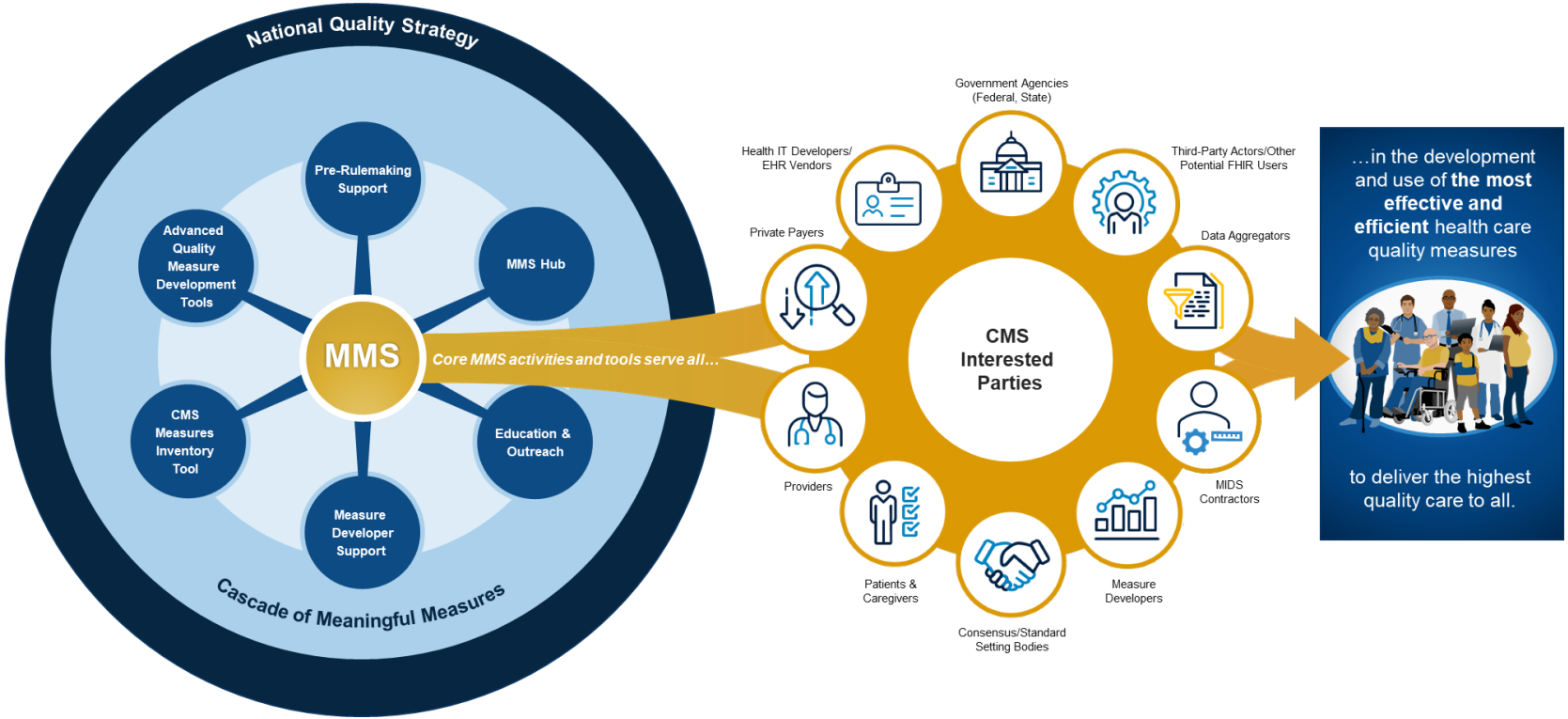
PUBLIC WEBINAR

Quality Counts, Safety Matters

Prioritizing Patient Safety Through Quality Measurement

Precious McCowan, MS
Michelle Schreiber, MD | CMS
Arjun Srinivasan, MD | CDC
Reena Duseja, MD, MS | VHA
Craig A. Umscheid, MD, MS | AHRQ

Measures Management System Overview



Learning Objectives

You will hear:

- A **patient's perspective** on the importance of patient safety.
- **Insights from health care experts** on using quality measurement to drive patient safety improvements.
- How the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), CMS, and the Veterans Health Administration (VHA) are **addressing preventable harms**.

Today's Presenters

- **Precious McCowan**, Patient Advocate
- **Michelle Schreiber**, CMS
- **Arjun Srinivasan**, Centers for Disease Control and Prevention
- **Reena Duseja**, Veterans Health Administration
- **Craig A. Umscheid**, Agency for Healthcare Research and Quality

Presenting the Patient Perspective

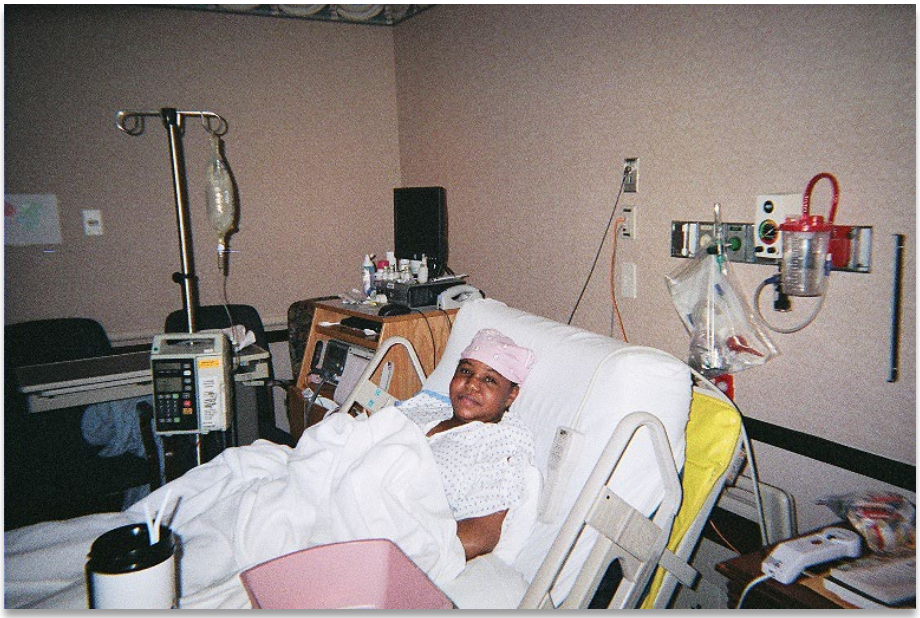
Presenting the Patient Perspective

Precious McCowan, MS

End-Stage Renal Disease (ESRD)

Patient Advocate, Educator, and Mentor

Presenting the Patient Perspective



Presenting the Patient Perspective

CMS Strategies for Patient Safety

Michelle Schreiber, M.D.
Deputy Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Michelle.Schreiber@cms.hhs.gov

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“If I were to tell you that more than 200 people were going to die today from a medical error, you could say, "That can't be," but that's exactly what's happening. We're essentially losing an airplane full of Americans pretty much every day from medical errors, but we don't think about it. But is it still the third, fourth leading cause of death in America?”

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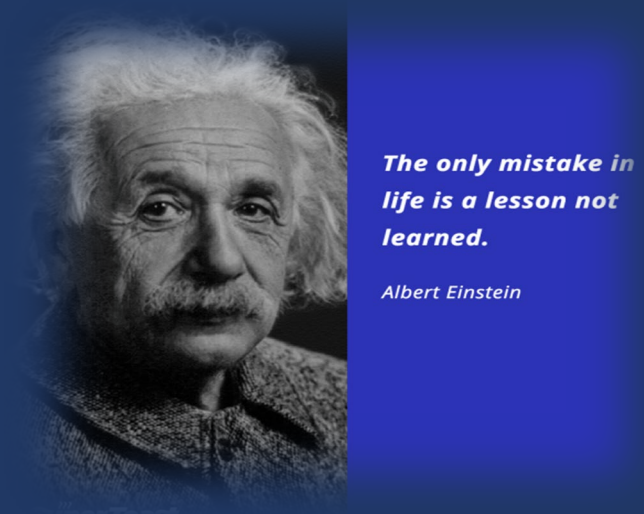
Lessons from COVID Influence Safety Strategy



- Marked reduction in Patient Safety (in some cases nearly eliminating many years of improvement)
- Expansion of digital and telehealth capabilities but need for interoperable data
- Rapid Scientific Advances
- Expanded Collaboration
- Stark Equity Gap
- Nursing Home care issues
- Need for interoperable data
- Resilience challenges - including workforce

CMS National Quality Strategy Goals

The Eight Goals of the CMS National Quality Strategy are Organized into Four Priority Areas:

Equity

Advance health equity and whole-person care

Engagement

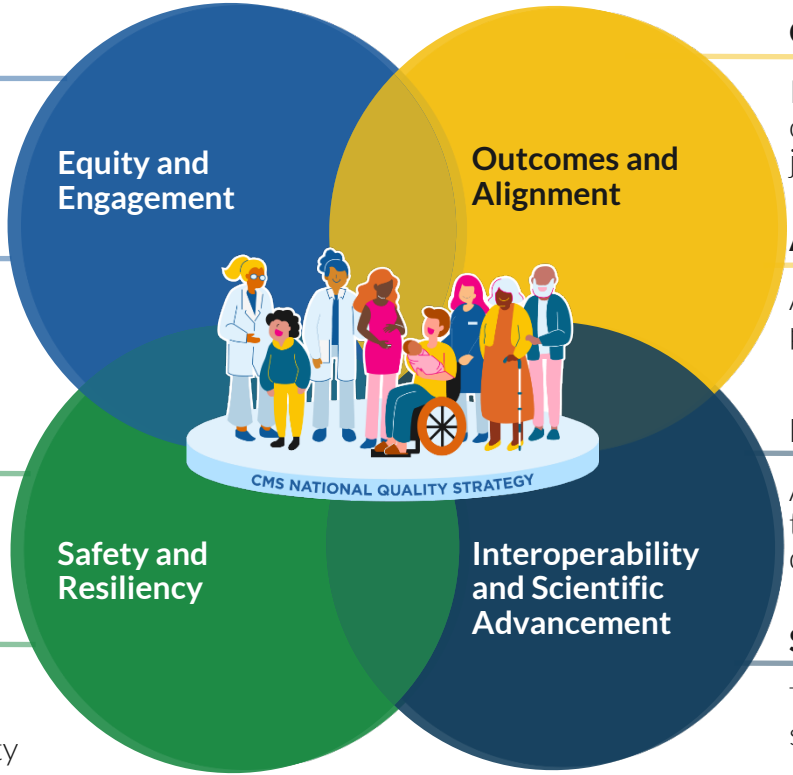
Engage individuals and communities to become partners in their care

Safety

Achieve zero preventable harm

Resiliency

Enable a responsive and resilient health care system to improve quality



Outcomes

Improve quality and health outcomes across the care journey

Alignment

Align and coordinate across programs and care settings

Interoperability

Accelerate and support the transition to a digital and data-driven health care system

Scientific Advancement

Transform health care using science, analytics, and technology

Safety and Resiliency

Safety: Achieve Zero Preventable Harm

OBJECTIVE

Improve performance on key patient safety metrics through the application of CMS levers such as quality measurement, payment, health and safety standards, and quality improvement support.

SUCCESS TARGET

Improve safety metrics with a goal to return to pre-pandemic levels by 2025 and reduce harm by an additional 25% by 2030 through expanded safety metrics, targeted quality improvement, patient engagement, and Conditions of Participation.

HIGHLIGHTED INITIAL ACTIONS

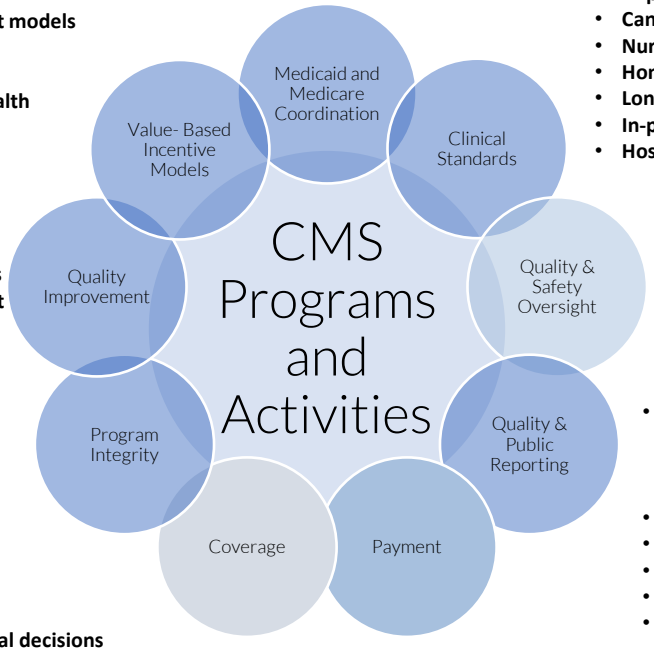
- Implement tracking to show progress towards reducing harm (e.g., healthcare-associated infections) to pre-pandemic levels and beyond.
- Expand the collection and use of safety indicator data across programs, including data on key areas such as maternal health, behavioral health, adverse events, and workforce issues.
- Align across HHS to implement actions from the President's Council of Advisors on Science and Technology (PCAST) to further enhance patient safety.

CMS Quality Levers, Programs & Activities

- 1115 Waivers
- Demonstration programs
- Innovation Accelerator Program

- Advanced Alternative payment models
- ACOs, PCMH, Bundles
- Multi-payer State agreements
- Prevention and Population Health
- Rapid Cycle Evaluation

- Conditions of Participation
- Hospital Inpatient/Outpatient
- In-patient psychiatric hospitals
- Cancer hospitals
- Nursing homes
- Home Health Agencies
- Long-term Care Acute Hospitals
- In-patient rehabilitation facilities
- Hospices



- Quality Improvement Organizations
- Hospital Innovation & Improvement Networks

- CLIA
- Target surveys
- Quality Assurance Performance Improvement
- Survey and Certification

- Provider Enrollment
- Fraud, Waste & Abuse Prevention & Detection
- Medical Review
- Audits and Investigations

- Hospitals, Home Health Agencies, Hospices, ESRD facilities, Post Acute Care, Inpatient Psychiatry, Cancer Hospitals, Clinicians
- MA Stars
- Medicaid Core Sets
- Marketplace QRS
- Quality Measurement/Measures
- Care Compare and Stars Programs

- National & Local decisions
- Mechanisms to support innovation (CED, parallel review, other)

- Part D
- VBP hospitals, SNF, HHA, ESRD
- Payment adjustments HAC, hospital RRP
- Physician Quality Payment Program (QPP)

CMS - Safety Action Steps

- New performance measures to support patient safety (OIG) - new eCQM to cover common safety events
- Maternal Safety – new metrics and "Birthing Friendly" designation
- Nursing Home Safety – expanded VBP and safety focus including staffing turnover and minimum staffing levels
- Expanded VBP Programs - new areas of safety focus
  - Rural Health – Rural Emergency Hospitals
  - Opioid Safety – Electronic Prescribing; Mandatory Query of PDMP
  - Expanded Home Health Value Based Program (expanded CMMI Model)
- Developing structural safety measure (hospital)
- Measure stratification for equity

Additional Safety Action Steps

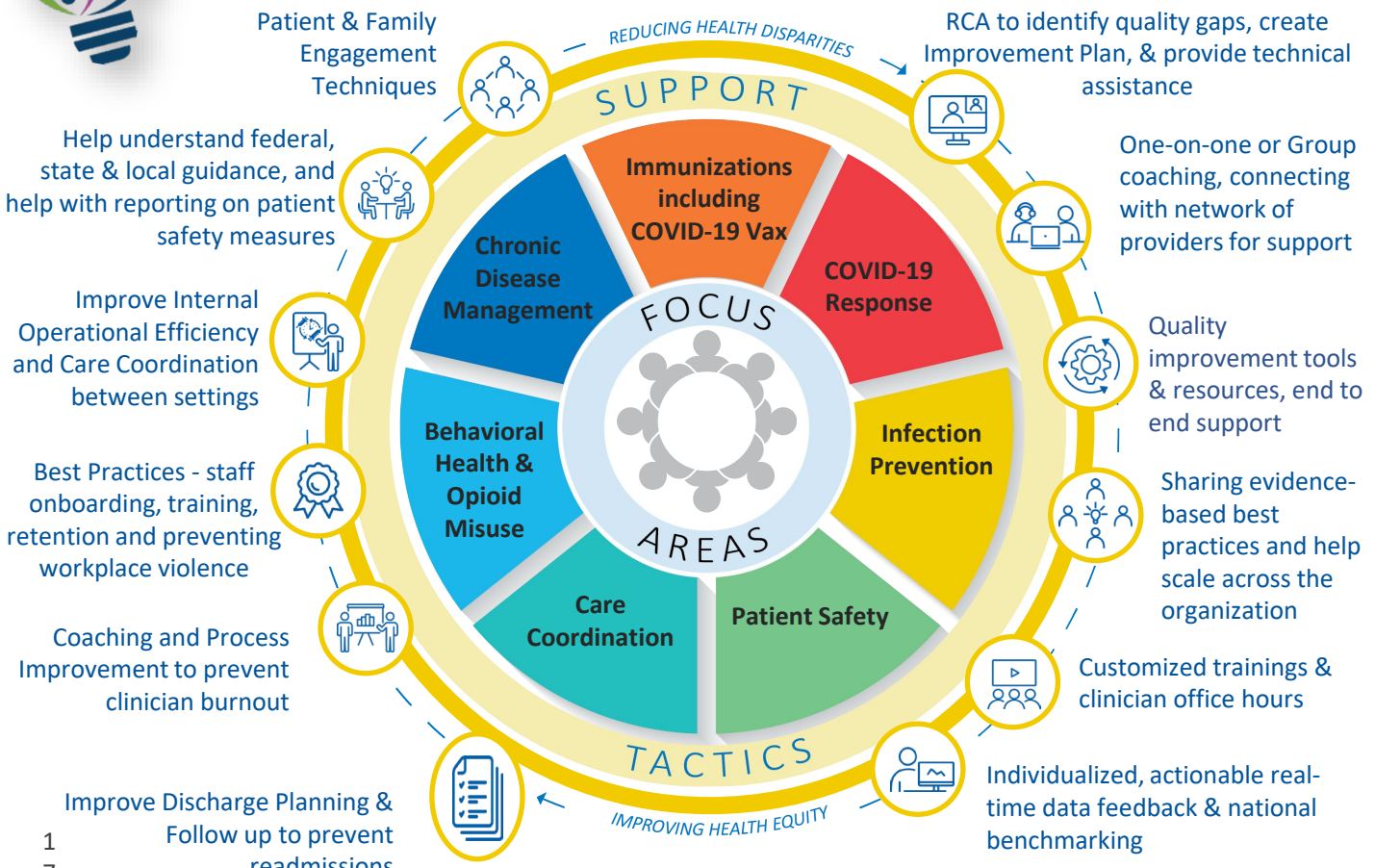
- Working across CMS for integrated safety action steps
- Targeted Quality Improvement Network support – Specific focus on patient safety
- Focus on leadership and governance – updated QAPI guidelines March 2023
- Support of Interoperability, TEFCA and FHIR - Transition to Digital Measurement as a safety issue (data completeness and availability)
- Public transparency and reporting (should safety be weighted more highly in Stars/public reporting?)
- Conditions of Participation and Survey

New Electronic Clinical Quality Measures for Safety

Measure	Status
Hyper and Hypoglycemia	Finalized
Opioid Overdose – Naloxone Administration	Finalized
Acute Kidney Injury	Finalized
Pressure Injury	Finalized
Severe Maternal Morbidity	Finalized
Falls With Injury	Under Consideration 2023
Post Operative Respiratory Failure	Under Consideration 2023
Sepsis Outcome	2024
Venous Thromboembolic Events	2024
Medication Related Bleeding	2024
Death Among Surgical Inpatients	Under Consideration 2023

Measures begin in IQR before being considered for Hospital Acquired Condition (HAC) Program

Example: CMS' National Quality Improvement Support for Patient Safety (www.qioprogram.org)



Current Work

~11,000 Community Partnerships in areas of highest disparities

~15,000 Nursing homes for vaccination and infection control assistance

~ 1,965 small, rural, CAH for patient safety and process improvements

24 Medicare-certified IHS hospitals for patient safety and coordination

~ 7,726 Dialysis Facilities for various improvement activities to improve quality & safety

QIO Focus on Safety

Focus of Safety – 12th SOW by Facility	
ESRD	Decreasing hemodialysis catheter infection rates, decreasing incidence of peritonitis, decreasing hospital admissions/readmissions
Nursing Homes	C. Difficile, Adverse Drug Events, Hospitalizations related to infections including Covid 19
Hospitals	CAUTI, CLABSI, Pressure Injuries, Sepsis and Septic Shock, Adverse Drug Events especially from anticoagulation, hypoglycemia

HHS Cross Agency Collaboration

AHRQ – CDC – CMS – FDA – ONC

- Leadership Action Alliance for Safety webinar series
- Safer Together: A National Action Plan to Advance Patient Safety (Institute for Healthcare Improvement)
- CDC expanded patient safety reporting through NHSN using digital tools
- Promoting Interoperability and Digital Data Collection thru Standard Data Elements/USCDI and USCDI+
- Patient Safety Organization – use of AHRQ Network of Patient Safety Databases
- Assessment of safety of new devices and medications
- Alignment of Quality and Safety measures
- Collaboration across other agencies including VA, DoD and others

AHRQ - Agency for Healthcare Research and Quality
CDC - Centers for Disease Control
CMS - Centers for Medicare & Medicaid Services
FDA - Food and Drug Administration
ONC - Office of National Coordinator for Health Information Technology

Future Considerations: System Approaches

- How to develop more standardization in healthcare
- Human factors engineering
- Learning from error – advanced analytics, machine learning, NLP
- Standardized definition of safety (including taxonomy of error reporting)
- Direct link of safety to productivity/finance

Thank You!

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Measuring For Prevention

Arjun Srinivasan, MD
CAPT USPHS
Deputy Director for Program Improvement
Division of Healthcare Quality Promotion

What Gets Measured Gets Done

- Patient safety successes of the past several years include significant pre-pandemic reductions in healthcare associated infections and antimicrobial resistance.
- Healthcare associated infections- reductions in central line associated blood stream infections (approaching 50% over 5 years), catheter associated urinary tract infections, modest reductions in some surgical site infections.
- Antimicrobial resistance: reductions in Methicillin resistant *S. aureus*, *Clostridioides difficile* and carbapenem resistant Enterobacterales (very hard to treat bacteria)

What Contributes to Safety Success?

- Many have pointed out that the long-standing presence of a dedicated monitoring system with well established definitions and dedicated expertise have been foundational to our success in reducing healthcare associated infections and antimicrobial resistance.
- The system is important- CDC's National Healthcare Safety Network is used by more than 35,000 healthcare facilities of all types to report safety events.
- Familiarity is really important in life- that applies to healthcare too.

The National Healthcare Safety Network is a System Supported By Deep Expertise

- The National Healthcare Safety Network is so much more than a “reporting platform” because it is embedded within a prevention oriented division, The CDC’s Division of Healthcare Quality Promotion.
- NHSN is supported by a team of experts, not just with specific expertise on analyzing healthcare safety data. But also by a team with extensive expertise on investigating, researching and preventing healthcare associated infections and antimicrobial resistance.
- This combination of measurement and action has been essential to success. The data informs action and then helps us know if the actions are working.

Advancing Measurement

- The growing power of electronic health records and the ability to securely share healthcare data through means like Fast Healthcare Interoperability Resources (FHIR) is allowing important advances in safety measurement.
- It allows us to expand event reporting in ways that would be too burdensome for manual collection.
  - Expanded data collection also facilitates the collection of ancillary safety measures.
- It allows for far more detailed and sophisticated risk adjustment.

A Practical Example- Moving Beyond Central Line Associated Bloodstream Infections

- Many patients develop bloodstream infections in hospitals that are not related to central lines but that might be preventable.
  - For example- bloodstream infections due to peripheral intravenous catheters.
- Electronic data capture makes reporting of **all** hospital onset bacteremia events practical.
- And would allow us to calculate other important safety measures- for example, how often blood cultures might represent contamination during collection.

CDC's Approach for Expanding Reporting to Hospital Onset Bacteremia Events

- All of our work in this area is informed by extensive partnerships at every step.
- Developing a definition that has clinical importance
- Assessing risk adjustment options
- Testing to see that the measure will respond as expected to prevention efforts.
  - A measure that doesn't respond to an intervention is not a very useful measure!

What's Next? Near Term

- Using electronic reporting via FHIR to improve measurement of *Clostridioides difficile*
  - Combining a positive test with treatment of the infection yields a measure that's more clinically meaningful.
- An electronic measure of outcomes in patients with sepsis
  - In partnership with CMS

What's Next? Slightly Longer Term

- We are starting to work with CMS to consider how NHSN can be used to support and inform the reporting and prevention of non-infectious harms.
- Though NHSN has long focused on infectious harms, there is no reason why this same approach could not be effective in other areas.
- We have begun work on:
  - Glycemic events, Deep venous thrombosis, Opioid related adverse events, Kidney injury in hospitalized patients
- We are partnering with CMS to think about how best to bring our efforts together to advance safety measures. And how to partner with the broader community.

What's Next? Longer Term

- What are harms that we can't measure at all right now that we might be able to capture with electronic reporting
  - "Electronic native" measures
- These are areas where we first have to define how to measure the harm, e.g. pediatric sepsis, sepsis in pregnant patients

We Have to Remember

- With electronic reporting and technology like FHIR, we are approaching a day where the burden of reporting will not be the primary challenge.
- With that new power comes even more responsibility.
- How do we collaborate to ensure that we have a well-developed prevention portfolio that can accompany and support any measure we develop?
- How do we collaborate to ensure those prevention measures are implemented effectively and equitably?
  - Measurement without prevention is just counting.
  - Prevention without measurement is just guessing.

VHA Patient Safety Journey and Impact on Performance

Reena Duseja, MD, MS

Senior Advisor

Office of Assistant Undersecretary for Health for Quality and Patient Safety

Veterans Health Administration

VA | U.S. Department of Veterans Affairs

Veterans Health Administration

What is a High Reliability Organization?

High Reliability Organizations excel in safety and consistently prevent errors and accidents, despite operating in highly complex, high-risk environments.

- Originally adopted in the aviation and nuclear power industries, the concept expanded to health care systems – including VHA.
- **HRO Vision:** Safest Health Care System for All
- **HRO Goal:** High reliability is integrated into the fabric of VHA operations and culture

HROs experience fewer than anticipated accidents or events of harm, despite operating in complex, high-risk environments

Fewer than anticipated accidents or events of harm

An “accident or event of harm” could be more broadly defined as **any event that causes disruption to safe and reliable operations across the system**

Unclear Policy

Error in Data Report

Unjust Response to Adverse Event

Operating in complex, high-risk environments

VHA leaders and staff members help manage business processes for the **most complex health care system in the nation**

Unique Veteran Health Care Needs

Legislative Requirements

Community Partnership

HRO Principles, Pillars, and Values

3 Pillars

LEADERSHIP COMMITMENT

Safety and reliability is reflected in leadership's vision, decisions and actions.

CULTURE OF SAFETY

Throughout our organization, safety values and practices are used to prevent harm and learn from mistakes.

CONTINUOUS PROCESS IMPROVEMENT

Across the organization, teams use effective tools for continuous learning and improvement.

5 Principles

Sensitivity to Operations: Focus on the Front Line Staff and Care Processes

Preoccupation with Failure: Anticipate Risk - Every Staff Member is a Problem Solver

Reluctance to Simplify: Get to the Root Causes

Commitment to Resilience: Bounce Back from Mistakes

Deference to Expertise: Empower and Value Expertise and Diversity

7 Values

It's About the Veteran

Support a Culture of Safety

Commit to Zero Harm

Learn, Inquire and Improve

Duty to Speak Up

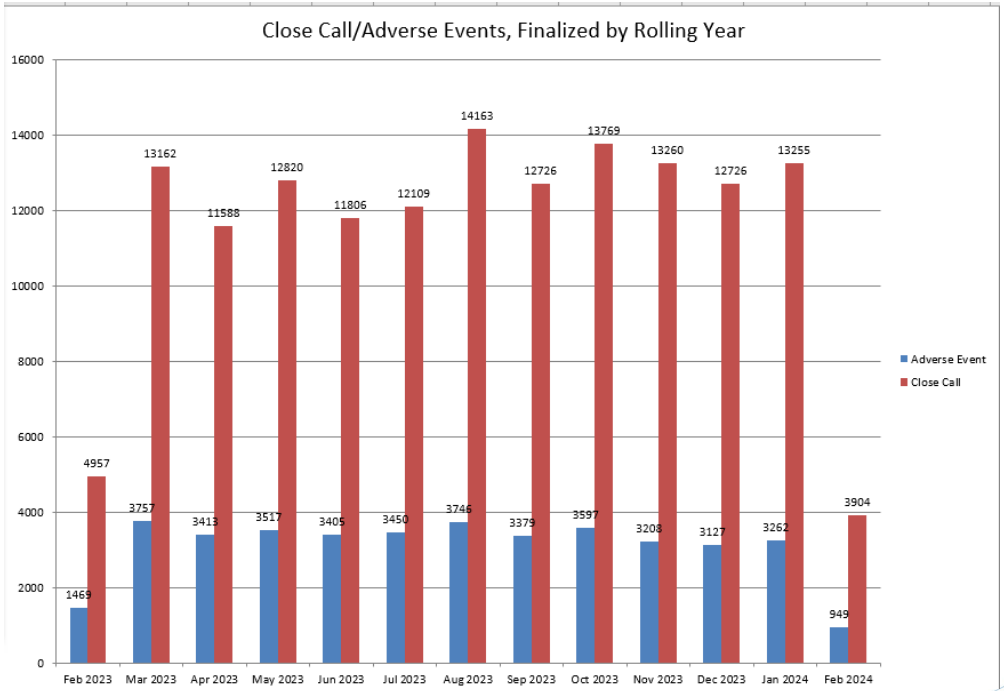
Respect for People

Clear Communications

Six Enterprise-wide HRO Activities

Joint Patient Safety Reporting System (JPSR)

- **JPSR:** Veterans Health Administration (VHA) patient safety event reporting system and database.
- **Adverse Event**: Adverse events are untoward diagnostic or therapeutic incidents, Iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers.
- **Close Call:** Close calls are events or situations that could have resulted in an adverse event but did not, either by change or through timely intervention.



Becoming an HRO
(As of FY23 Q3)

HRO Culture Measures and Reporting Trends

Leadership Engagement

"I have trust and confidence in my supervisor."

Between FY 19, at the beginning of VHA's Journey, and FY 22, positive responses to this question **rose from 3.94 to 4.06**, increasing each year.

Stop the Line

"Staff will freely speak up if they see something that may negatively affect patient care."

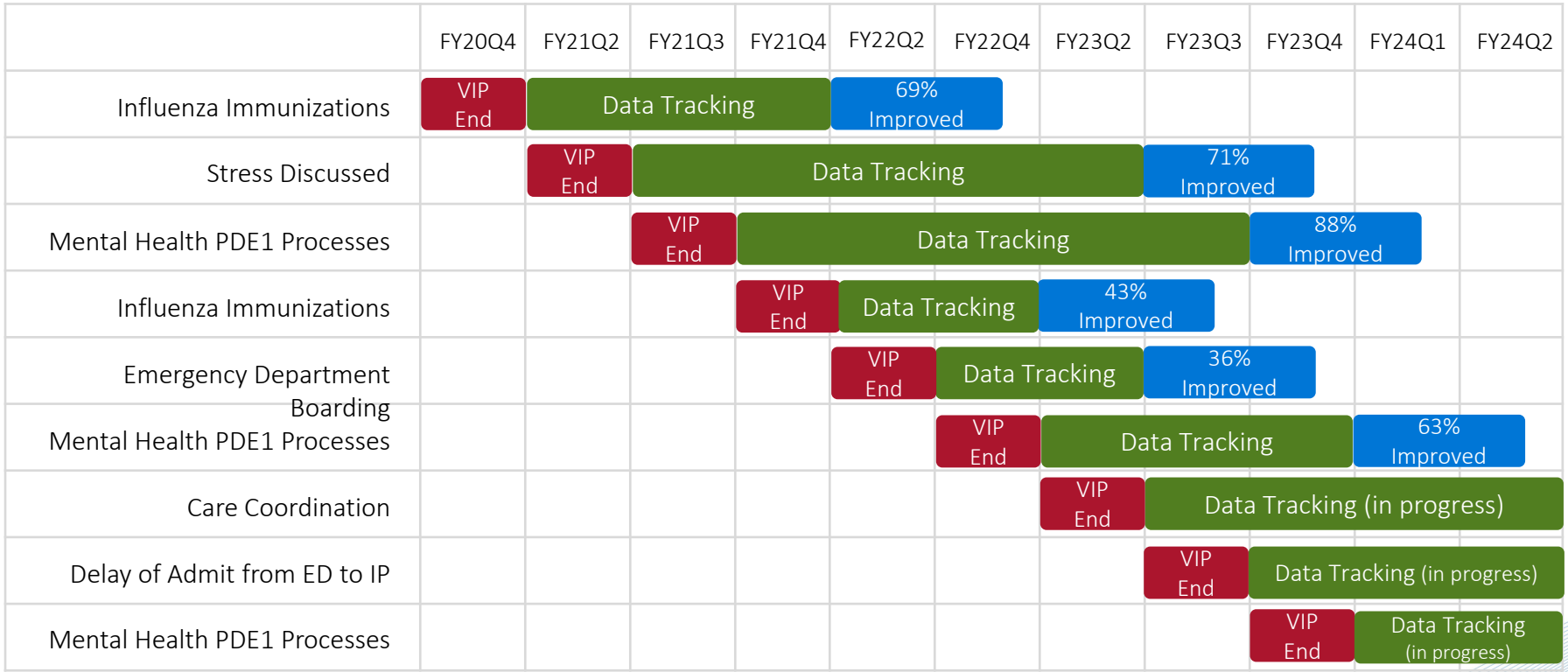
All Employee Survey scores for this question steadily **increased across all** HRO Cohorts.

Close Call (CC)/Adverse Event (AE) Reporting

A high CC/AE reporting ratio may indicate a positive reporting culture in which Close Calls are reported and Adverse Events are prevented.

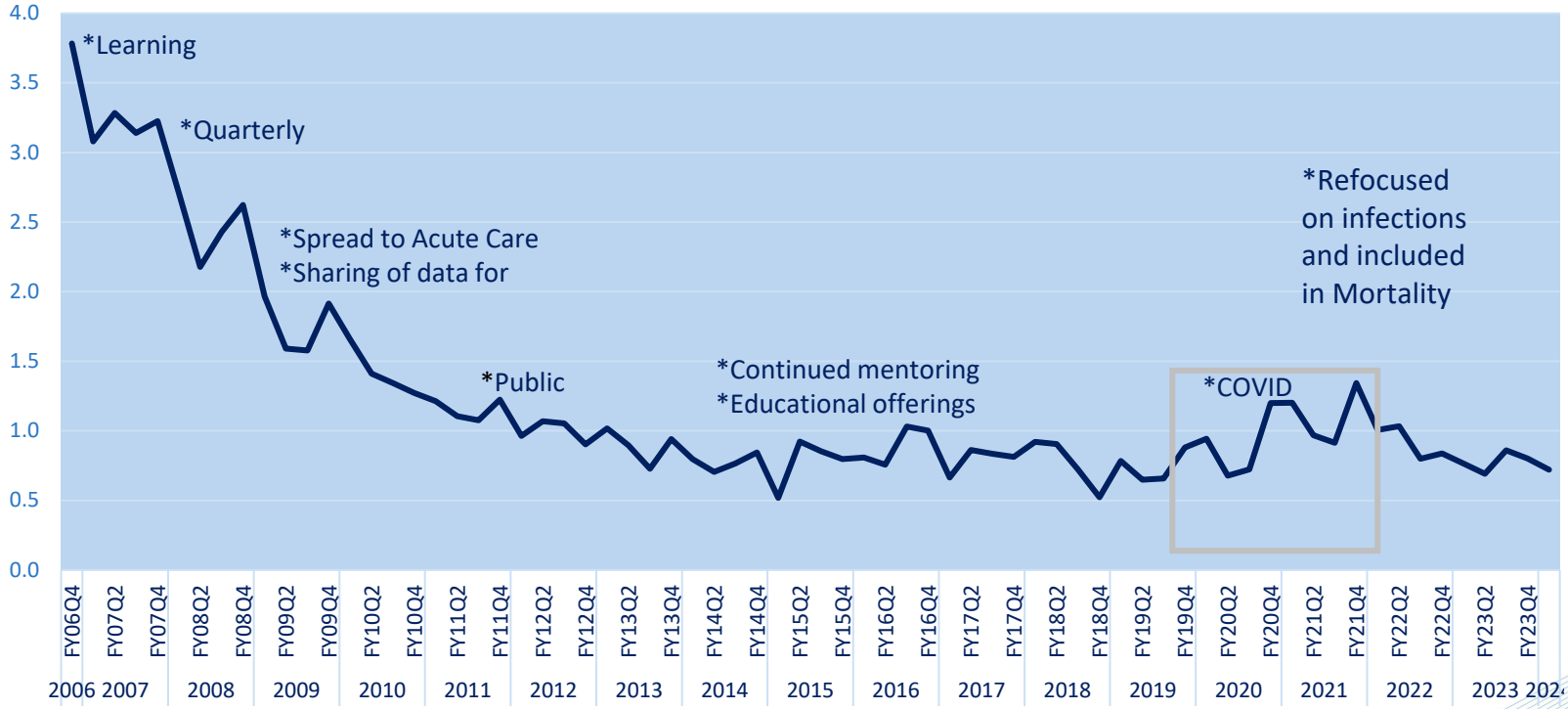
The health system-wide ratio of CC/AE **rose from FY 22 Q2 to FY 23 Q3 (0.66 to 3.43).**

Multi-Site Improvement: Virtual Improvement Program (VIP)

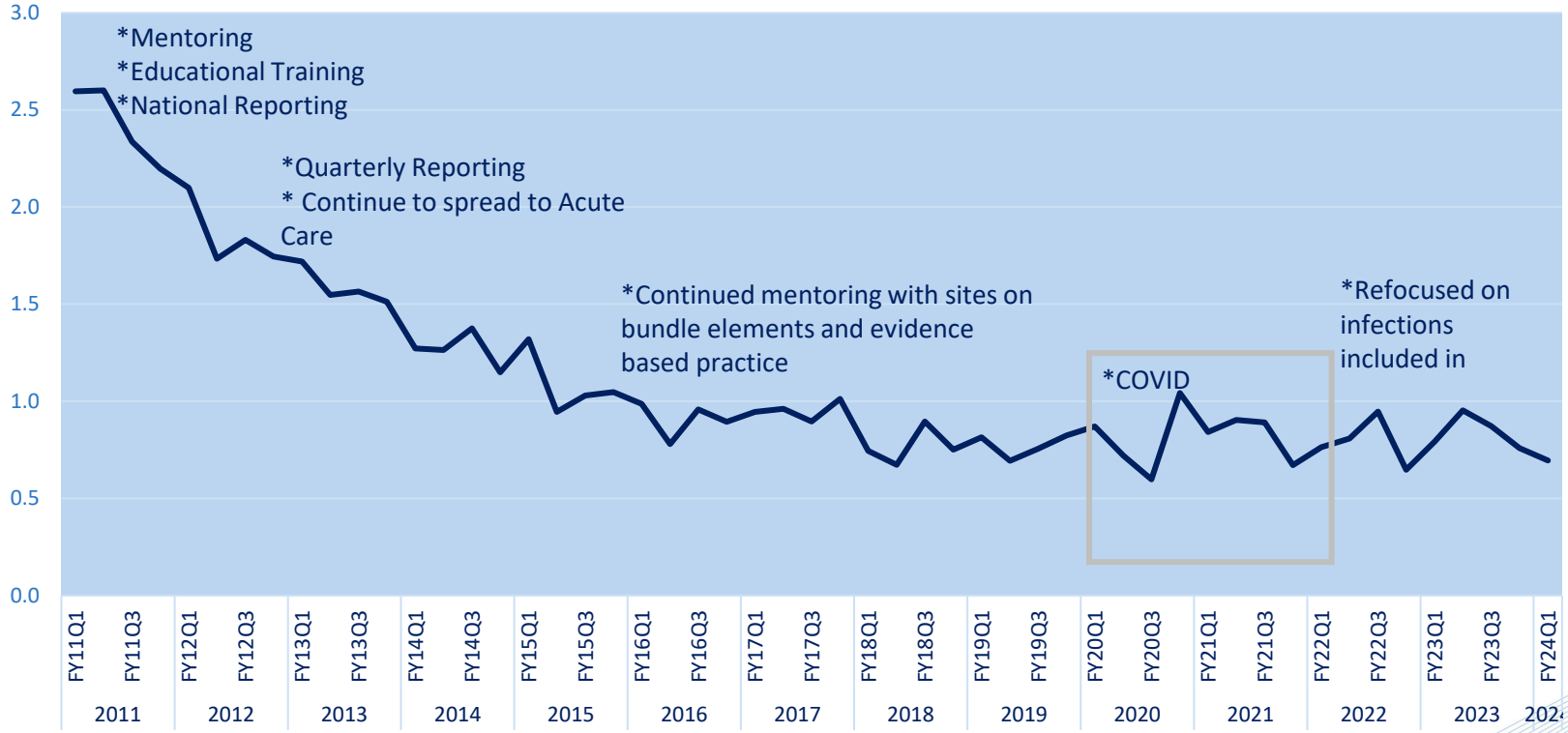


**This represents the work of 48% (67 out of 139) Medical Centers

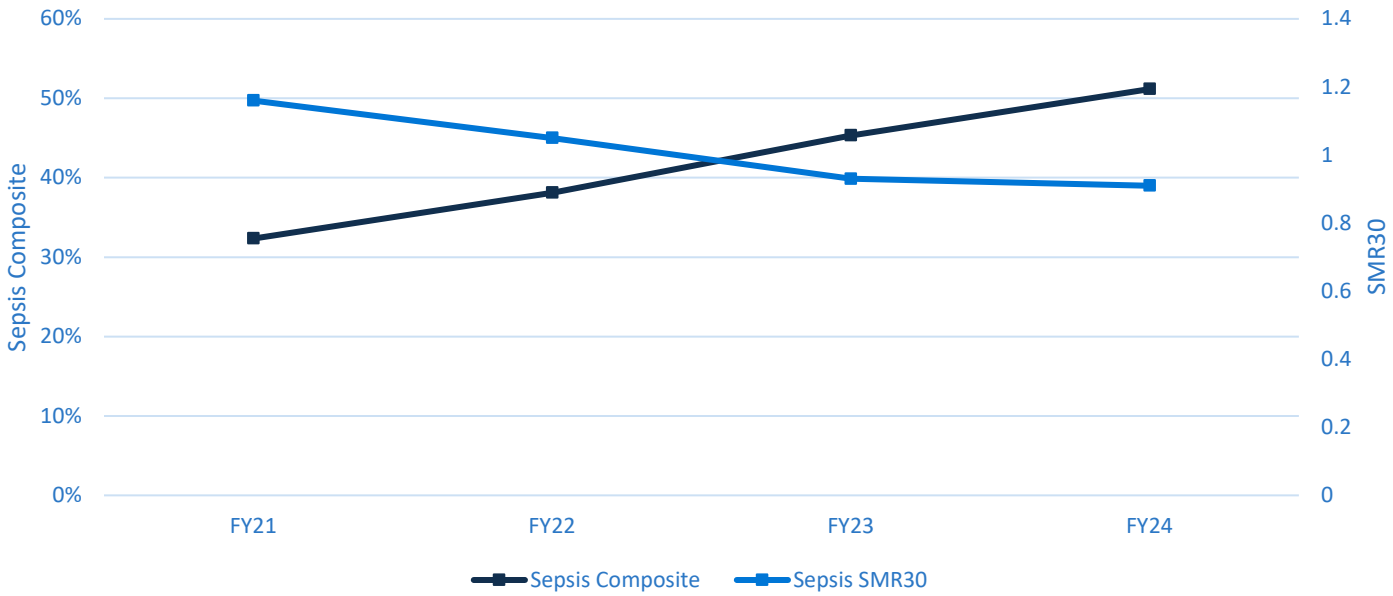
CLABSI (Acute Care & ICU)



CAUTI (Acute Care & ICU)



Comparison of Sepsis Composite (SEP-1) - Early Management Bundle with Sepsis 30-Day Standardized Mortality



Thank you



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

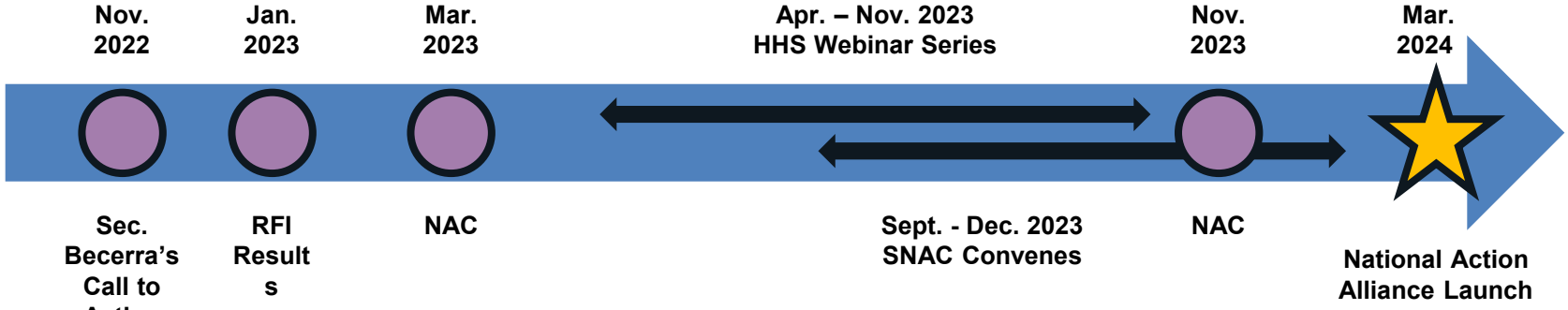
AHRQ

The National Action Alliance for Patient and Workforce Safety

Craig Umscheid, MD, MS
Director, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

Prioritizing Patient Safety Through Measurement
March 2024

National Action Alliance Timeline



NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Subcommittee of the National Advisory Council: Informing the National Action Alliance to Advance Patient and Workforce Safety

Final Report: December 19, 2023

Submitted by:
Lucy A. Savitz, Ph.D., MBA on behalf of the AHRQ Subcommittee

Five Aims of the National Action Alliance for Patient & Workforce Safety

1. **Advance Organizational Safety Strategies Using National Action Plan Foundations**
   - make commitment
   - perform safety self-assessments
   - enact safety strategy
2. **Empower Patient Voice in Safety Strategy**
   - submission of safety events
   - inclusion in event review
   - input on safety initiatives
   - communication and resolution programs
3. **Healthcare Safer by Design**
   - identify/address five high-priority safety engineering needs
4. **Strengthen Safety Competencies**
   - develop, adopt and report
   - not just safety officers, but all team members
5. **Learning and Research Network**
   - scalable bundle of safe practices
   - learning and sharing across network
   - spotlighting change leaders
   - promoting robust system (and national) measurement
   - research to address high-priority needs

The National Action Alliance Builds Upon the Foundational Elements of the National Action Plan

- **Culture, Leadership, Governance**
  - **Organizational safety goals** with champions
  - Leader **annual reviews** incorporate safety
  - Regular **safety culture surveys**
- **Patient and Family Engagement**
  - Actively engaged **PFACs**
  - **Shared decision-making** tools used widely
  - **Patient portals** used widely
  - **Analyzing safety data** using an **"equity lens"**
- **Workforce Safety**
  - Organization has **explicit worker safety strategy**
  - Organization employs **occupational safety experts**
- **Learning Healthcare Systems**
  - **Defined safety education and competencies** for all workers
  - Organization regularly participates in **learning networks**

Organizing to Achieve Alliance Aims

Healthcare Providers Organizations

- Encourage and facilitate commitment to safety self-assessment to inform safety strategy
- Recruit high-performing organizations across the nation to serve as change leaders for the Action Alliance

Potential partners:
- AHA, AEH, ACHE, AAMC
- CMS, CDC, HRSA, IHS, VA, DOD, PCORI
- Joint Commission, DNV
- Press Ganey, Vizient, PSOs

Engineering Safe Practices Group

- Identify high-priority opportunities to further engineer safety into technologies used in healthcare
- Work collaboratively with federal and private partners including patients and clinicians to identify solutions and implement

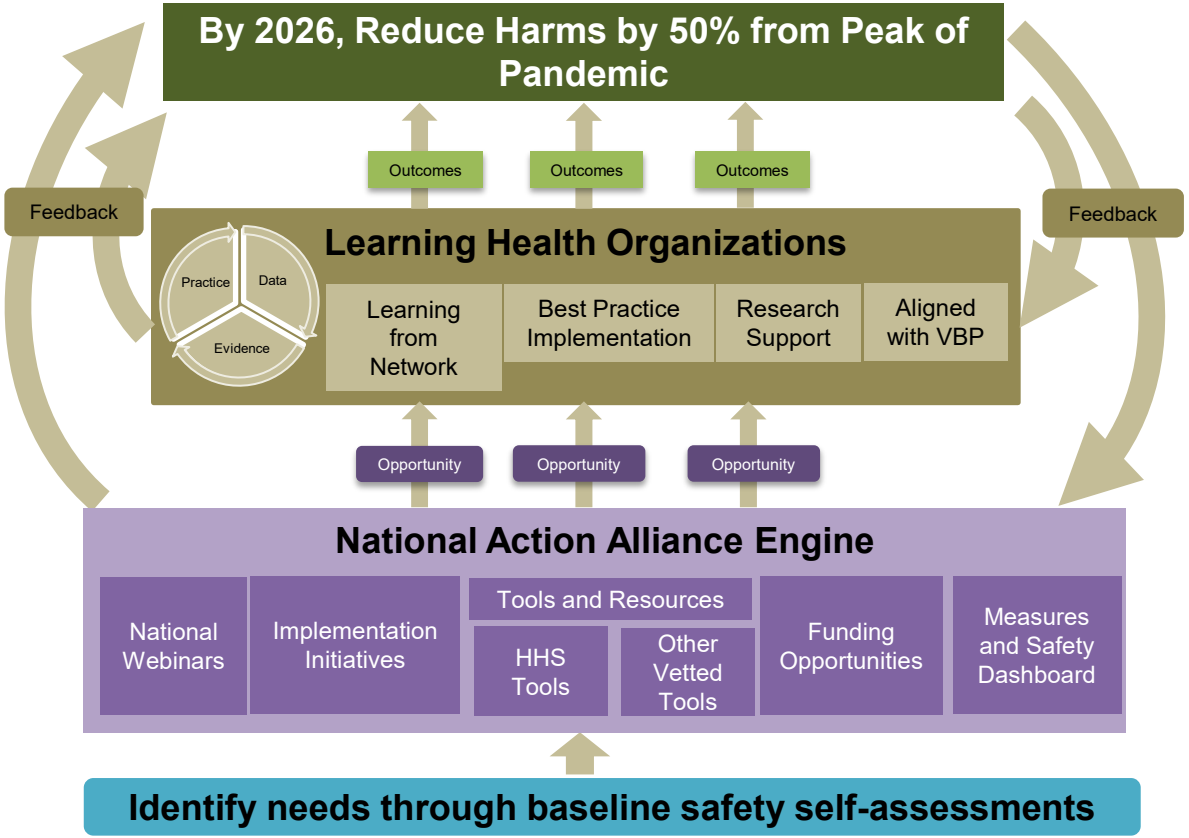
Potential partners:
- FDA, ONC, ARPA
- EHR vendors
- Device manufacturers
- ECRI

Safety Science Competencies Group

- Engage partners on curriculum development, education, training and accreditation
- Develop or update safety science competencies for healthcare community
- Work collaboratively to drive implementation

Potential partners:
- AAMC, ACGME
- ABMS
- NAHQ, IHI, Vizient
- ANA, AMA, ACP, ACHE

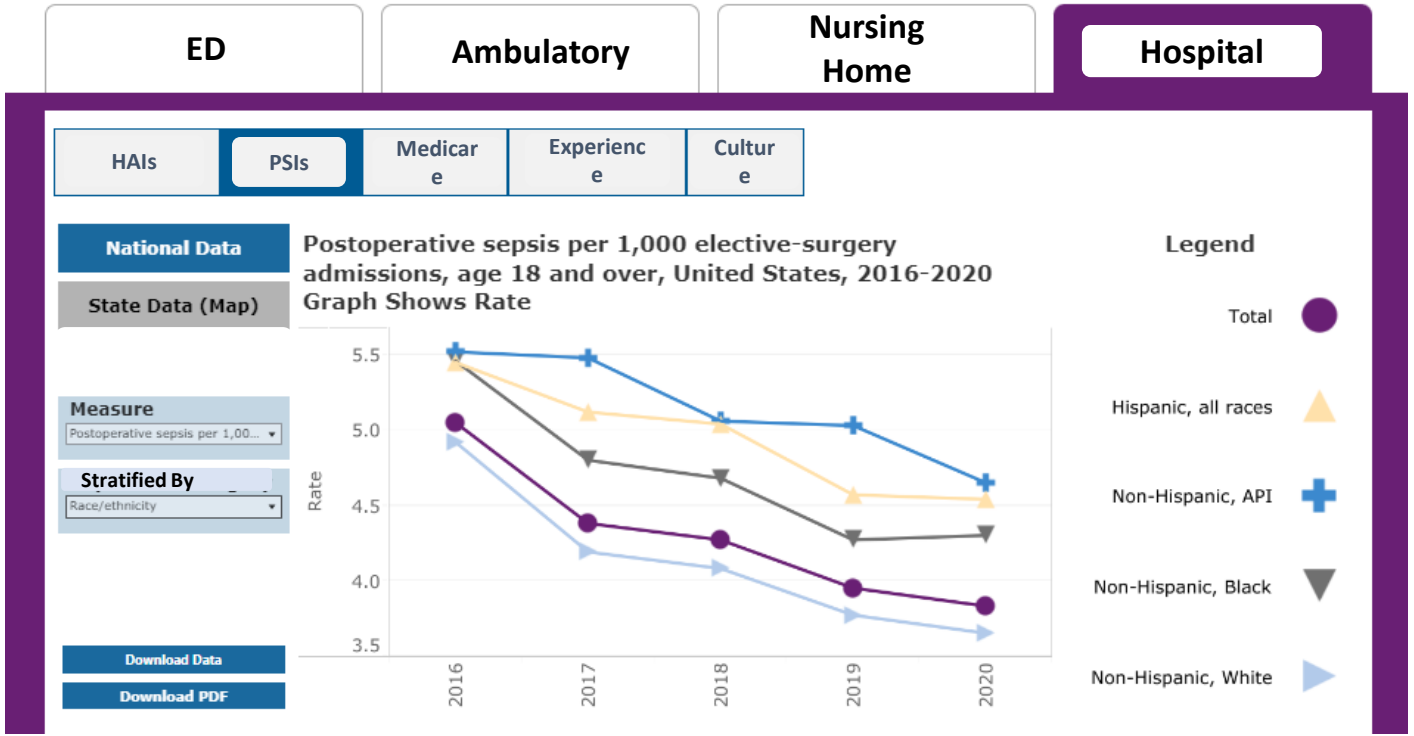
Engaging the National Action Alliance Engine to Power "Safe Care Everywhere, Zero Preventable Harm for All"



Examples of Select Tools, Funding Opportunities, and Implementation Initiatives from AHRQ

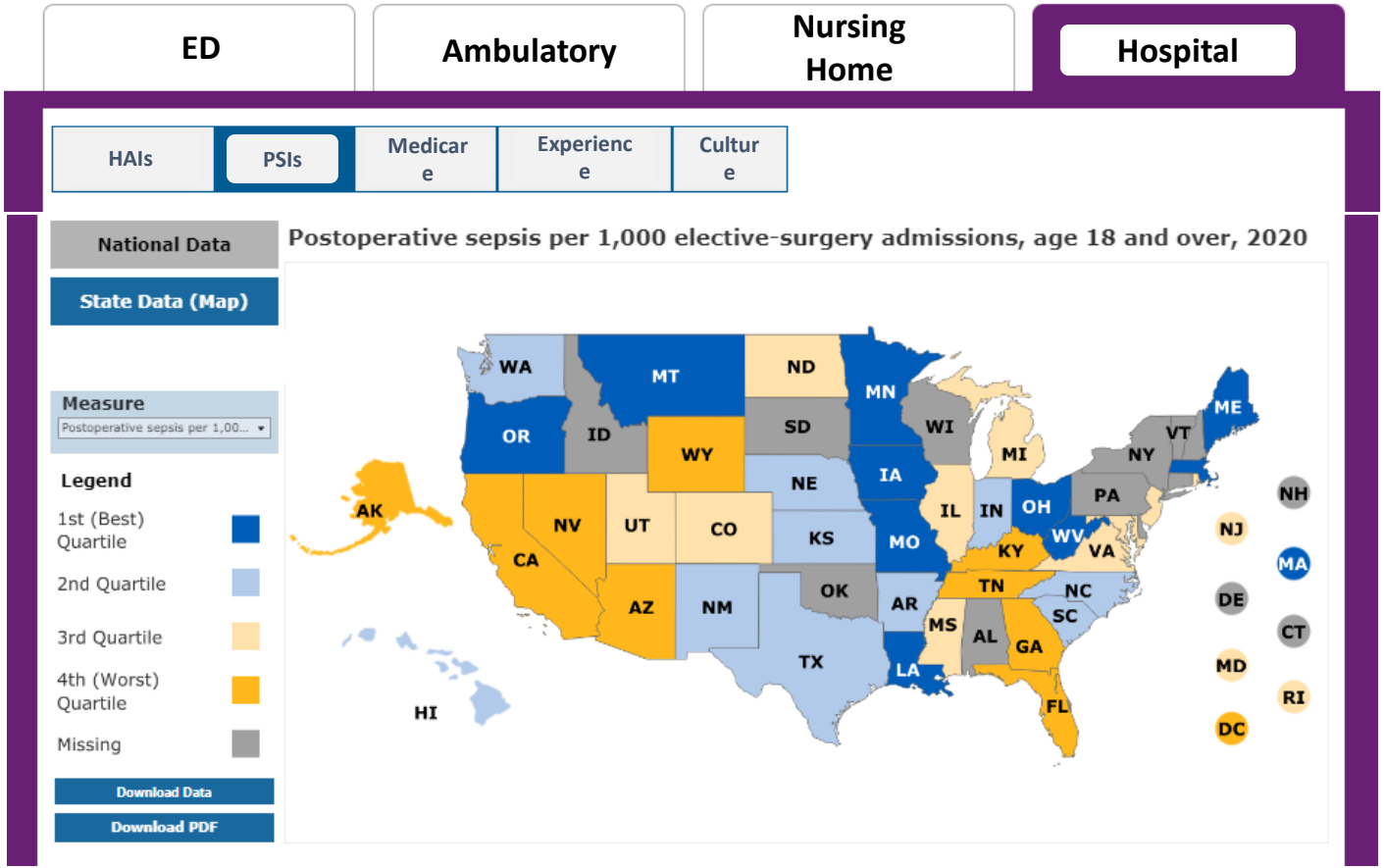
Culture, Leadership, and Governance	Patient and Family Engagement	Workforce Safety	Learning System
• **Surveys on Patient Safety Culture** (tool)	• **TeamSTEPPS 3.0** (tool & implementation initiative) • **CANDOR** (tool)	• **New AHRQ R01:** Systems-Based Approaches to Improve Patient Safety by Improving Healthcare Worker Safety and Well-Being (up to $2M in funding)	• **PSNet** (tool) • **Calibrate Dx:** Resource to Improve Diagnostic Decisions (tool & implementation initiative)

Proposed National Healthcare Safety Dashboard



Adapted from current AHRQ NHQDR data tool:
https://www.ahrq.gov/data/data-tools/index.html

Proposed National Healthcare Safety Dashboard



Committing to the National Action Alliance for Patient and Workforce Safety

1. **Championing patient and workforce safety** by designating an Executive Lead accountable for safety
2. **Performing an organizational safety self-assessment** and implementing a safety plan that addresses gaps, including in healthcare equity
3. **Empowering the patient's voice** in all aspects of safety
4. **Strengthening safety competencies** for all team members
5. **Collaborating when it comes to safety** by sharing lessons learned and using and contributing to safety resources as an active Alliance participant

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

The National Action Alliance Website Serves as a Hub to Engage

https://www.ahrq.gov/action-alliance/index.html

craig.umscheid@ahrq.hhs.gov

Questions & Answers

Stay Connected

Visit MMS Hub Website:
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