



Quality & Safety Provisions in the Affordable Care Act (ACA)

James B. Battles, PhD

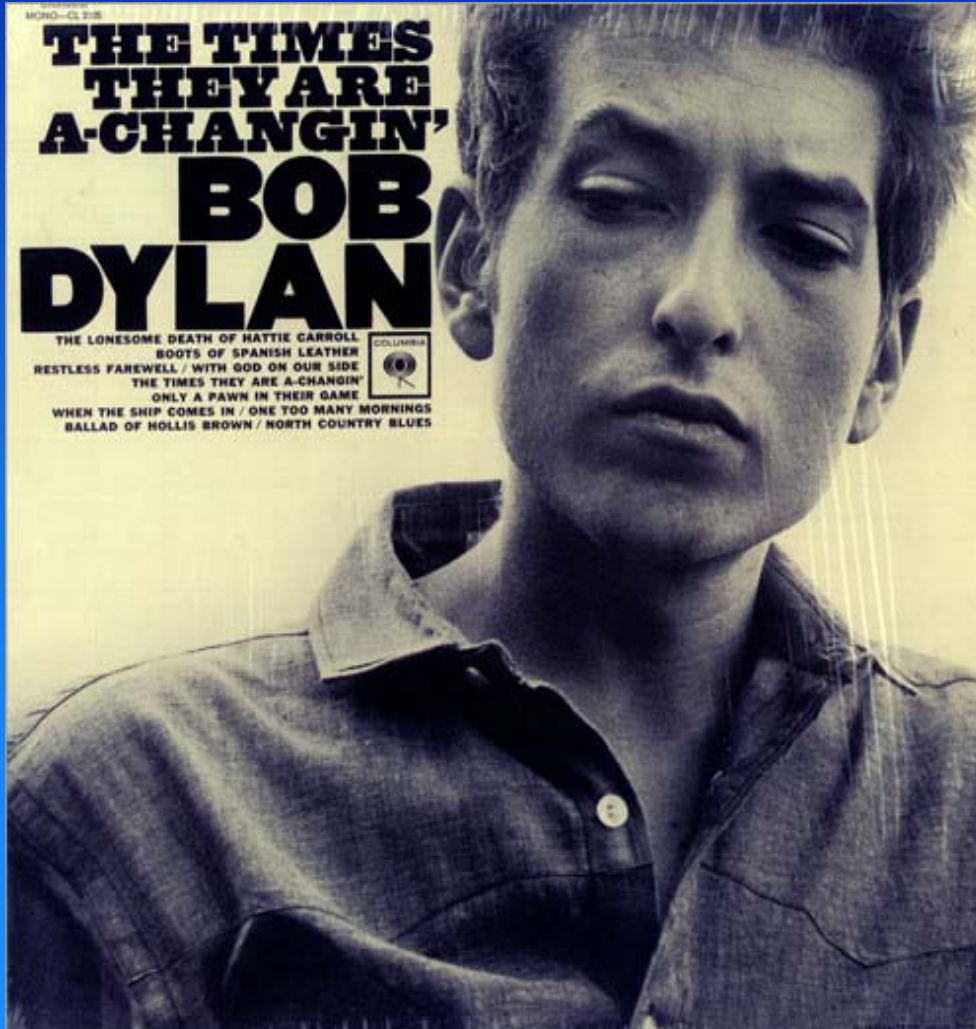
Agency for Healthcare Research and Quality

Center for Quality Improvement and Patient Safety

**Conference for Healthcare
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Stand By The Times They are a-Changin'



- As Bob Dylan song said the times are a-changin' in health care and in quality and patient safety



The Patient Protection & Affordable Care Act

March 23, 2010



- Health Reform has a significant role for AHRQ
- Establishes a Center for Quality Improvement and Patient Safety (CQIPS) within AHRQ by law
- Focus of research, development and implementation and technical assistance for quality Improvement and patient safety





National Strategy for Quality Improvement

SEC. 3011. (pp. 692-698)

- The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.
- In identifying priorities, the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act (i.e. NQF) and other stakeholders.
- The Secretary shall collaborate, coordinate, and consult with State agencies administering Medicaid and CHIP with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities.



National Strategy for Quality Improvement

- The strategic plan shall include provisions for addressing, at a minimum, the
 - Coordination among agencies within the Department.
 - Agency-specific strategic plans to achieve national priorities
 - Establishment of annual benchmarks for each relevant agency to achieve national priorities
 - A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan
 - Strategies to align public and private payers with regard to quality and patient safety efforts.
 - Incorporating quality improvement and measurement in the strategic plan for health information technology required by the ARRA of 2009.





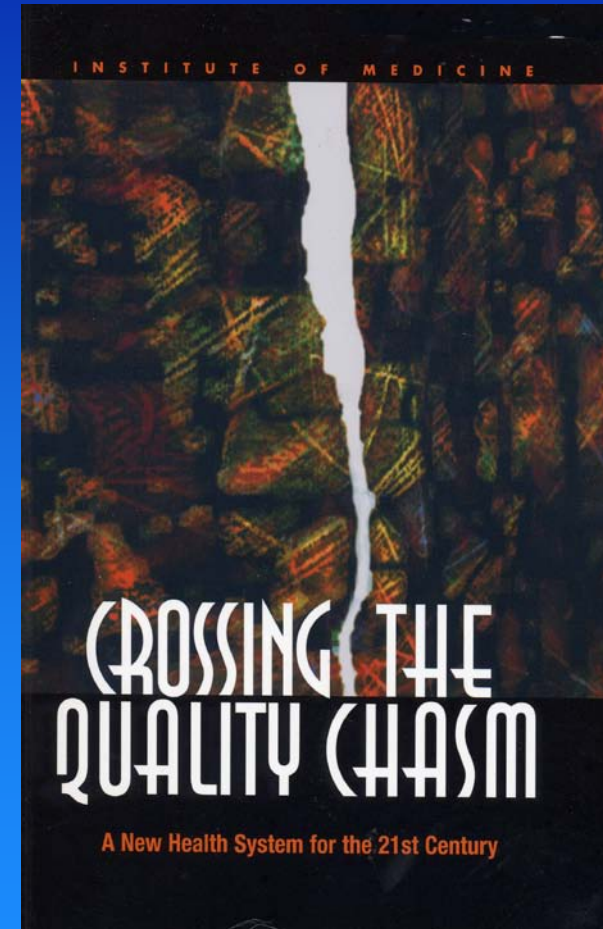
Quality Improvement

SEC. 3501. (pp. 1053-1067)

- Requires the Center for Quality Improvement and Patient Safety (**CQuIPS**) at AHRQ to conduct or support research and development of best practices for quality improvement, and to find ways to translate those into practice.
- Encourages AHRQ to support a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating interventions to improve quality and efficiency in health care.
- Requires prioritization based on national strategic plan under Sec. 3011, as well as ICU care, anti-biotic resistant infections, and preventable readmissions.
- Creates a grant program for technical assistance to health care providers with limited infrastructure and financial resources to support quality improvement activities.



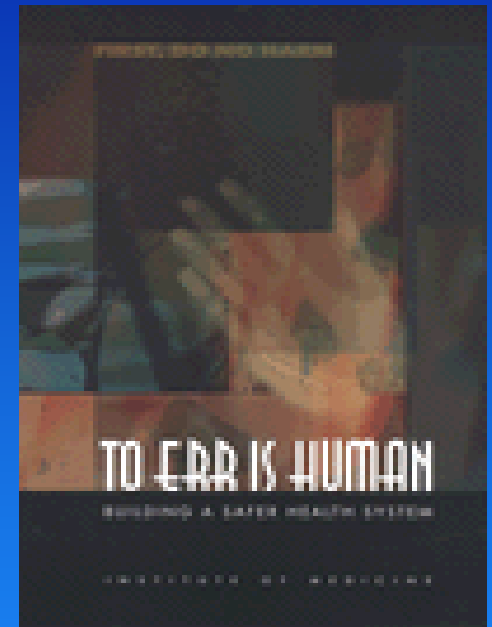
Patient Safety and Quality Road Maps





To Err is Human: Building Safer Health System

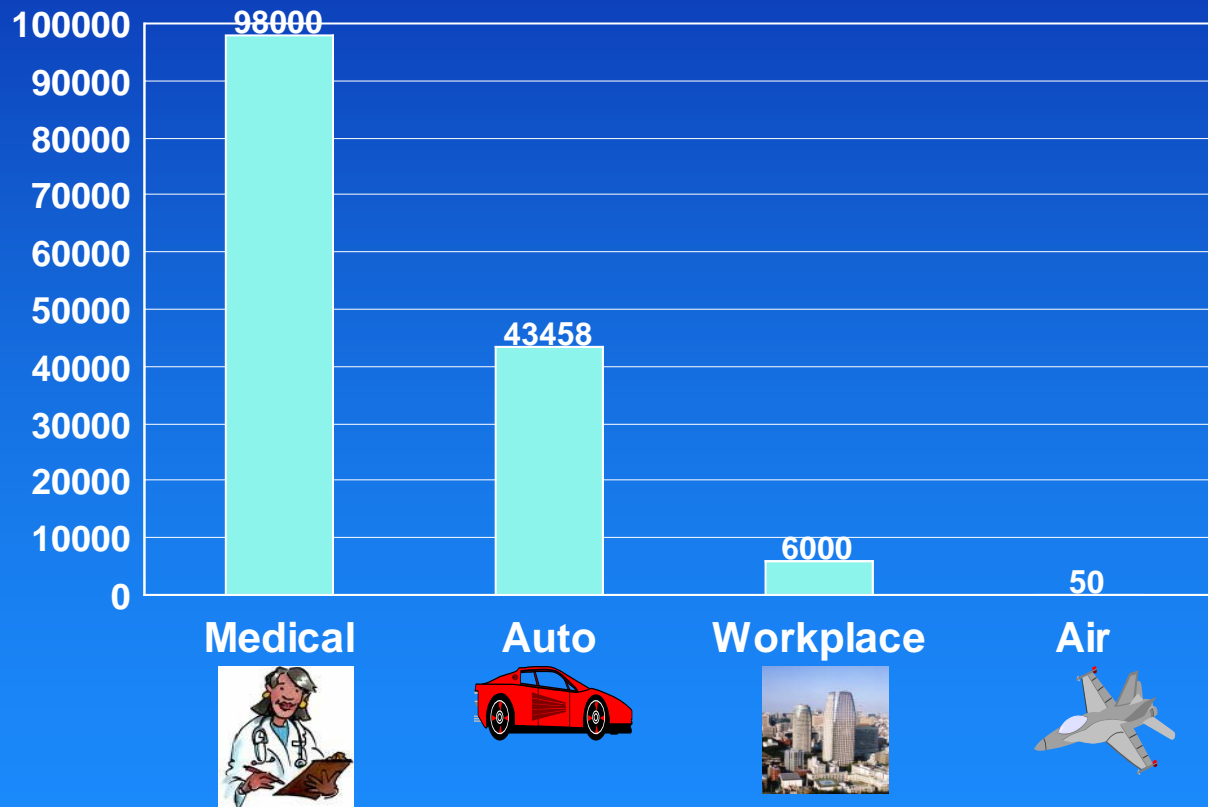
- 44,000 – 98,000 deaths/year
- 8th leading cause of death in US
- National Costs: \$17 to \$29 billion
- Adverse Drug Events: \$2 billion, alone
- 2% hospital admissions (preventable)
- Impact: \$4,700 in costs added to each hospitalization



Source: *To Err Is Human*, Institute of Medicine, 1999

Patient Safety: Relative Scope of the Problem

Patient Safety Related Deaths



Source: *To Err Is Human*, IOM, 1999



From Error to Harm

There is a shift from focusing on errors to a focus on harm

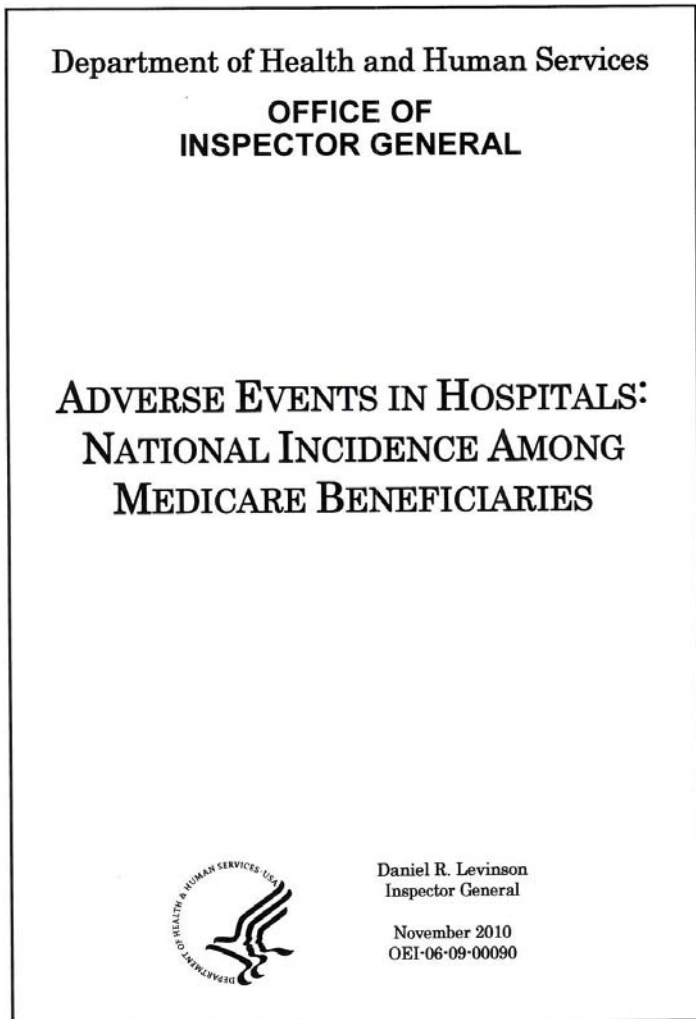
■ Health Care Associated Injury

- An injury or harm to a patient attributed to the process of care rather than underlying physiological conditions

- 15% of patients entering the hospital are harmed during their stay
- Reducing preventable harm would reduce the cost of care significantly(\$25 billion in three years)



OIG Report on Adverse Events in Hospitals (November 2010)



- 1 in 7 hospitalized Medicare beneficiaries experienced adverse events during their hospital stays or 13.5 percent
- \$4.4 Billion spent on care associated with adverse events



Harm

- There is also a shift from focusing on rates to absolutes
- Set a vision of ZERO Health Care Associated Injury



Health Care Associated Injury by other names

- Healthcare associated infections – HAIs
- Hospital acquired conditions – HACs
- Serious reportable events - SRE
- Serious adverse events – SAE
- Never Events



Healthcare associated infections HAIs

- Catheter-Associated Urinary Tract Infections - CAUTI
- Central Line-Associated Bloodstream Infections - CLASI
- Surgical Site Infections - SSI
- Ventilator-Associated Pneumonia - VAP
- MRSA
- *Clostridium difficile* – C-dif



HAI Problem

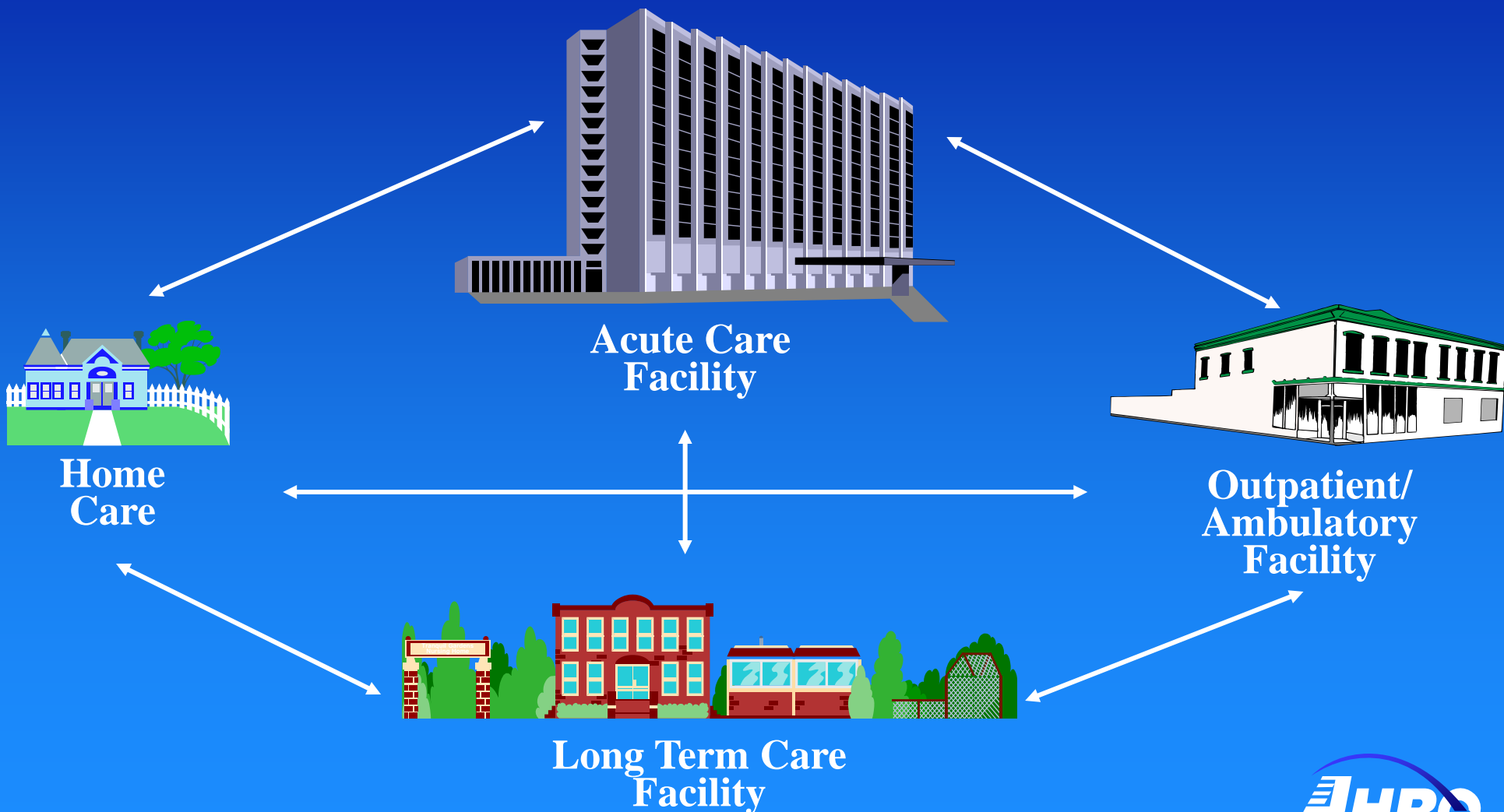
- 1.7 million HAIs in hospitals—unknown burden in other healthcare settings
- 99,000 deaths per year
- \$28-33 billion in added healthcare costs

HAI Prevention

Implementing what we know for prevention can lead to up to a 70% or more reduction in HAIs



Increasing Need for Public Health Approach Across the Continuum of Care





HHS Action Plan to Prevent Healthcare-Associated Infections

Development and Implementation



State Action Plans

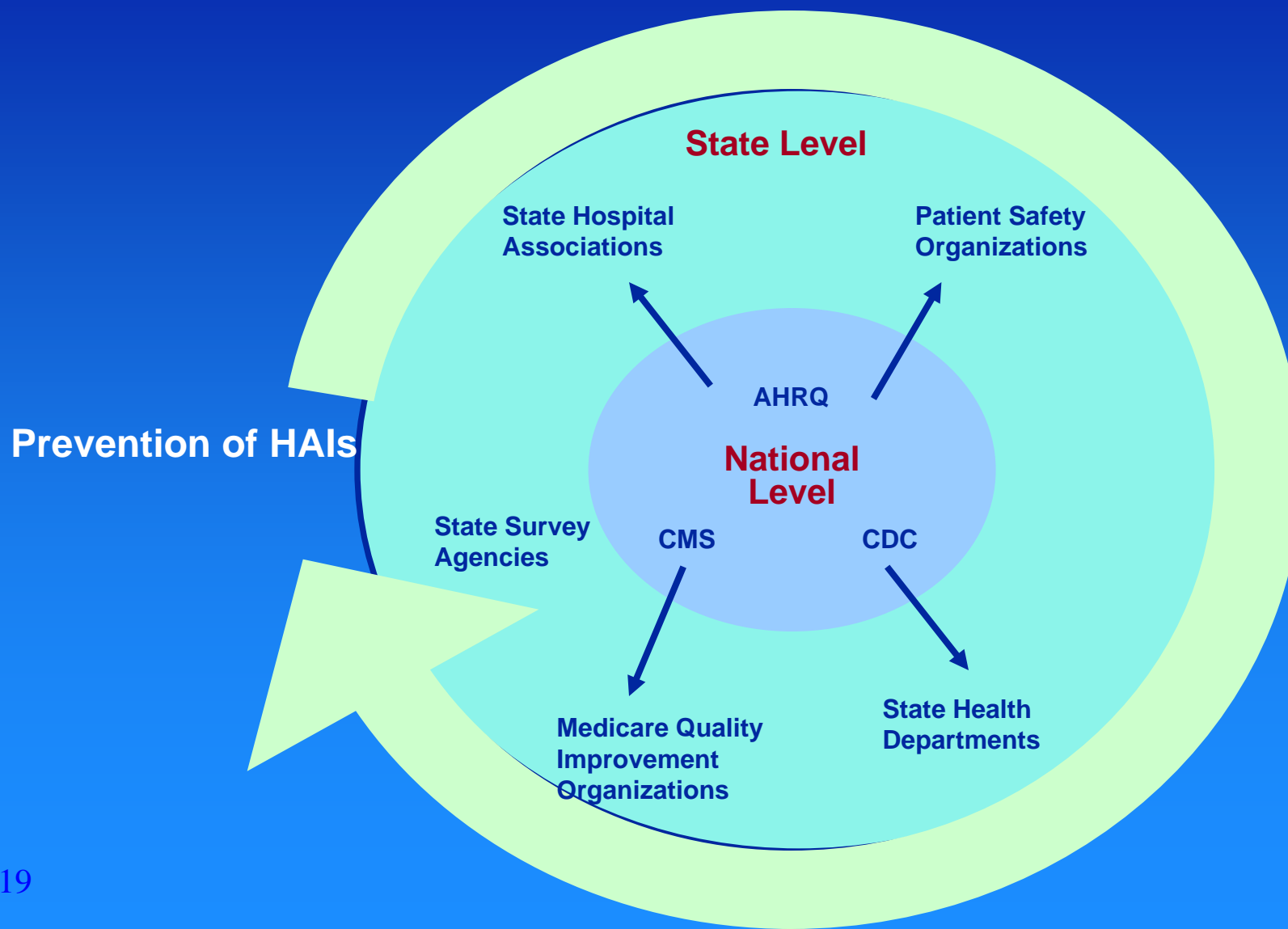
■ Fiscal Year 2009 Omnibus Bill:

- States receiving Preventive Health and Health Services (PHHS) Block Grant funds must submit a plan to the Secretary of HHS by **January 1, 2010**
- Authorizes CDC to **withhold 25%** of states allocated funds until this certification is submitted

■ CDC created a template to assist states in plan development

■ Technical assistance sessions and calls were provided to assist states in plan development

Coordinated State Level Activities Across HHS





Beyond HAIs

- What is next
- Using the HAI action plan as a model
- look for addressing other areas of harm - HACs and hospital readmissions



Hospital Acquired Conditions - HAC

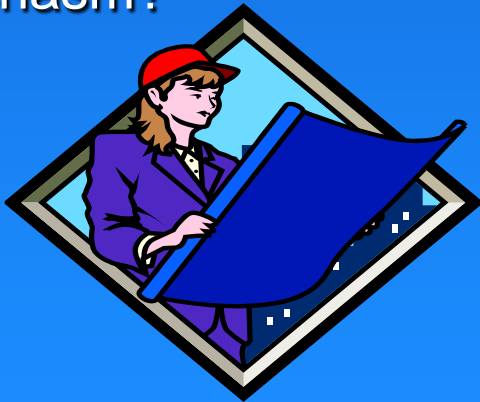
- A hospital acquired condition is a healthcare associated injury or harm that occurred in the in-patient setting i.e. the hospital stay such as:
 - HAIs are HACs
 - Venous Thromboembolism – VTE
 - Pressure Ulcers
 - Injury from Falls
 - Surgical Complications including SSI
 - Adverse Drug Events – ADEs
 - High alert medications
 - Medication reconciliation'
 - Obstetrical Adverse Events

Paradigm Shift Reactive to Proactive

- Isn't time we stopped measuring the width and depth of the quality chasm?

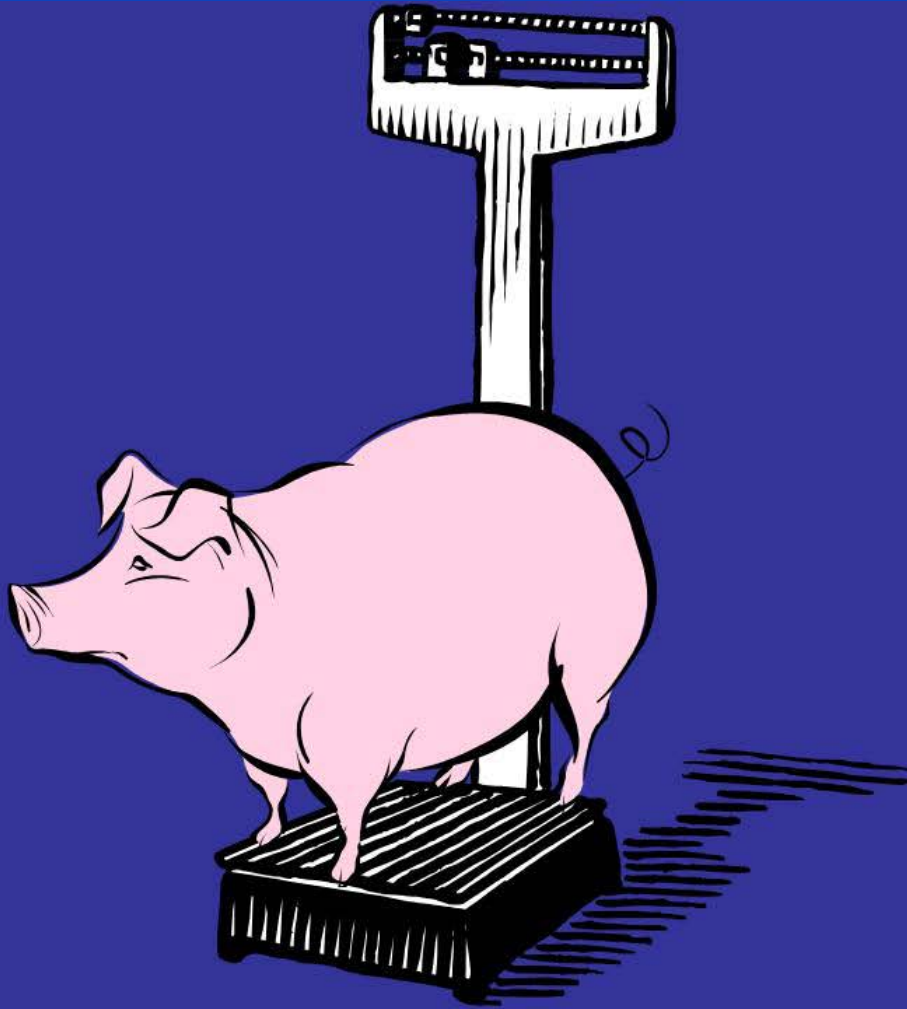


- And to begin designing and building the bridge to cross quality chasm?



From Measurement to Change

A pig never gained weight by just standing on a scale





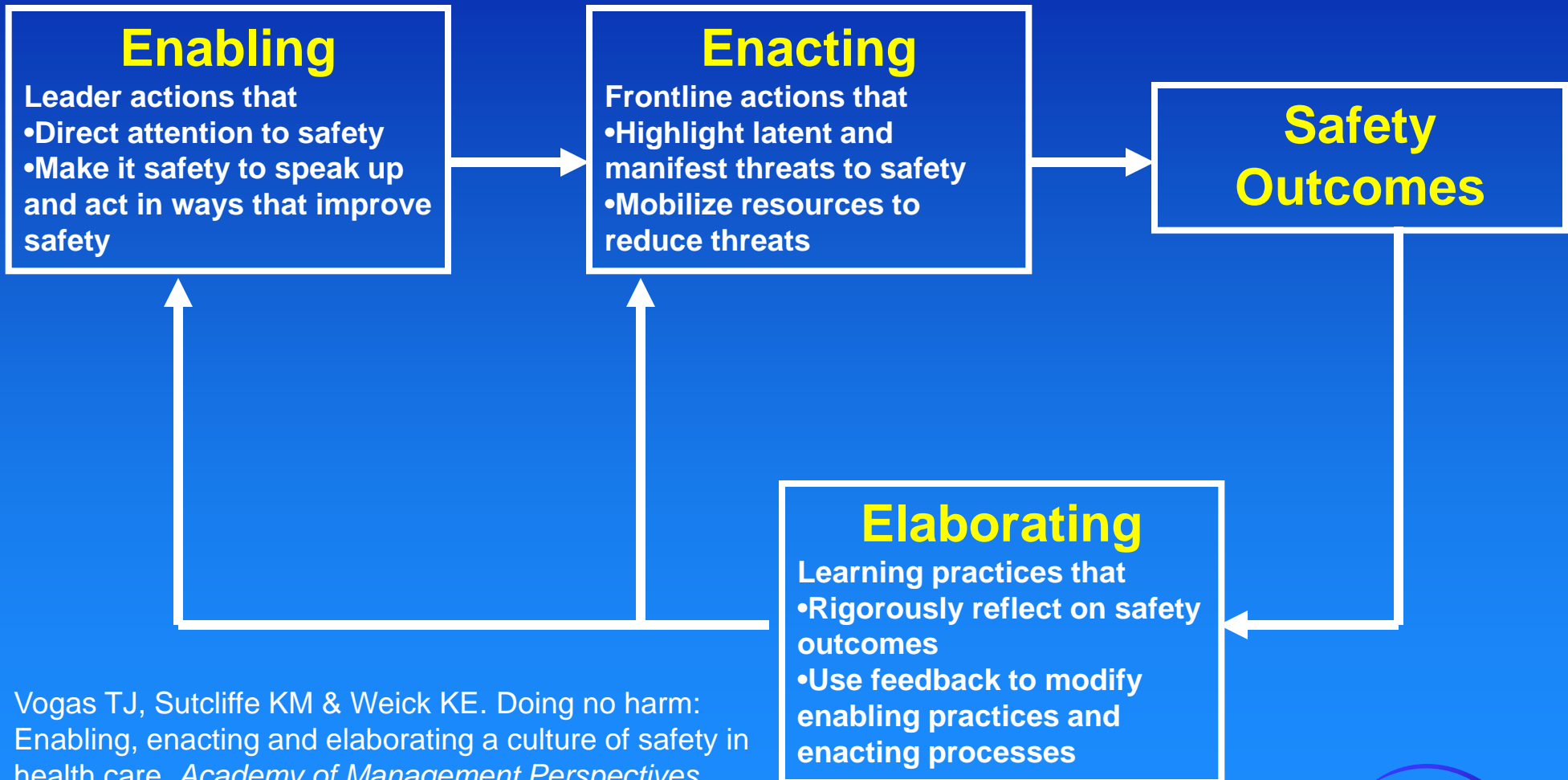
Safety Culture and Unit Practice Change

- Safety culture involves actions that single out and focus safety-relevant premises and cultural practices that reduce harm this entails:
 - Enabling, which consolidates the premises for a safety culture
 - Enacting, which translates considerate premises into concrete practices that prioritize safety
 - Elaborating, which enlarges and refines the consolidation and translation

Vogas TJ, Sutcliffe KM & Weick KE. Doing no harm: Enabling, enacting and elaborating a culture of safety in health care. *Academy of Management Perspectives* November 2010 60-77



Safety Culture



Vogas TJ, Sutcliffe KM & Weick KE. Doing no harm: Enabling, enacting and elaborating a culture of safety in health care. *Academy of Management Perspectives* November 2010 60-77



Comprehensive Unit-based Safety Program (CUSP)

- The CUSP approach was developed by Pronovost at Johns Hopkins to reduce harm from CLABSI
- The CUSP puts safety culture into action



CUPS for CLABSI

CUSP

- Assign executive to adopt unit
- Educate on the science of safety
- Identify defects
- Learn from defects
- Implement teamwork and communication tools

CLASBI

- Wash hands prior to procedure
- Use maximal barrier precautions
- Clean skin with chlorhexidine
- Avoid femoral lines
- Remove unnecessary lines



Core Tools for Change

- Engage hospital leadership
- Assess cultural climate with AHRQ Hospital survey on Safety culture
- Educate staff on science of safety –context
- Identify defects – event reporting
- Implement practice bundle & checklists
- Learn from defects conduct sensemaking sessions
- Team work improvement with TeamSTEPPS tools
- Assess outcomes of care





Achieving a Culture of Safety





Health Care and Teamwork


- Communication failures account for the overwhelming majority of adverse events
- Medical care is complex and human performance has inherent limitations
- Effective teamwork can prevent mistakes
- Embedding evidence-based training and team behaviors can enhance safety

Leonard, Graham, & Bonacum, 2004

- Team training has a positive impact on work force retention

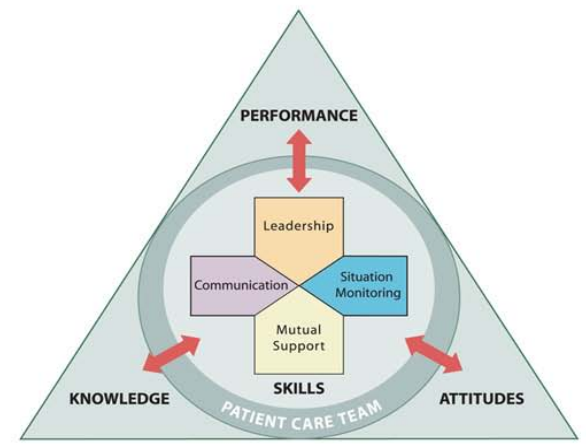
Evidence-based team training & implementation toolkit

- Improves communication & teamwork skills among health care professionals
- Set of ready-to-use materials & training curricula to integrate teamwork principles
- Collaboration between AHRQ & Department of Defense's military health system




TeamSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety



"Creating a Safety Net for Healthcare Organizations"





Change is Hard Work

- Everyone has a role to play
 - Health care providers
 - Health care organizations
 - Insurers private and public
 - Employers
 - Consumers
- Everyone must play
- Everyone wins by eliminating harm



Questions?



Thank You

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