



Patient Safety Organizations in Acute Care and Transitions in Care

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Objectives

1. Review the protections of the Patient Safety & Quality Improvement Act
2. Explore the relationship between event reporting and patient safety culture
3. Discuss how alternative care settings and integrated healthcare systems can benefit from Patient Safety Organizations

The Patient Safety & Quality Improvement Act of 2005

- Authorizes the creation of PSOs
- Aims to improve safety by addressing
 - Fear of malpractice litigation
 - Inadequate protection by state laws
 - Inability to aggregate data on a large scale
- Encourages voluntary reporting of patient safety events without fear that the reports will be used against the provider
- Creates a network of patient safety database (NPSD)

What is a Patient Safety Organization (PSO)?

- An entity or a component of another organization (component organization) listed by AHRQ that meets the requirements established by the Patient Safety Rule
- Conducts activities to improve patient safety and healthcare quality

Patient Safety Act Protections

- **Confidentiality protections** are key to voluntary reporting; breaches may result in civil monetary penalties
- **Privilege protections** are enforced by the judicial system; these provisions limit or forbid the use of protected information in criminal, civil, administrative, or other proceedings

Adverse Events in the News



Our view on your health: Preventable medical mistakes take an intolerable toll

Updated 11/18/2010 9:13 PM



2009 USA TODAY photo

In hospitals: Study finds 44% of adverse events are preventable.

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The report says the deaths of a Of those, rough could be caught infections deve medication or a right drug. Asid medical care re costs taxpayer

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•**Transparency** word of mouth they wanted to increasingly ro allow patients t TODAY.com at comparisons.) consumers anc do better.

•**Financial ince**

- 13.5% of hospitalized Medicare patients experience an adverse event (1:7)
- 44% were preventable
- Costs to Medicare = \$324M in October 2008

OIG (Nov, 2010). *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*

Responses to Events Vary

Reactive:

- Increasing public pressure
- Regulation and oversight
- Non-reimbursement policies and penalties
- Mandatory state reporting

Proactive:

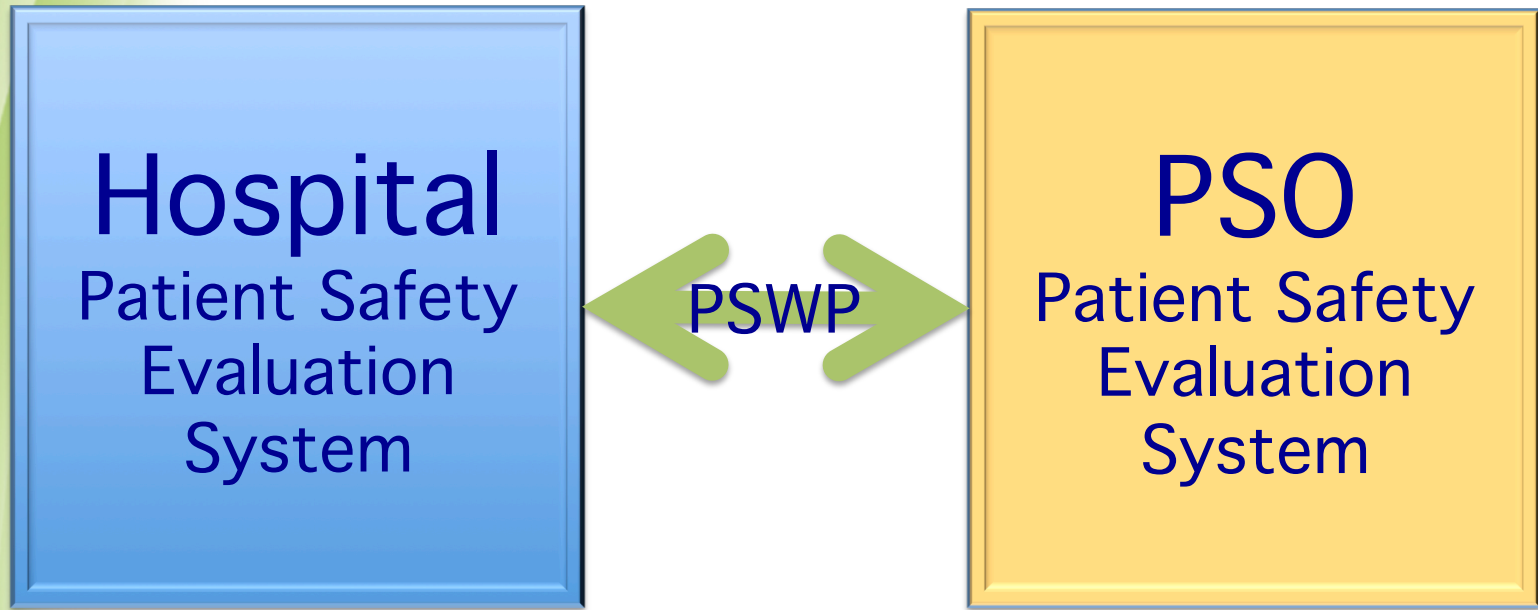
- Encourage hospitals to join PSOs
- Implement a Culture of Safety



Common Formats

- Common definitions and reporting formats used to facilitate the collection and reporting of patient safety events
- Updated annually
- Future versions: **ASC, physician & practitioner offices, home health**
- Eventually, the entire “Improvement Cycle”

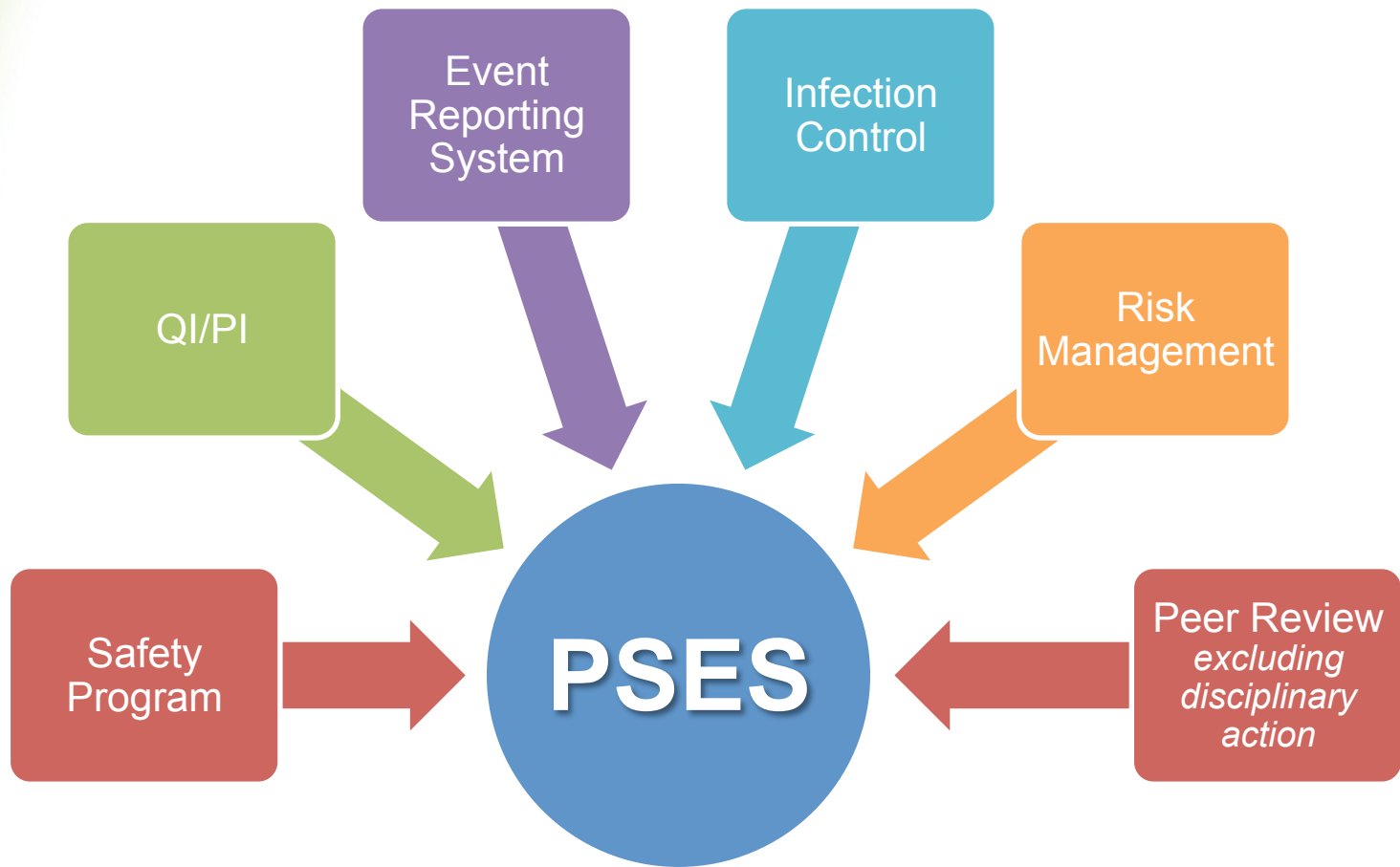
Hospital & PSO Information Flow



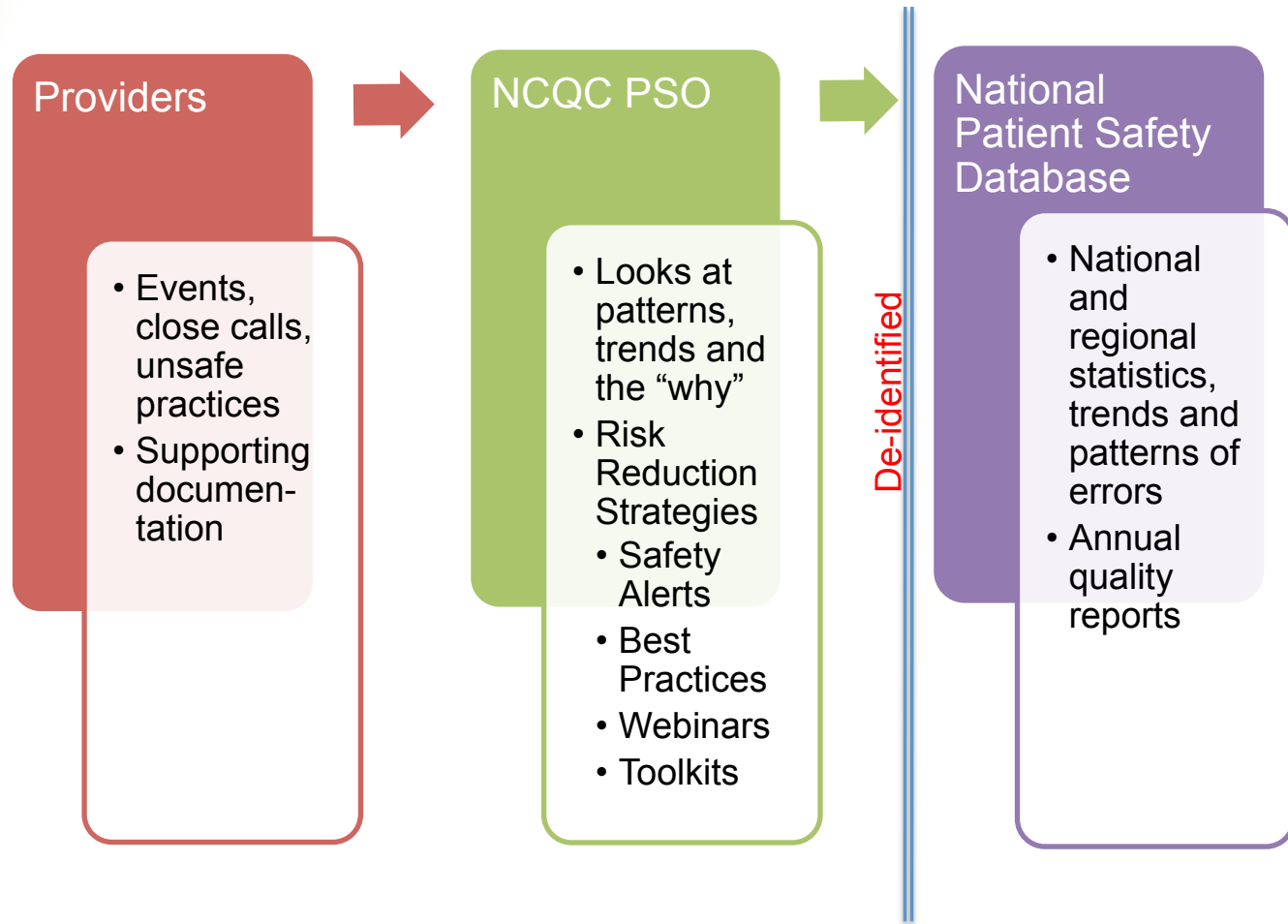
Patient Safety Evaluation System (PSES) is the collection, management or analysis of information for reporting to or by a PSO PSWP.

Patient Safety Work Product (PSWP) is information gained during the process of patient safety improvement activities and means "any data, reports, records, memoranda, analyses (ie, root cause analyses), or written or oral statements" that "could result in improved patient safety, health care quality, or health care outcomes

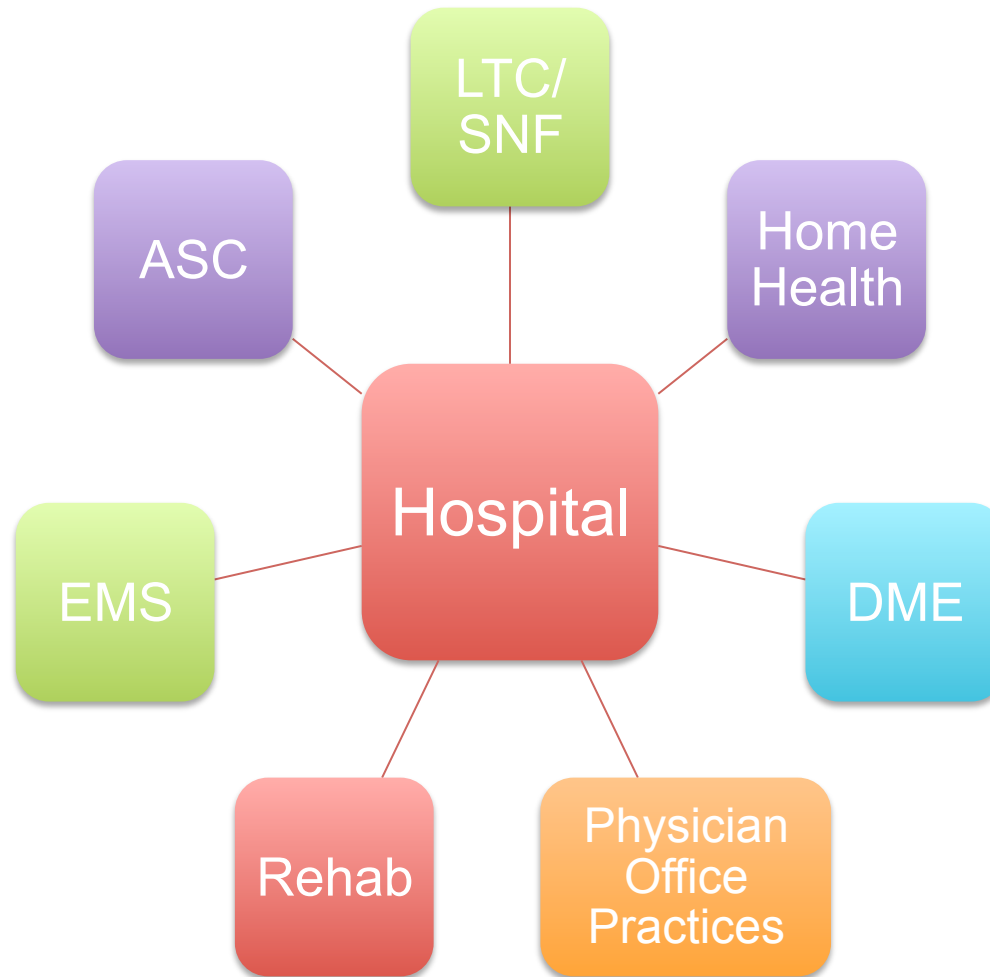
How Does Data Enter the PSES?



Data Sharing Levels



Think About Your Organization



PSO Protection: Think Outside the Box

- Most hospitals only include the hospital itself
- Consider adding other affiliates/services
- Opens up new opportunities
- Offers opportunities to discuss patient transitions

Event Reporting & Patient Safety Culture

- In a successful culture of safety:
 - Every staff member demonstrates a commitment to safety
 - Evidenced in staff communication
 - Errors are reported and learned from
 - Organizational commitment to safety
 - Just Culture supported
 - Ongoing reassessment of growth

Health Care Reform

- **Section 3025: Hospital readmissions reduction program**
 - FY 2013 - Adjusts IPPS payments based on each hospital's percentage of potentially preventable Medicare readmissions for HF, AMI and Pneumonia
 - Penalties set at 1% and eventually reaching 3%

Readmission Reduction Program Timeline for Implementation

2012
Conditions

- Heart Failure
- Heart Attack
- Pneumonia

2015
Conditions

- COPD
- PTCA
- CABG
- Vascular Diseases

Health Care Reform

- **Section 3026: Community-based care transitions program**
 - CMS sponsored
 - Mandated and funded by Affordable Care Act, Section 3026
 - Goal is to improve transitions of beneficiaries from hospitals to other care settings and reduce readmissions for high risk beneficiaries

Partnership For Patients

Improve care transitions

*By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be **reduced by 20%** compared to 2010*

Achieving this goal would mean more than **1.6 million patients would recover** from illness without suffering a preventable complication requiring re-admission within 30 days of discharge

PSO Common Formats

- Risk Assessment & Preventive Actions
 - Protocol employed
 - Follow-up appointment
 - Med reconciliation at discharge
 - Discharge plan
 - Patient education
 - Follow up phone call
 - Unscheduled contacts with healthcare system after index admission

PSO Common Formats

- Circumstances of Readmission
 - Source of readmission
 - Risk Factors
 - >5 medications
 - >2 hospitalizations in last 6 months
 - Contributing factors

Community Based Care Transition Program

- State average rates were calculated for AMI, HF and Pneumonia
- Hospitals were sorted into quartiles
- 631 hospitals had readmission rates on 2 out of 3 or all 3 in the worst quartile
- These hospitals are encouraged to participate in this project

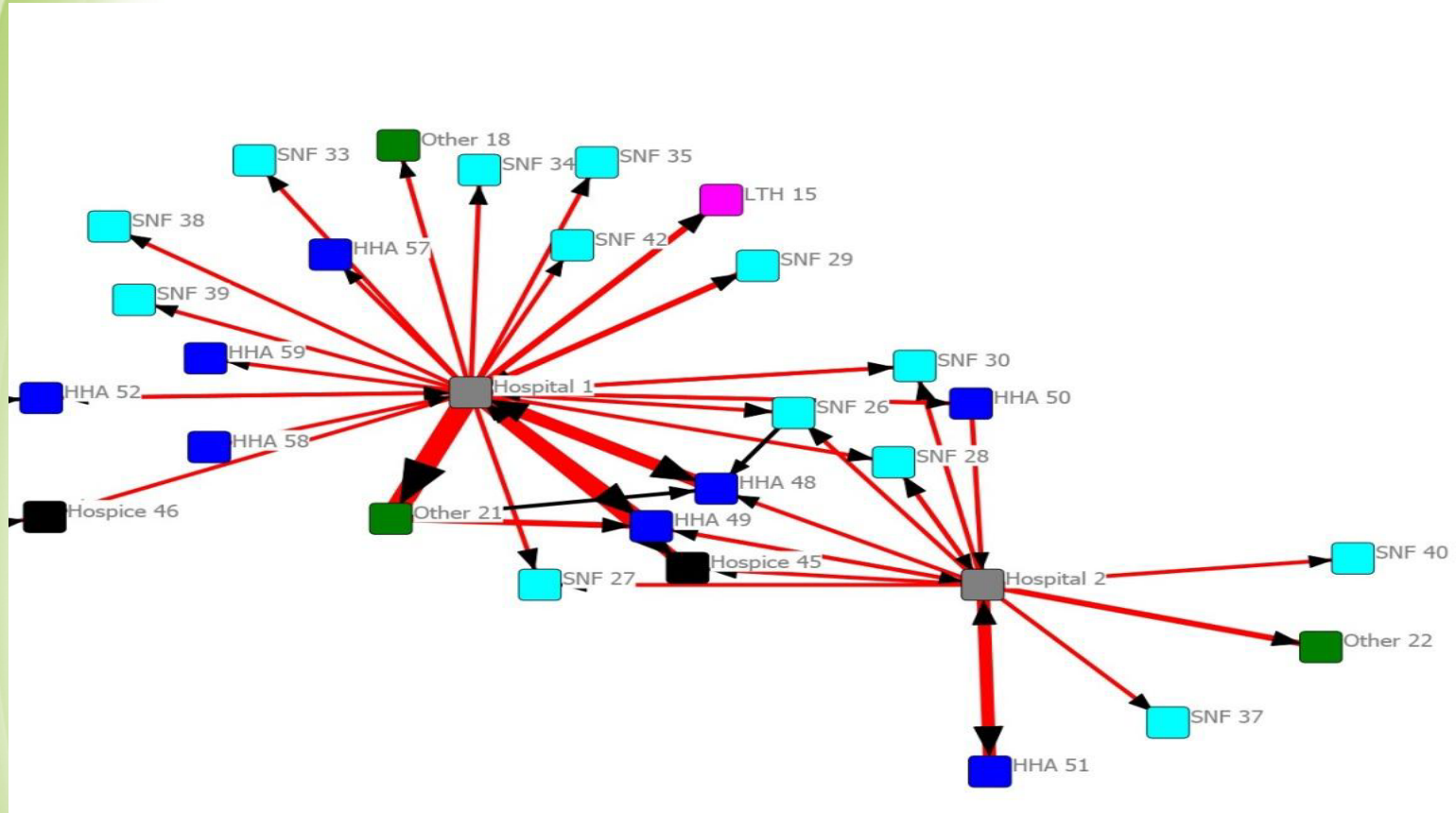
All Cause Readmissions (2008)

- Readmission rates for all causes among privately insured non-maternal adults age 45-64 were:
 - 7 day: 4.2%
 - 14 day: 7.1%
 - 30 day: 11.9%
- Non-maternal adults age 45-64 that were covered by Medicaid
 - 7 day: 8.1%
 - 14 day: 14.2%
 - 30 day: 24.4%

Readmission Analysis

- Review current trends
- Top readmission DRGs
- Medical record review
- Case management
- Patient interviews
- Review internal processes and systems for discharge planning
- RCAs

Identify Your Readmission Patterns



Readmission RCAs Indicate

- Patients experienced readmissions because of:
 - Unmanaged worsening of their conditions
 - The use of suboptimal medication regimens
 - Returning to emergency departments instead of accessing a different type of medical service

Three Drivers of Readmissions

1. Lack of engagement or activation of patients and families into effective post-acute self management
2. Lack of standard and known processes among providers for transferring patients and medical responsibility
3. Ineffective or unreliable sharing of relevant clinical information

Improving Transitions



DME

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Build a Motivated Community

- Identify your referral patterns
- Create a forum for routine discussion
 - Quality
 - Utilization
- Routine discussion of readmission cases
 - Multi-institution “transitional care” rounds
 - RCA selected cases
- Map/create handover management processes

Any questions?