GREATER NEW YORK HOSPITAL ASSOCIATION

Medical Malpractice Medicaid Redesign Work Group

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October 17, 2011

Background

1985: Medical Malpractice Crisis in New York State

- Incident reporting – increase transparency, mandatory review and corrective actions
- Med mal prevention – physician profiling, more stringent privileging and credentialing criteria

1999: To Err is Human, *Building a Safer Health System*

- Medical errors in hospitals

2001: Institute of Medicine "*Crossing the Quality Chasm: A New Health System for the 21st Century*"

- Health care needs to be: safe, effective, patient centered, timely, efficient, and equitable

2007: Institute for Healthcare Improvement Triple Aim

- Better health, better care, lower costs

Incident Reporting/NYPORTS

- NY one of the first states to mandate incident/adverse event reporting by health care providers
- Serious events with injury require root cause analysis and corrective action implementation
- DOH periodically reports on lessons learned to prevent like occurrences
- NYPORTS reporting trends:
  - More procedures reported than non-procedural events
  - Some variation in reporting exists

Centers for Medicare & Medicaid Services (CMS) Quality Improvement Program

Pay for Reporting

- Public reporting of hospital performance on key measures through the CMS Hospital Compare Web site (2003)
- CMS' goal to incentivize improved performance and inform consumer health care decisions
- Over time the measures have been expanded
  - Process measures, such as aspirin on arrival and at discharge for cardiac patients
  - 30-day risk adjusted mortality rates for AMI, heart failure and pneumonia
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care
  - 30-day risk adjusted readmission rates

CMS Quality Improvement Program (cont'd)

Pay for Performance

- Health Care-Acquired Conditions (HACs)
  - Medicare – Never events → HACs
  - NY Medicaid – Serious adverse events (2008) → Medicaid HACs (2011)
- Value-Based Purchasing – FY 2013
- Readmissions Penalties
  - Medicare – FY 2013
  - Medicaid – Discharges July 2010 →

Adverse events with payment impact

	Medicare			Medicaid
Measure	**DRG Suppression Policy**	**IPPS Hospital IQR**	**VBP**	**NY SAE Policy***
Foreign Object Retained After Surgery	✓	✓	✓	✓
Air Embolism	✓	✓	✓	✓
Blood Incompatibility	✓	✓	✓	✓
Stage III and IV Pressure Ulcers	✓	✓	✓	✓
Falls and Trauma	✓	✓	✓	✓
Manifestations of Poor Glycemic Control	✓	✓	✓	✓
Catheter-Associated Urinary Tract Infection	✓	✓	✓	✓
Vascular Catheter-Associated Infection	✓	✓	✓	✓
Surgical Site Infection	✓			✓
Deep Vein Thrombosis/Pulmonary Embolism	✓			✓

* Excludes pediatric and obstetric cases

2008 GAO Report on Adverse Events in Hospitals: Key Issues

- Incidence of events varies widely; measurement is difficult
- Impact of non-payment policies for adverse events
  - Incentive to reduce incidents
- Barriers to complete reporting
- Underreporting exists, however, it is not necessary to report every event to improve practices
- Public reporting of adverse events can drive improvement, but may inhibit full disclosure

GAO Report on Adverse Events: Key Issues (cont'd)

- Strategies that may accelerate progress in reducing the incidence of adverse events in hospitals:
  - More rapid and routine adoption of recommended best practices
  - Data collection:
    - Standardize definitions and streamline reporting requirements
  - Expand the use of electronic health records within and between hospitals to improve communication and continuity of care
  - Monitor the impact of policies to deny hospitals payment for cases complicated by selected adverse events

GNYHA Addresses CMS Policy, GAO Recommendations

Collaborative quality improvement model

- A structured process within which hospitals apply evidence-based medicine and practices to clinical targets
- Provides access to clinical expertise and operational solutions to overcome implementation barriers
- Requires organizational commitment to:
  - Create and promote a culture of safety, including full and complete reporting of adverse events – transparency drives improvement
  - Adopt a "bundle" of evidence-based best practices/strategies to effect and sustain improvement
  - Provide the resources to support staff participation
    - Multi-disciplinary team training and educational programs
  - Collect and act upon data to drive improvement
  - Share successful improvement strategies

Targeting Med Mal Drivers

Perinatal Safety Interventions

- Crew Resource Management (CRM) or other team training programs
- Standardized EFM interpretation and required examination
- Drills of simulated maternal and fetal emergencies
- Culture of safety surveys
- Peer review and anonymous event reporting

Perinatal Safety Interventions: Effective Implementation

Organizations	Outcomes
Yale-New Haven Hospital and MCIC Vermont, Inc.[1]	-Statistically significant decrease in Adverse Outcome Index -Percentage of respondents reporting "good teamwork climate" on SAQ score improved from 38.5% to 55.4%
Catholic Healthcare Partners (CHP)[2]	-Decreased birth trauma rates from 5.0 to 0.17 per 1,000 births -Average cost per obstetrical claim decreased from $1 million to <$500,000
Beth Israel Deaconess Medical Center[3]	-23.0% decrease in adverse events -Nearly 62% decrease in number of high-severity adverse events claims
North Bronx Healthcare Network[4]	-Decreased rate of deliveries complicated by shoulder dystocia from 4% (in 2008) to 1.4% -Negligible rates of Erb's Palsy (0.4% in 2008 to 0.08%) -Decreased number of overall adverse occurrences from 80/month to 35/month
North Shore-LIJ Health System[5]	-Statistically significant decrease in Modified Adverse Outcome Index -Significant decrease in returns to OR, birth trauma

1Pettker C.M., Thung S.F., Norwitz E.R., et al. "Impact of a comprehensive patient safety strategy on obstetric adverse events." *American Journal of Obstetrics & Gynecology* (2009): 200:492.e1-492.e8.
[2]Simpson K.R., Kortz C.C., Knox E. "A comprehensive perinatal patient safety program to reduce preventable adverse outcomes and costs of liability claims." *Joint Commission Journal on Quality and Patient Safety* 35, no. 11 (2009):565-574.
[3]Pratt S.D., Mann S., Salisbury M., et al. "Impact of CRM-Based Team Training on Obstetric Outcomes and Clinicians' Patient Safety Attitudes." *Joint Commission Journal on Quality and Patient Safety* 33, no. 12 (2007): 720-725.
[4]Press Release. NBHN's Women's Health Service Receives Prominent National Association of Public Hospitals and Health Systems Safety Net Patient Safety Award. July 2011. http://www.nyc.gov/html/hhc/html/pressroom/press-release-20110720-nbhn-award.shtml
[5]Wagner B., Meirowitz N., Shah J., et al. "Comprehensive Perinatal Safety Initiative to Reduce Adverse Obstetric Events." *Journal for Healthcare Quality* (2011): 1-10.

GNYHA Perinatal Safety Collaborative Incorporates Proven Practices

- Goal: To reduce adverse events/injury
  - Implementation of evidence-based bundle of protocols and practices to standardize and reduce variation
  - Widespread dissemination and adherence to protocols
  - Teamwork and communication using standardized nomenclature (specifically around EFM interpretation)
    - Use of simulation resources to train and drill on obstetric emergencies
  - Empower frontline staff to initiate early interventions, escalate cases
  - Engage senior leadership to ensure that changes are sustainable

GNYHA Collaborative Results

- Widespread adoption of recommended practices
  - Clinical protocols for oxytocin/Pitocin, hemorrhage, shoulder dystocia, obese patients
- Hospitals scoring well above the national average on safety culture of labor and delivery units
  - Implementation of effective escalation policies
- Effective and sustainable multi-disciplinary EFM training and proficiency testing
- Individual hospital successes

Applying GNYHA Model to Other Med Mal Drivers

Surgical Safety Focus

- Goals:
  - To improve communication among the OR team and reduce variation in practices among individual surgeons
  - To reduce surgical complications
- How:
  - Widespread adoption and effective use of a standard surgical checklist
- Measurement:
  - Regular monitoring of organizational practices (adherence to checklists, time outs, site marking), safety culture, and surgical complications including surgical site infections (SSIs)

Other GNYHA Areas of Focus (cont'd)

Infection Prevention and Reduction

- Goal: To reduce health care-associated infections (HAIs)
  - *Central Line Associated Bloodstream Infections Collaborative*
    - *Results:* Participating hospitals decreased ICU CLABSI rates on average 54%.
  - *Clostridium difficile Collaborative (C.difficile)*
    - Participating hospitals experienced a statistically significant reduction in the rate of hospital associated *C.difficile* infections over a period of 16 months.

Infection Prevention and Reduction

- **Supporting public reporting of HAI rates**
  - NYS Public Health Law requires acute care hospitals in NYS to report select HAIs to the DOH (2007)
  - Current HAI indicators: CLABSIs; SSIs following coronary artery bypass graft (CABG), colon, hip replacement; *C.difficile* infection
    - Highlights from the 4th NYS HAI Report (2010 data)
      - Overall statewide decline in HAIs
      - 37% decrease in CLABs for adult/pediatric/neonatal ICUs since 2007
      - 15% decrease in SSIs since 2007
  - In 2012 HAI reporting will include SSIs associated with abdominal hysterectomy.

Building Clinical Infrastructure

- **Critical Care Leadership Network**
  - Goal: To implement evidence-based practices, and to standardize clinical training, to improve outcomes in critical care.
- ***STOP* Sepsis Collaborative**
  - Goal: To decrease mortality patients with severe sepsis by:
    - Early identification and treatment of sepsis
  - Results: Hospitals are observing an overall reduction in the time it takes for clinical resuscitation goals to be met for serve sepsis patients –a reduction by about 50% from arrival time in ED to treatment; as well as a decrease in time to antibiotic treatment.
- Saving lives through the use of **Rapid Response Systems** (RRS)
  - Results: Statistically significant decrease in RRS utilization and reduction in the rate of non-ICU codes.

Building Clinical Infrastructure and Training

- **Clinical Quality Fellowship Program**
  - Designed to develop the next generation of clinical quality improvement leaders
- Using **health information technology** to create reliable systems and to improve patient care
  - Ongoing implementation of cross setting IT systems to facilitate information exchange
- **Responding to adverse events**
  - Intensive root cause analysis training (1670 hospital staff trained)
  - Building staff communication skills to achieve full and effective disclosure, and apology when warranted

What's next?

CMS Partnership for Patients

- Center for Medicare & Medicaid Innovation (CMMI) will lead efforts to:
  - **Decrease preventable HACs by 40% by 2013**
  - **Reduce hospital readmissions by 20% by decreasing preventable complications during transitions in care by 2013**
  - Save up to $35 billion over 3 years
- CMS has committed a total of $1 billion
  - Support for Hospitals: $500 million to test models of safer care delivery and promote implementation of best practices
  - Support for Community-based Organizations: $500 million for a Community-based Care Transition to support safe transitions from the hospital to other care settings.

CMS Partnership for Patients

Community-based Transitions Program Goals

- Improve transitions of patients from the inpatient hospital setting to home or other care settings
- Improve quality of care
- Reduce readmissions for high risk patients
- Document measureable savings to the Medicare program

Hospital Engagement Contractor (HEC) Goals

- Eliminate Preventable Inpatient Harm
  - HACs
- Improve Care Transitions
  - Readmissions

Partnership for Patients: *The Role of the HEC*

- HECs will:
  - Engage hospitals and other stakeholders
  - Provide education, technical assistance, and support
  - Report regularly to CMS on participant engagement
  - Implement programs using consensus guidelines and materials from the National Content Developer
  - Collect and report data to CMS
  - Engage in other PFP activities
- Federal contract starting October 2011 through September 2013 with option of a third year

Partnership for Patients: Areas of Focus

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism (VTE)
- Ventilator-Associated Pneumonia (VAP)
- Preventable Readmissions
- Culture and Leadership

The HANYS–GNYHA Partnership

- The two organizations have submitted a joint HEC application to:
  - Jointly engage hospitals statewide
  - Maximize resources, and operational, data analytic and research capabilities
  - Promote a single statewide approach

NYSPFP Approach: *Proposed Improvement Activities*

The Collaborative Approach

- **Focus Areas: CAUTI, CLABSI, OB, SSI, VAP, Readmissions**
- Clinical Advisors/Workgroups
- Assessment of practices and reassessment
- Hands on support for hospital implementation teams
- Robust measurement strategy
- Education, training, and program resources
- Regional Support—Web conferences, Office Hours, and Site Visits

The Learning Network Approach

- **Focus Areas: Adverse drug events; Falls; Pressure Ulcers; VTE**
- A strong focus on risk assessment
- Clinical Advisors/Workgroups
- Educational programs
- Measurement and tracking

Culture and Leadership

NYSPFP Approach: *HANYS and GNYHA Role*

- Engage hospitals to join the NYSPFP and reduce the targeted adverse events
- Convene clinical and quality experts to help design program activities and support hospital improvement
- Provide tailored educational programs, in-person facilitated meetings, Webinars/conference calls, and other resources
- Develop data collection tools
- Conduct site visits to help drive improvement and offer consultation
- Design and disseminate hospital-specific and aggregate data reports to monitor results and provide feedback

NYSPFP Approach: *Hospital Participation in NYSPFP*

- Formally commit to participating in the NYSPFP
- Provide necessary resources to support the team, including staff time to devote to these efforts
- Assess existing practices and areas of greatest need for improvement
- Be active participants in the quality improvement activities related to the highest priority topic areas
- Provide regular, timely reports, including details of implemented changes and data on process and outcome measures related to each of the areas of focus

NYS Partnership for Patients

Support

- NYSDOH is strongly considering the NYSPFP to meet quality requirements in NYS Public Health Law calling for the DOH to develop a New York State Hospital Quality Initiative.
- Approximately 140 hospitals across the state have registered their support
- NYSDOH, NYS Congressional Delegation have expressed their support