hospitals’ payments based on their performance on four domains that reflect hospital quality: the Clinical Process of Care domain, the Patient Experience of Care domain, the Outcome domain, and the Efficiency domain. The Total Performance Score (TPS) is comprised of the Clinical Process of Care domain score (weighted as 20% of the TPS), the Patient Experience of Care domain (weighted as 30% of the TPS), the Outcome domain score (weighted as 30% of the TPS), and the Efficiency domain score (weighted as 20% of the TPS).

The following data points are included in each data set:

A measure/dimension score
This represents the higher of either the achievement or improvement points.

An achievement score
Scores awarded to hospitals that achieve certain levels of performance compared to other hospitals.
Clinical Process of Care Domain

Clinical process of care domain

The Hospital Value-Based Purchasing (VBP) Program uses 12 quality measures that hospitals already report to Medicare via the Hospital Inpatient Quality Reporting (IQR) program. The measures fall under five clinical areas where Medicare is focused on improving care and paying for good quality care.

Acute myocardial infarction (AMI or heart attack)
- AMI-7a: Heart attack patients given fibrinolytic medication within 30 minutes of arrival
- AMI-8a: Heart attack patients given PCI within 90 minutes of arrival

Heart failure (HF)
- HF-1: Heart failure patients given discharge instructions

Pneumonia (PN)
- PN-3b: Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics
- PN-6: Pneumonia patients given the most appropriate initial antibiotic(s)

Surgical Care Improvement Project (SCIP)
- SCIP-Card-2: Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery
- SCIP-VTE-2: Patients who got treatment at the right time (within 24 hours before or after their
Surgical Care Improvement Project (SCIP)

- **SCIP-Card-2**: Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.
- **SCIP-VTE-2**: Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.

Healthcare associated infections (HAI)

- **SCIP-Inf-1**: Surgery patients who are given an antibiotic at the right time (within one hour before surgery) to help prevent infection.
- **SCIP-Inf-2**: Surgery patients who are given the right kind of antibiotic to help prevent infection.
- **SCIP-Inf-3**: Surgery patients whose preventive antibiotics are stopped at the right time (within 24 hours after surgery).
- **SCIP-Inf-4**: Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.
- **SCIP-Inf-9**: Surgery patients whose urinary catheters were removed on the first or second day after surgery.
Patient Experience of Care domain

The Patient Experience of Care Domain in Hospital VBP is based on the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey. HCAHPS is a national, standardized survey that asks adult patients about their experiences during a recent hospital stay. The Patient Experience of Care domain scores encompass eight important aspects of hospital quality:

Communication with nurses

Shown as percentage of patients who reported that their nurses "Always" communicated well. This means nurses explained things clearly, listened carefully, and treated the patient with courtesy and respect.

Communication with doctors

Shown as percentage of patients who reported that their doctors "Always" communicated well. This means doctors explained things clearly, listened carefully, and treated the patient with courtesy and respect.

Responsiveness of hospital staff

Shown as percentage of patients who reported that hospital staff were "Always" responsive to their needs. This means the patient was helped quickly when he or she used the call button or needed help in getting to the bathroom or using a bedpan.

Pain management

Shown as percentage of patients who reported that their pain was "Always" well controlled. This means the patient's pain was well controlled and hospital staff did everything they could to help.

Cleanliness and quietness of hospital environment

Shown as percentage of patients who reported that the hospital environment was "Always" clean and quiet. This means the patient's hospital room and bathroom were kept clean and the area around the
Hospital Value-Based Purchasing Program

FACT SHEET

How Does Hospital Value-Based Purchasing Work?
Starting in October 2012, Medicare rewards hospitals that provide high quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. For the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

This Hospital VBP Program, established by the Affordable Care Act, will implement a pay-for-performance approach to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,600 hospitals across the country.

Under the Hospital VBP Program, Medicare will make incentive payments to hospitals beginning in Fiscal Year (FY) 2013 based on either:

1) How well they perform on each measure, or
2) How much they improve their performance on each measure compared to their performance during a baseline period.

The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients as well as improve their experience of care during hospital stays.

Under Medicare’s Hospital VBP Program, hospitals will receive incentive payments based on how well they perform on 12 Clinical Process of Care Measures and 8 Patient Experience of Care Measures or on how much their performance improves relative to a baseline performance.

Performance Periods

"Instead of payment that asks, “How much did you do?” the Affordable Care Act cleverly moves us toward payment that asks, “How well did you do?” and more importantly, “How well did the patient do?”

Dr. Don Berwick, Centers for Medicare & Medicaid Services (CMS) Administrator
April 11, 2011
Hospital CoPs for QAPI  263

- Standard: Must have PI program that is ongoing, data driven, and effective
- Board must make sure that PI program reflects the complexity of the hospital’s organization and services
- Must involve all departments including contracted services
- Focus on indicators to improve health outcomes
Hospital CoPs for PI

- Includes all departments even if contracted services
- Must focus on indicators related to improve health outcomes
  - How do you improve outcomes in the patient with hyponatremia?
  - How to improve outcomes in the diabetic patient admitted with hyperosmolar syndrome?
- Must focus on the prevention and reduction of medical errors
  - What do you do to prevent medical errors such as medication errors which is the most common type?
Program Scope

- Standard: PI program needs to be ongoing and show measurable improvements to improve health outcomes
  - Must measure, analyze and track the quality indicators
  - Must track other areas of performance that assess processes of care, hospital service and operations
  - MI patients get their thrombolytics timely which helps to dissolve the clot to increase blood though the coronary artery which increases their survival
Ongoing Program

- Hospitals has improved patient flow and admitted patients now get to their bed in four hours or less
- Patients get their antibiotics timely in the OR now
- Patients with pneumonia now get their antibiotics within the six hour window
- Use of the sepsis bundle has improved survival rate
Track Quality Indicators

- The hospital must measure, analyze, and track quality indicators which would include adverse events.

- Want to focus on aspects and processes that related to the health and safety of patient care services.

- Look at what could result in a sentinel event if not properly managed.
  - TJC has a sentinel event policy and lists reviewable SE.
Sentinel Events (SE)

I. Sentinel Events
In support of its mission to continuously improve the safety and quality of health care provided to the public, The Joint Commission in its accreditation process reviews hospitals’ activities in response to sentinel events. The accreditation process includes all full accreditation surveys and, as appropriate, for-cause surveys, and random validation surveys specific to Evidence of Standards Compliance (ESC).

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events are called “sentinel” because they signal the need for immediate investigation and response.
- The terms “sentinel event” and “error” are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

II. Goals of the Sentinel Event Policy
The policy has four goals:
1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To focus the attention of a hospital that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organizational culture), and on changing the hospital’s culture, systems, and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention
4. To maintain the confidence of the public and accredited hospitals in the accreditation process
Reviewable Sentinel Events

- The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition.

or

- The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition):
  - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
  - Unanticipated death of a full-term infant
  - Abduction of any patient receiving care, treatment, and services
  - Discharge of an infant to the wrong family
  - Sexual abuse/assault (including rape)
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
### Table 1. Examples of Sentinel Events That Are Reviewable Under The Joint Commission’s Sentinel Event Policy

**Note:** This list may not apply to all settings.

Examples include the following:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient’s body, on the wrong site on the patient’s body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery
So what is the scope of activities of your PI program?

- Is the scope your PI program to include an overall assessment of the efficacy of the PI activities with a focus on continually improving the care provided at your hospital?

- Does it look at indicators for both process and outcome?

- Are the indicators objective, measurable, and based on current knowledge and experience?
<table>
<thead>
<tr>
<th>STK</th>
<th>STROKE</th>
</tr>
</thead>
<tbody>
<tr>
<td>STK-1</td>
<td>Venous Thromboembolism (VTE) Prophylaxis</td>
</tr>
<tr>
<td>STK-2</td>
<td>Discharged on Antithrombotic Therapy</td>
</tr>
<tr>
<td>STK-3</td>
<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
</tr>
<tr>
<td>STK-4</td>
<td>Thrombolytic Therapy</td>
</tr>
<tr>
<td>STK-5</td>
<td>Antithrombotic Therapy by End of Hospital Day 2</td>
</tr>
<tr>
<td>STK-6</td>
<td>Discharged on Statin Medication</td>
</tr>
<tr>
<td>STK-8</td>
<td>Stroke Education</td>
</tr>
<tr>
<td>STK-10</td>
<td>Assessed for Rehabilitation</td>
</tr>
<tr>
<td></td>
<td><strong>VENOUS THROMBOEMBOLISM</strong></td>
</tr>
<tr>
<td>VTE-1</td>
<td>Venous Thromboembolism Prophylaxis</td>
</tr>
<tr>
<td>VTE-2</td>
<td>Intensive Care Unit Venous Thromboembolism Prophylaxis</td>
</tr>
<tr>
<td>VTE-3</td>
<td>Venous Thromboembolism Patients with Anticoagulation Overlap Therapy</td>
</tr>
<tr>
<td>VTE-4</td>
<td>Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol</td>
</tr>
<tr>
<td>VTE-5</td>
<td>Venous Thromboembolism Discharge Instructions</td>
</tr>
<tr>
<td>VTE-6</td>
<td>Incidence of Potentially-Preventable Venous Thromboembolism</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT Core Measure Group</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCIP</td>
<td><strong>SURGICAL CARE IMPROVEMENT PROJECT</strong></td>
</tr>
<tr>
<td></td>
<td>OP-6 Timing of Antibiotic Prophylaxis (Prophylactic ABX initiated within 1 Hr. prior to Surgical Incision)</td>
</tr>
<tr>
<td></td>
<td>OP-7 Antibiotic Selection</td>
</tr>
<tr>
<td>ED</td>
<td><strong>ED -THROUGHPUT</strong></td>
</tr>
<tr>
<td></td>
<td>OP-18 Median time from ED arrival to ED departure for discharged ED patients</td>
</tr>
<tr>
<td></td>
<td>OP-19 Transition record with specified elements received by discharged patients</td>
</tr>
</tbody>
</table>
What is the Scope of Your PI Program?

- Medication therapy/medication use
  - Includes medication reconciliation
  - Includes the use of dangerous abbreviations
- Threats to patient safety
  - Such as falls, patient identification, trauma
- Infection control system, including healthcare associated infections (HAI)
- Utilization Management System
- Patient experience or patient satisfaction
What is the Scope of Your PI Program?

- Discrepant pathology reports
- Unanticipated deaths, adverse and/or sentinel events
- Adverse event/near miss
- Physical Environment Management Systems
- Operative and invasive procedures
  - Including wrong site/wrong patient/wrong procedure surgery
- Anesthesia/moderate sedation, Complaints
- Blood and blood components, blood incompatibility
- Restraint use/seclusion use and injury
What is the Scope of Your PI Program?

- Effectiveness of pain management system
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of four hours
- ED throughput with median time from ED arrival to ED departure for discharged patients
- ED door to door diagnostic evaluation by QMP
- Patients who are AMA or LWBS
- Median time to pain management for long bone fractures
What is the Scope of Your PI Program?

- Timing of antibiotics within 1 hour of surgical incision and antibiotic selection
- Other adverse events, CaUTI, SSI, air embolism
- Critical and/or pertinent processes, both clinical and supportive
- Medical record delinquency
- Other aspects of performance that assess process of care, hospital service and operation
- Contract reviews, immunizations, SCIP, Hospital based inpatient psych services, VTE, stroke, etc.
Program Data: The PI program must incorporate quality data

This must include patient care data and other relevant data

For example, information submitted to or received from the hospital’s QIO

- Hospital works with QIO on quality project to reduce falls, readmissions, and to reduce SSI, CaUTI, CDI and CLABSI
Abbreviations

- Central line bloodstream infections (CLABSI)
  - Catheter-associated urinary tract infections (CAUTI)
  - Clostridium difficile infections (CDI)
  - Surgical site infections (SSI)
The hospital must use data collected to monitor the effectiveness and safety of services and quality of care.

- Data shows that hospital reduced their fall rate by 25% after new initiatives were implemented.
- Hospital reduced their CaUTI rate by 40%.

The frequency and detail of data must be specified by the board.

- Some data may be collected quarterly while some may be collected monthly.
What’s in Your PI Plan?

<table>
<thead>
<tr>
<th>General Hospital PI Plan</th>
<th>POLICY NUMBER: 114.104</th>
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<tr>
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**PURPOSE**

The purpose of the Organizational Performance Improvement Plan at General Hospital is to ensure that the Board of Directors, medical staff and professional service staff demonstrate a consistent endeavor to deliver care that is optimal in an environment of minimal risk.

In keeping with General Hospital’s mission:

To be dedicated to providing a healing environment for maintaining and improving the health of residents of the district as well as providing quality healthcare services to those persons visiting or traveling through the district. In carrying out this mission, the DISTRICT will provide a coordinated range of services including acute inpatient and outpatient services, long-term care, education, referral services and recruitment of healthcare personnel to the area.

In support of this Mission, the hospital is pledged to:

- Foster a trust relationship with the communities served which includes broad-based community involvement in the development of services and programs.
- Promote a commonality of goals, objectives, and expectations within the community of
General Hospital Core Values:

- **UNDERSTANDING**: Exhibited by the presence of receptivity, assessable and generosity. Creating an environment for fruitful communication.
- **TRUST**: Our behavior is composed of sincerity, mutual respect and genuineness leading to honest communication.
- **LEADERSHIP**: We each take responsibility in creating a positive organization in which our values can flourish. We lead by modeling "we go there first".
- **QUALITY**: Is our constant commitment as evidenced by positive customer outcomes, financial performance, and continuous operational improvement.
- **ACCOUNTABILITY**: Taking ownership of our responsibilities and actions and following through to contribute to the success of our organization.

The Organizational Performance Improvement Plan allows for a systematic, coordinated and continuous approach to process design and performance measure analysis and improvement, focusing upon the aspects and dimensions that address this mission and values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the Performance Improvement activities at General Hospital. The Organizational Performance Improvement Program, established by the medical staff and interdisciplinary Performance Improvement Committee, with support and approval from the Board of Directors, has the responsibility for monitoring every aspect of patient care, from the time the patient enters the hospital through diagnosis, treatment, recovery and discharge in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

**GOALS OF Performance Improvement:**

The primary goal of the Organizational Performance Improvement Plan is to continually and
systematically plan, design, measure, assess and improve performance of hospital-wide key functions and processes relative to patient care. To achieve the primary goal, the plan strives to:

- Incorporate quality planning throughout the facility: Provide a systematic mechanism for the facility's appropriate individuals, departments and professions to function collaboratively in their efforts toward Performance Improvement.

- Provide for a hospital-wide program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others.

- Assure that the improvement process is organization-wide, monitoring, assessing and evaluating the quality and appropriateness of patient care and clinical performance to identify changes that will lead to improved performance and reduce the risk of sentinel events.

- Achieve and sustain improvements made in performance throughout the organization.

- To demonstrate our ability to consistently provide services that meets customer and applicable statutory and regulatory requirements.

- To enhance customer satisfaction through the effective application of the system, including processes for continual improvement of the system and the assurance of conformity to customer.

- Appropriate reporting of information to the Board of Directors to provide it with the information it needs in fulfilling its responsibility for the quality of patient care and safety is a required mandate of this plan.
Scope of Activities of the PI Plan

- Necessary information is to be communicated among department/services when problems or opportunities to improve patient care involve more than one department/service.

- The status of identified problems is tracked to assure improvement or problem resolution.

- Information from departments/services and the findings of discreet Performance Improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.

The objectives, scope, organization and mechanisms for overseeing the effectiveness of planning, designing, measuring, analyzing and improving performance via the Performance Improvement Program are evaluated annually and revised as necessary. Important key aspects and processes of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, those tending to produce problems for patients, their families or staff, and those that may lead to sentinel events.

SCOPE OF ACTIVITIES:

The scope of the Organizational Performance Improvement Program includes an overall assessment of the efficacy of Performance Improvement activities with a focus on continually improving care provided throughout General Hospital. The program consists of three focus components:

Performance Improvement, quality assessment/improvement and quality control activities. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by all appropriate departments/services and disciplines of the facility in an effort to improve organizational performance. These indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid performance
measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time.

The X trending reports are tools to be utilized by the facility to identify problems and assure improvement. X documents and reports shall remain confidential and protected. X reports and documents shall be transmitted to the Medical Staff Performance Improvement Committee through the Performance Improvement Coordinator.

The scope of the Organizational Performance Improvement Program includes performance of the following medical staff functions:

The monitoring, assessment, and of performance of patient care and the clinical performance of all individuals with clinical privileges. At monthly/bimonthly meetings of medical staff service committees, findings of the continuous Performance Improvement activities of the medical staff and all appropriate departments/services and disciplines that impact patient care and medical staff services within the medical staff service committee will be reviewed, assessed and evaluated.

The functions to be measured at a minimum will include the following (as applicable):

- Evaluation of all patient care services and other services provided affecting patient health and safety, quality and appropriateness of the diagnosis and treatment (including outcomes) provided by the PA, NP and nursing staff. This evaluation must be performed by a staff or contract Physician; (485.616(b), 485.641(b)(1); 485.641(b)(3)
- Credentialing and quality and appropriateness of the diagnosis and treatment (including outcomes) provided by Physicians. This credentialing and clinical review must be performed by: (485.616(b), 485.641(b)(4),485.603(c)
- Participation in QualityNet (QIO) measures (485.616(b)(2); 485.641(b)(4)(ii), 485.603(c)(2)
- Annual credentialing and quality review by California Critical Access Hospital Network (CCAHN) or other qualified entity (another CAH or any licensed firms, businesses, or agencies
Scope of PI Plan and Program

that provide credentialing and QA services, an entity qualified by the state rural health care plan). (485.616(b)(3); 485.641(b)(4)(iii); 485.603(c)(3)

- Threats to patient safety; 485.641(b)(1), (i.e. falls, patient identification, injuries)
- Medication therapy/medication use; (this may include medication reconciliation and the use of dangerous abbreviations; 485.641(b)(2), 485.635(a)(3)(v)
- Infection control system, including hospital acquired infections (HAI); 485.641(b)(2); 485.635(a)(3)(vi)
- Utilization Management System; 485.641(a)(1)(i)
- Customer satisfaction, both clinical and support areas;
- Discrepant pathology reports;
- Unanticipated deaths, adverse and/or sentinel events;
- Adverse event/near miss; and,
- Physical Environment Management Systems
- Operative and invasive procedures; (including wrong site/wrong patient/wrong procedure surgery)
- Anesthesia/moderate sedation;
- Blood and blood components
- Restraint use/seclusion;
- Effectiveness of pain management system;
- Patient flow issues, to include reporting of patients held in the Emergency Department in excess of eight hours.
- Other adverse events;
- Critical and/or pertinent processes, both clinical and supportive;
- Medical record delinquency;
- Other aspects of performance that assess process of care, hospital service and operation

Internal Audits (8.2.2) shall be conducted taking into consideration the status and importance of the processes and areas to be audited, as well as the results of previous audits. For a list of internal audits conducted refer to the "Hospital-Wide Quality Assessment and Performance Improvement"
Board is Responsible for Quality of Care

Plan”.

Relevant findings from Performance Improvement activities performed are considered part of:

- Reappraisal/reappointment of medical staff members;

- The renewal or revision of the clinical privileges of individuals who practice independently;

- The mechanism used to appraise the competence of all those individuals not permitted by the hospital to practice independently.

ORGANIZATION:

To achieve fulfillment of the objectives, goals and scope of the Organizational Performance Improvement Plan, the organizational structure of the program is designed to facilitate an effective system of measuring, analyzing and improving the care and services provided throughout General Hospital. The Performance Improvement Director is responsible to ensure the effectiveness of the Performance Improvement Program for the District.

The Board of Directors is responsible for the quality of patient care provided.

The Board of Directors requires the medical staff to implement and report on the activities and the mechanisms for process design and performance measurement, analysis and improvement; monitoring, assessing and evaluating the quality of patient care, for identifying and reducing the risk of sentinel events; for resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect effect on patient care, including management and administrative functions.

The Board of Directors provides for resources and support systems for the Performance Improvement
Role of MEC in PI Plan and Program

functions and risk management functions related to patient care and safety.

The Board of Directors has a responsibility to evaluate the effectiveness of the Performance Improvement activities performed throughout the hospital and the Organizational Performance Improvement Program as a whole to assure that improved performance is achieved and sustained.

With authority delegated by the Board of Directors, the medical staff strives to improve and assure the provision of quality patient care through the monitoring, assessment and evaluation of performance measurement and outcome.

The medical staff provides effective mechanisms to monitor, assess and improve the quality and appropriateness of patient care and the clinical performance and competency of all individuals with delineated clinical privileges. Performance Improvement opportunities are addressed, with improvement strategies and actions implemented, to assure improved performance is achieved and sustained.

The Medical Executive Committee delegates the oversight responsibility for performance activity monitoring, assessment and improvement of patient care services provided throughout the facility to the Performance Improvement Committee and Medical Staff Performance Improvement Committee.

With designated responsibility from the Performance Improvement Committee, Performance Improvement (PI) Teams will operate as functional groupings of individuals in the organization who meet to evaluate and improve a specific process, system or function within the hospital. Performance Improvement Teams are comprised of departmental leaders, medical staff on an as needed basis, and those individuals designated from each department, as appropriate, who may have the highest degree of knowledge regarding a given Performance Improvement topic.

Performance Improvement teams meet as necessary and are defined by the team, to perform the Performance Improvement processes required for improving processes involved in patient care and organizational function. Team reporting is performed at the organizational Performance Improvement
Hospital Uses PDCA and FOCUS

Team level, through the Organizational Performance Improvement Committee and medical staff committees, as appropriate. Performance Improvement team activity may also be incorporated into individual departmental Performance Improvement programs as the activity relates to that department.

METHODOLOGY:

FOCUS - PDCA process is utilized to plan, design, measure, assess and improve functions and processes related to patient care and service throughout the organization:

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>PDCA</th>
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<tbody>
<tr>
<td>Find the process to improve</td>
<td>Plan the improvement</td>
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<tr>
<td>Organize to improve the process</td>
<td>Do the improvement</td>
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<tr>
<td>Clarify current knowledge of the process</td>
<td>Check the results</td>
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<tr>
<td>Understand the process improvement</td>
<td>Act to hold the improvement</td>
</tr>
<tr>
<td>Select the process improvement</td>
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</table>

Responsibility
Assign responsibility for monitoring, assessing and improving performance.

Scope
Delineate the scope of care and services provided;

Important Aspects/Processes
Identify important key aspects of care, focusing on those aspects and processes that relate to the health and safety of the patients services, or that may result in a sentinel event if not optimally managed.

Measurement
Identify objective and statistically valid performance measures for monitoring and improving performance aspects/processes of care. Performance measures include processes performance
Focus on High Risk and High Volume

measures and outcome performance measures that affect a large percentage of patients; and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or are likely to be problem prone; and/or may result in sentinel events.

Performance measures are structured to focus on high risk, high volume, high cost, or problem prone areas; are based on current knowledge and clinical experience; and are structured to reflect cross-departmental, interdisciplinary processes, as appropriate. Measures will be further categorized whether the focus is to evaluate:
- Health Outcome
- Patient Safety
- Quality Care
- Medical Error/Adverse Events
- Satisfaction
- Quality Control and
- Compliance

The following criteria are utilized when determining appropriate performance measures to utilize to improve performance:

- The measure can identify the events it was intended to identify;
- The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable;
- The measure has defined data elements and allowable values;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities;
- The data intended for collection are available and accessible;
- Results can be reported in a manner that is useful to the organization and other interested healthcare participants.
Collect Data and Monitor

Data Collection: Monitor, assess and improve the important aspects/processes of care by assessment of data collected. Collected data allows the hospital to:

- Monitor its performance;
- Monitor performance of areas targeted for further study;
- Monitor the performance of processes that involve risks or may result in sentinel events (i.e. Quantros Report);
- Make informed judgments about the stability of existing processes; Identify opportunities for incrementally improving processes;
- Identify the need to redesign processes;
- Decide whether improvements or redesign of processes meet objectives. Data collection focuses upon:

Processes, particularly those that are high-risk, high-volume, problem-prone and/or may result in sentinel events; Outcomes; Comprehensive performance measures; Other gauges of performance; Evaluate/Analyze; Aggregating, analyzing and evaluating data allows the hospital to draw conclusions about its performance in relation to a process or the nature of an outcome. The following criteria are considered during data analysis and evaluation:

- Were the design specifications for new processes met?
- What is the current level of performance? How stable are current processes?
- What are the priorities for possible improvement of existing processes or implementation of
Identify Change and Implement

new processes?

- Is the data displayed utilizing appropriate statistical techniques to allow for optimal analysis?
- Does analysis include internal (historical) and external data comparison? Is internal and external data displayed in a format that allows for comparison over time?
- Does the data include information that will lead to the reduction of sentinel events?
- Was a strategy to stabilize or improve performance effective (as appropriate)?

**Identify Change**
Changes required to improve performance and reduce the risk of sentinel events are identified based on the analysis of data, either from ongoing monitoring or targeted study results.

**Improve**
Implement actions to improve the performance of new or existing processes, systems and/or functions, as well as to reduce or eliminate sentinel events.

**Evaluate**
Evaluate whether the change(s) implemented and actions taken to improve have been effective, documenting the achievement of improved performance, monitoring the aspect/process until there is documented proof that the improvement is (or can be) sustained.

**Report**
Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services, the Hospital Performance Improvement Committee, Medical Staff Performance Improvement Committee and to the Governing Body.

Any variation, or deficiency identified shall be addressed by appropriate corrective or preventive
Quality Improvement Activities

- Standard: The hospital must collect data to identify opportunities for improvement.
- Standard: Hospital must set priorities that focus on high risk, high volume, or problem prone areas.
- Must consider the incidence, prevalence, and severity of problems in those areas.
- Look at issues that affect health outcomes, patient safety and quality of care.
- Track performance to ensure improvements are sustained.
Standard: PI program must include indicators to identify and reduce medical errors
- Track medical errors and ADE

Analyze their causes and implement preventive actions
- Example would be a RCA or root cause analysis

Board is responsible for the operations of the hospital

Medical staff and administrative staff are accountable to make sure clear expectations for safety
Identify and Reduce Medical Errors

- Need a system that includes feedback and learning throughout the hospital

- First, the hospital need to identify that there is a medical error
  - It needs to be reported into the PI system
  - Risk management and hospital staff cannot fix a problem they do not know exists

- Second, the hospital evaluates it to determine what processes can be put in place to prevent it from occurring

- RCA and FMEA are two tools that can be used
Identify and Reduce Medical Errors

- Medical errors may be difficult to detect in hospitals and are under reported
- Make sure incident reports filled out for errors and near misses
- Are there any diagnostic errors, equipment failures, blood transfusion injuries, or medication errors
- Trigger tools by IHI can assist in finding medical errors and opportunities for improvement
Trigger Tool for Measuring Adverse Drug Events

**Trigger Tool for Measuring Adverse Drug Events**

The use of "triggers," or clues, to identify adverse drug events (ADEs) is an effective method for measuring the overall level of harm from medications in a health care organization. The Trigger Tool for Measuring Adverse Drug Events provides instructions for conducting a retrospective review of patient records using triggers to identify possible ADEs. This tool includes a list of known ADE triggers and instructions for collecting the data you need to measure the number of ADEs per 1,000 doses and the percentage of admissions with an ADE.

NOTE: You can use this tool in conjunction with the Interactive Trigger Tool for Measuring ADEs in the Workspace area on IHI.org. Enter your detailed data from all of your ADE Patient Record Review Sheets into the interactive Trigger Tool for Measuring ADEs. The Tool will automatically calculate and graph two measures: ADEs per 1,000 Doses and Percent of Admissions with an ADE.

**This tool contains:**
- Background
- List of ADE Triggers
- General Instructions
Resources


PI Projects  297

- Standard: Hospital must conduct PI projects
- How many the hospital does depends on how big they are and what types of services are provided
- May develop and information technology system to improve patient safety and quality
- Document the projects and reasons for doing
- Can participate in a QIO project or do one that is of comparable effort
QIO to advance quality of care for Medicare patients

Every state has a QIO or Quality Improvement Organization under contract by CMS

Sign up with your state QIO to get newsletters and other information

CMS has a website on information about QIOs

CMS has the mission to improve services provided to Medicare patients
Quality Improvement Organizations

What are QIOs?

CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, to serve as that state/jurisdiction’s Quality Improvement Organization (QIO) contractor. QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care. QIO contracts are 3 years in length, with each 3-year cycle referenced as an ordinal “SOW.”

What do QIOs do?

By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Based on this statutory charge, and CMS’ Program experience, CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints, provider-based notice appeals, violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Why does CMS have QIOs?

CMS relies on QIOs to improve the quality of health care for all Medicare beneficiaries. Furthermore, QIOs are required under Sections 1152-1154 of the Social Security Act. CMS views the QIO Program as an important resource in its effort to improve quality and efficiency of care for Medicare beneficiaries. Throughout its history, the Program has been instrumental in advancing national efforts to motivate providers in improving quality, and in measuring and
List of QIOs

Medicare: Quality Improvement Organizations (QIOs) work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations.

QIOs safeguard the integrity of the Medicare program by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

Under the direction of the Centers for Medicare & Medicaid Services (CMS), the Medicare QIO program consists of a national network of 53 QIOs responsible for each U.S. state, territory, and the District of Columbia. To locate a QIO, select the state below.

State: select...

<table>
<thead>
<tr>
<th>State</th>
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<td>Alabama</td>
<td>AQAF <a href="http://www.aqaf.com">www.aqaf.com</a></td>
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<tr>
<td>Alaska</td>
<td>Mountain-Pacific Quality Health <a href="http://www.mpqhf.org">www.mpqhf.org</a></td>
<td>800-497-8232</td>
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<td>Arizona</td>
<td>Health Services Advisory Group, Inc. <a href="http://www.hsaq.com">www.hsaq.com</a></td>
<td>602-264-6382</td>
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<td>Arkansas Foundation for Medical Care <a href="http://www.afmc.org">www.afmc.org</a></td>
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<td>Health Services Advisory Group of California, Inc. <a href="http://www.hsaq.com">www.hsaq.com</a></td>
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<td>Connecticut</td>
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<td>Delaware</td>
<td>Quality Insights of Delaware <a href="http://www.qide.org">www.qide.org</a></td>
<td>302-478-3600</td>
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<tr>
<td>Columbia</td>
<td>Florida FHMQAI <a href="http://www.fmqai.com">www.fmqai.com</a></td>
<td>800-564-7490</td>
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</table>
Data Collection (\& CART)
Hospitals - Outpatient

CART, the CMS Abstraction & Reporting Tool, is a powerful application for the collection and analysis of quality improvement data. Through data collection, retrospective analyses and real-time reporting, CART enables hospitals to comprehensively evaluate and manage quality improvement efforts. Whether a hospital is seeking Medicare certification or undertaking its own quality improvement initiatives, CART is ideal for the data collection and analyses that are essential to the success of all quality improvement efforts. The application is available at no charge to hospitals or other organizations seeking to improve the quality of care in the following clinical areas:

- Acute Myocardial Infarction
- Chest Pain
- Emergency Department (ED) – Throughput
- Pain Management
- Stroke
- Surgery

CART- Outpatient is available for use on a stand-alone, Windows-based computer, in a computer network or in environments without computing resources (paper tool).
### Clinical Quality Measures

Please note: The CQM's and Value Sets defined in the final rule for stage 2 of meaningful use are not linked to a specific stage of meaningful use but rather to an implementation year (2014) and they are therefore referenced as 2014 CQMs or 2014 eCQMs. All participants in the EHR Incentive Program must report on the 2014 CQMs beginning in 2014 whether they are in stage 1 or stage 2 of meaningful use.

![Screenshot of AHRQ Health Information Knowledgebase](https://ushik.ahrq.gov/QualityMeasuresListing?system=mu&stage=Stage+2&filter520=Eligible%20Hospitals&sortField=570&sortDirection=ascending&filter590=April+2014+EH&enableAsynchronousLoading=true)

#### Table of Clinical Quality Measures

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<th>Name</th>
<th>Eligibility</th>
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<td>April 2014 EH</td>
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Executive Responsibilities  309

- Standard: Board assumes full legal authority and responsibility for the operations of the hospital

- Medical Staff and Administrative officials are responsible and accountable for the following:
  - Ongoing PI program that includes patient safety including reducing medical errors
  - Hospital wide PI and patient safety program
  - A determination of the number of PI projects that is conducted annually
Standard: The board, Medical Staff, and Administrative Officials are accountable for measuring, assessing, improving and sustaining the hospital’s performance.

This also requires reducing risk to patients.

Example: hospitals created a process to ensure MI patients got their thrombolytics timely, that PCI was done before 90 minutes and pneumonia patients got their antibiotics and blood culture timely.

Process to make sure the improvements continue.
QAPI Patient Safety

- This means people who can attend meetings, data so analysis can be made and other resources

- Safer IV pumps, new anticoagulant program, implement central line bundle, sepsis, and VAP bundle, preventing inpatient suicides, wrong site surgery, retained FB, new processes for neuromuscular blocker agents, implement policy on Phenergan administration and Fentanyl patches

- So what’s in your PI and Safety Plans?
National Quality Forum  NQF

- NQF is an excellent resource
- Has the ABCs of measurement
- A list of NQF endorsed standards
- A list of consensus projects
- Resources
- Can do a search of measures such as AAA repair mortality rate, accidental puncture or laceration rate, 30 day post hospital MI discharge care transition rate, stroke mortality rate, adherence to medication for diabetic patients, etc.
AHRQ Has Excellent Resources

You Are Here: AHRQ Home > Quality & Patient Safety

Quality & Patient Safety

CAHPS®—Consumer Assessment of Healthcare Providers and Systems
Consumer feedback — survey and report tools — fact sheet — impact

Health Information Technology
Electronic health records — innovation — privacy — international standards — data sources — clinical vocabulary

Measuring Healthcare Quality
Studies and projects — standardized methods — performance measures

Medical Liability & Patient Safety Initiative
Funding announcements — technical assistance — fact sheet

National Quality Measures Clearinghouse™
Evaluate health care quality — online database — process — outcome — access — patient experience

Patient Safety & Medical Errors
Research program — patient safety tools — patient tips

Quality Diagnostic Tools for States
Events & technical assistance opportunities — quality improvement tools

Quality Indicators
Hospital quality measures — prevention — inpatient — patient safety

Quality Indicators—Hospital Toolkit
Hospital quality measures — inpatient — patient safety — quality improvement
Quality Indicator Toolkit

AHRQ Quality Indicators™ Toolkit for Hospitals

Improving Performance on the AHRQ Quality Indicators

This toolkit is designed to help your hospital understand the Quality Indicators (QIs) from the Agency for Healthcare Research and Quality (AHRQ), and support your use of them to successfully improve quality and patient safety in your hospital. The toolkit is a general guide to using improvement methods, with a particular focus on the QIs. It focuses on the 17 Patient Safety Indicators (PSIs) and the 28 Inpatient Quality Indicators (IQIs).

Select to download the print version of the introduction (PDF File, 180 KB). Plugin Software Help.

Select to download the entire toolkit (PDF Portfolio, 11.5 MB) [Plugin Software Help]; Zipped Word®, PowerPoint®, and Excel® Files, 2.3 MB).

Select to download individual sections from the AHRQ Quality Indicators™ Toolkit Roadmap.

Introduction

This toolkit is designed to help your hospital understand the Quality Indicators (QIs) from AHRQ, and support your use of them to successfully improve quality and patient safety in your hospital. Created by the RAND Corporation and the University HealthSystem Consortium with funding from AHRQ, it is available for all hospitals to use free of charge. The toolkit is a general guide to using improvement methods, with a particular focus on the QIs. For more information, select for the AHRQ Quality Indicators™ Toolkit for Hospitals. Fact Sheet.

The AHRQ QIs use hospital administrative data to assess the quality of care provided, identify areas of concern in need of further investigation, and monitor progress over time. This toolkit focuses on the 17 Patient Safety Indicators (PSIs) and the 28 Inpatient Quality Indicators (IQIs). More information on the QIs is available in the Fact Sheets on the IQIs and PSIs (Tools A.1a and A.1b).

A Sequence of Steps for Improvement. The complete improvement process includes the following sequence of steps, in which you will set priorities and plan for performance improvements on the QIs, implement improvement strategies, and sustain improvements achieved:

- Determining Readiness To Change.
- Applying QIs to the Hospital Data.
- Identifying Opportunities for Improvement.
- Selecting the Right Improvement Strategies.
- Implementing Improvement Strategies.
- Monitoring Results.
Patient Safety Indicators

AHRQ Quality Indicators

Quality Indicator User Guide: Patient Safety Indicators (PSI) Composite Measures
Version 4.4

Prepared for:
Agency for Healthcare Research and Quality
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540 Gaither Road
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http://www.qualityindicators.ahrq.gov

Contract No. HHSA290201200001C

Prepared by:
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505 King Avenue
Columbus, OH 43201
Types of Indicators; Inpatient, PS, Peds

Introduction
The Agency for Healthcare Research and Quality (AHRQ) has developed an array of health care decision making and research tools that can be used by program managers, researchers, and others at the Federal, State and local levels. The Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The current AHRQ QI modules expand HCUP QIs. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- **Prevention Quality Indicators** identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care. (first released November 2000, last updated March 2012)
- **Inpatient Quality Indicators** reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. (first released May 2002, last updated March 2012)
- **Patient Safety Indicators** reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. (first released March 2003, last updated March 2012)
- **Pediatric Quality Indicators** use indicators from the other three modules with adaptations for use among children and neonates to reflect quality of care inside hospitals, as well as geographic areas, and identify potentially avoidable hospitalizations. (first released April 2006, last updated March 2012)

The AHRQ QIs are used in free software distributed by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

NEWS
2013

- **February 8, 2013** — Federal Register Notice for a time-limited workgroup and a standing workgroup
- **February 4, 2013** — AHRQ QI Newsletter Issue 1
- **January 4, 2013** — AHRQ QI User Survey Available (Click here to participate)
<table>
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<td>(Pediatric) ESRD Patients Receiving Dialysis: Hemoglobin Level &lt; 10g/dL</td>
<td>1667</td>
<td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)</td>
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COMMENT: Gastrointestinal / Genitourinary Stage 2 – through May 24

COMMENT: Common Formats for Patient Safety Data: Version 1.2 – open comment period

www.qualityforum.org/Home.aspx
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The End! Questions??

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