Quality News

Nassau-Suffolk Hospital Council, Inc.

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Quality Measures Considered for 2012 Rulemaking

HHS has released for "pre-rulemaking" comments a list of quality measures under consideration for 2012 rulemaking. AHA, with the Measure Application Partnership (a group convened by the National Quality Forum) is submitting comments about them.

The list includes 13 hospital value-based purchasing (VBP) measures, 22 hospital inpatient quality reporting (IQR) measures and 39 quality measures for the hospital electronic health record (EHR) incentive program.

The 13 **hospital VBP measures** are:

- Patient Death or Disability Associated with Air Embolism
- AMI -10 Statin Prescribed at Discharge
- Death or Disability Associated with Blood Incompatibility
- Catheter-Associated Urinary Tract Infection
- Central Line- Associated Blood Stream Infection
- Falls and Trauma
- IQI 91 Mortality for Selected Medical Conditions
- Manifestations of Poor Glycemic Control
- Pressure Ulcer Stages III & IV
- PSI 90 Complications/Patient Safety for Selected Indicators
- SCIF-Inf-10 Surgery Patients Preoperative Temperature Management
- Vascular Catheter-Associated Infections
- Medicare Spending Per Beneficiary

Most of the quality measures for the **hospital EHR incentive program** are IQR **measures**. Below are those **which are not IQR measures:**

- Elective Delivery Prior to 39 Completed Wks of Gestation
- Exclusive Breastfeeding (Livebirths) at Hospital Discharge
- First Temperature Measured One Hr After Admission to the NICU
- First NICU Temperature < 36 Degrees C
- Healthy Term Newborns
- Hearing Screening of Newborns Prior to Hospital Discharge
- Home Care Plan of Care Document Given to Patient/Caregiver
- Neonatal Immunization
- PICU Pain Assessment on Admission
- PICU Periodic Pain Assessment
- Proportion of Infants 22-29 Wks Gestation Treated with Surfactant Within 2 Hrs of Birth
- Use of Relievers for Inpatient Asthma
- Use of Systemic Corticosteroids for Inpatient Asthma

The **IQR Measures** being considered include additional measures for AMI, Heart Failure and Pneumonia along with measures focused on Hip/Knee Surgery, Treating Tobacco and Alcohol Use, ***Use of*** a Safe Surgery Checklist, Hospital-Wide All Cause Readmission Rates for All Conditions and a Care Transition Measure. The Care Transition Measure requires the distribution of a patient survey that measures three dimensions of care transition: the patient's understanding of his/her self-care role and how to manage his/her medications, along with the incorporation of patient preferences into the care plan.

Although HHS indicated that "the vast majority of the new measures under consideration will not be required for reporting but rather be optional," many HHS-required measures start as optional before becoming mandatory.

For further information go to:
http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx

Joint Commission Sentinel Event Alert: Health Care Worker Fatigue and Patient Safety

In December, The Joint Commission (TJC) issued a Sentinel Event Alert on *Health Care Worker Fatigue and Patient Safety*. In the alert, TJC noted that "the link between healthcare worker fatigue and adverse events is well documented. Studies show that fatigue increases the risk of adverse events, compromises patient safety and increases risk to personal safety and well being. Shift length and work schedules have a significant effect on health care providers' quantity and quality of sleep and consequently their job performance." TJC cited findings from a groundbreaking 2004 study which showed that nurses who work shifts of 12.5 hours or longer are three times more likely to make an error in patient care. Residents who work recurrent 24-hour shifts make five times as many serious diagnostic errors and 36 percent more serious preventable adverse events.

TJC made the following evidence- based suggestions:

- Assess your organization for fatigue-related risks
- Consider fatigue as a potential contributing factor when reviewing all adverse events
- Create and implement a fatigue management plan that includes scientific strategies for fighting fatigue
- For support staff who work extensive hours, encourage teamwork or independent checks for critical or complex tasks
- For organizations with a current policy that allows for sleep breaks for staff, assess the environment provided for sleep breaks to ensure that it fully protects sleep.

For a copy of the Sentinel Event Alert go to:
http://www.jointcommission.org/assets/1/18/SEA_48.pdf

Palliative Care Access Act Now In Effect

On Sept. 27, 2011 the New York State Palliative Care Access Act (PCAA) became effective. This Act requires hospitals, nursing homes, home care agencies, special needs assisted living residences and enhanced assisted living residences to provide access to information and counseling regarding options for palliative care appropriate to patients with advanced life-limiting conditions and illnesses. The Act was built upon, but significantly differs from, the Palliative Care Information Act (PCIA) which took effect Feb. 1, 2011. The PCAA focuses on hospitals and other health care facilities listed above. The PCIA targets physicians and nurse practitioners. The PCAA applies to patients or residents with "advanced life-limiting conditions or illnesses who might benefit from palliative care"; the PCIA only applies to those who are terminally ill.

According to the PCAA, the covered providers and residences must **provide access to information and counseling** regarding options for palliative care appropriate to patients/residents with advanced life-limiting conditions and illnesses who might benefit from palliative care services. These providers and residences must **also facilitate access to appropriate palliative care consultation and services,** including associated pain management consultation services consistent with patients'/residents' needs and preferences. When a patient/resident lacks capacity to make health care decisions, providers and residences **must also have policies and procedures** in place to identify the patient's/resident's legally-authorized health care decision-maker and provide access to information and counseling to that person.

The PCAA is intended to benefit patients/residents with advanced life-limiting conditions or illnesses, generally understood to mean a medical condition causing significant functional and quality of life impairments that is not likely to be reversible by curative therapies and that is likely to progress over time and ultimately contribute to physiological and functional decline and shortened survival.

Health care providers should implement policies and tools for identifying such patients.

For additional information on PCAA see the FAQs:
http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/2011-12-14_questions_and_answers.htm#h2

For examples of policies and procedures go to:
http://www.capc.org/support-from-capc/capc_publications/nqf-crosswalk.pdf

For more information, contact: Mary Jane Milano, Director of Quality and Education, NSHC, mmilano@seagatealliance.com

Upcoming HANYS Webconferences of Interest

- The Joint Commission's Performance Measurement Activities - January 25, 2012 11 a.m. – noon. For HANYS and Greater New York Hospital Association members only.
- Dialogue with DOH: Quality and Surveillance (for Long-Term Care Facilities and TCUs) January 27, 2012 1 - 2:30 p.m. For HANYS members only.
- Hospice and Palliative Medicine: Physician Credentialing - January 30, 2012 1 - 2:30 p.m. For HANYS members only.
- Human Factors: Understanding Human Capabilities and Their Role in Medication Safety- January 31, 2012 10-11 am.

For further information and to register for these events go to HANYS' website: http://www.hanys.org/index.cfm

Guidelines for Determining Brain Death Released

Last month, the New York State Department of Health and the New York State Task Force on Life and the Law released "Guidelines for Determining Brain Death". The guidelines update the department's 2005 Brain Death Determination Guidelines to bring them in line with current medical evidence and with updated clinical advice published by the American Academy of Neurology in 2010. They build upon a consensus-building process that included ethical, legal and clinical review by the Task Force and input by an outside panel of expert physicians and stakeholders from across the state.

The key revisions include:

- Reliance on a single rigorous clinical examination – rather than two examinations – showing that brain stem function has ceased, prior to performance of an apnea test
- New guidance on waiting periods to exclude the possibility of recovery
- Updated information on ancillary testing
- Clarification of the role of the second physician in certifying brain death for patients who are organ donor candidates and
- Modifications of the clinical checklist.

For a copy of the guidelines go to:
http://www.health.ny.gov/professionals/hospital_administrator/letters/2011/brain_death_guidelines.pdf

NSHC Releases Quality Compendium

NSHC has released a Quality Compendium containing a crosswalk of inpatient quality measures & serious adverse events along with Medicare outpatient, ambulatory surgery center, long-term hospital and rehabilitation quality measures. For a copy of this, contact us at mmilano@seagatealliance.com