Testimony – House Health Care Committee
Thursday, April 25, 2013

Update – VPQHC

Materials: 2012 Annual Quality Report
Brochure
Strategic Goals
Updated Board Member List
Staff Skill Sets
AHA Advertorial – WSJ April 23, 2013

Introduction

Good morning. My name is Catherine Fulton and I am the Executive Director of the Vermont Program for Quality in Health Care (VPQHC) based here in Montpelier, Vermont. I would like to thank the committee for this opportunity to provide the Committee with an update on current VPQHC operations.

The following statement provides a contextual framework for the work VPQHC undertakes; based on the health care delivery system concepts of Access, Cost and Quality, VPQHC directly supports the State's continuing health care reform efforts from the *quality* perspective. Our focus is to support hospitals with delivery system changes, ensure quality service delivery and initiate improvement efforts that in turn benefit patient outcomes and experiences.

Overview

This testimony is organized to provide the Committee with an overview of our four major areas of project deliverables:

1. Core Services VPQHC delivers to hospitals and insurers
2. Additional specialized support directed toward the Critical Access Hospitals (CAHs)
3. Focused special projects
4. Brief information on routine deliverables.

1. Core Services to Hospitals and Insurers

Examples of key services to hospitals and insurers includes performance improvement projects that help to focus efforts and resources to areas that will support success as health care reform payment incentives shift from volume to value. These examples include:

- Transitions of Care – improving discharge process
- Reducing Avoidable Readmissions
- Reducing/Eliminating Harm – Patient Safety reporting and analysis

- NHSN Support for Reporting Hospital Acquired Infections
- Act 53 Public Reporting
- Centralized resource/support for QI Directors
- Common Physician Measurement

Transitions of Care and Reducing Avoidable Readmissions

Background Information:

- Repeat acute care hospital visits are increasingly used as a measure to evaluate quality of health care
- Approximately 1 out of 5 Medicare beneficiaries in the United States is readmitted within 30 days
- When comparing readmission rates among Medicare patients, rates in most Vermont hospitals do not differ significantly from national rates
- Medicare began levying reimbursement penalties for 30 day readmissions in Jan 2013 for mid-sized and large hospitals – CAHs are preparing for this eventuality

Transitions of Care and Reducing Readmissions are inexorably linked; if the transition at discharge is thorough, complete and successful, this effort will reduce or eliminate the potential need for a hospital readmission.

We are entering the third year in FY2014 of our transitions work. Specific hospital projects to reduce 30 day readmissions and improve transitions of care, include interventions such as:

- Patient and family involvement in discharge planning and coordination of services,
- use of Teach back
- medication reconciliation
- timely handover communication
- post discharge care plan in patient friendly language
- post discharge follow up visit

The 8 CAH and 4 midsized hospitals implement these discharge planning interventions with at least 3 community partners (PCPs, Home Health, Area Agency on Aging), thereby increasing the success for continuing treatment in the community.

These projects are aligned with efforts of multiple partners such as the Quality Improvement Organization (QIO), Vermont Home Health Association (VHHA), Vermont Heath Care Association (VHCA), Vermont Ethics Network (VEN), Blueprint, Vermont Medical Society (VMS), Vermont Association of Hospitals and Health Systems (VAHHS), Department of Aging and Independent Living (DAIL), and the Area Agencies on Aging (AAA). The intent of alignment is to limit duplicative or overlapping efforts that can cause confusion and strain on limited organizational resources.

Reducing/Eliminating Harm – Patient Safety Reporting and Analysis

The Patient Safety Surveillance and Improvement System (PSSIS) captures Serious Reportable Event (SRE) information for the purpose of improving patient safety, eliminating adverse events in Vermont hospitals, and supporting and facilitating quality improvement efforts by hospitals. The Patient Safety Coordinator provides an on-site patient safety review of all hospitals and psychiatric facilities in the state, and monitors all root cause analyses (RCAs) and corrective action plans (CAPs) submitted in response to events.

Act 53 Public Reporting

Vermont law requires hospitals to publish annual reports containing information about quality of care, hospital infection rates, patient safety, nurse staffing levels, financial health, costs for services, and other hospital characteristics. VPQHC annually supports the State of Vermont in the development and publication of Hospital Report Cards by producing the following reports:

- Surgical Site Infection (SSI) Standardized Infection Ratios (SIRs) for Hips, Knees, and Hysterectomies
- Central Line Associated Bloodstream Infections (CLABSI) SIRs
- 30-day hospital readmission and mortality rates for heart failure, heart attack, and pneumonia
- Abdominal aortic aneurysm repair volume and mortality rates
- Esophageal resection volume and mortality rates
- Pancreatic resection volume and mortality rates
- Implementation of recommendations for prevention and control of antibiotic resistant infections and central line associated bloodstream infections
- Nurse staffing hours

In addition to creating detailed reports, VPQHC provides support and data validation to hospitals reporting Hospital Acquired Infections (HAIs) through the National Healthcare Safety Network (NHSN).

Centralized resource/support for QI Directors

Quarterly meetings including webinars directed at skill development, clarification of regulatory requirements, new initiatives and professional development help to support the local quality improvement specialists. In addition many hours are spent researching specific hospital questions in relation to quality, patient safety, risk management, peer review, regulatory oversight, and other topics as requested.

Support to Insurers

Vermont's managed care regulation requires commercial health plans to produce and report performance measures for primary care and specialist physicians. However, because providers see patients with multiple insurers, data from any one health plan is incomplete. The Common Physician Measurement workgroup was convened to explore the utility of aggregating physician-level data from health plans in order to make physician-level reporting more complete and meaningful. The initial focus of this pilot is on creating physician-level reports for approximately **70** individual physicians in 14 pediatric practices. Quality of care is reported using three HEDIS measures.

1. Appropriate testing for children with pharyngitis
2. Appropriate medications for children with asthma
3. Appropriate use of medication for children with upper respiratory infections

2. Specialized Support to CAH

The second major area of project deliverables provides specialized projects and services to the Critical Access Hospitals (CAHs).

Critical Access Hospitals receive the benefits of all of the initiatives described above, but through separate funding streams that are coordinated through the State Office of Rural Health, have received additional focused support in the following areas:

- Conditions of Participation (CoPs) Quality Assurance Performance Improvement (QAPI) Surveys
- CPHQ and Middle Manager Training
- ICD-10 Transition

CoPs Quality Assurance Performance Improvement (QAPI) Surveys

Staff conduct periodic evaluation and quality assurance review for each of the Critical Access including clinical record and health care policy review, utilization of services, appropriateness of care, infection control and medication safety. A review of services affecting patient health and safety including quality and appropriateness of diagnosis and treatment furnished by MD/DO/NP/PAs etc. which is a mandatory requirement of CAHs. Survey visits provide an opportunity for questions, research, and best practice review to reinforce the learning systems approach to compliance and survey readiness.

Developing/deploying CPHQ and Middle Manager Training Statewide

VPQHC coordinated with New England Performance Improvement Initiative (NEPI) of the New England Rural Health Round Table (NERHRT) to provide financial remuneration to candidates to prepare for and pass the Certified Professional in Healthcare Quality examination. The intent was

to raise the training and certification levels of currently employed quality leaders who will then embrace and implement the quality improvement body of knowledge in their organizations.

The 2013 training focused on developing skill sets for middle managers who often find themselves newly assigned to a supervisory or leadership role without requisite experience or specific training. This opportunity helps raise the knowledge level for these managers in the following areas:

- lead quality improvement efforts in their local settings
- linking department-level improvement activities to the organization's goals and overall strategic plan
- successful partnering with front-line staff in quality improvement activities

New Project: ICD 10 conversion support for CAHs:

On October 1, 2014 all healthcare billing will be required to use new ICD-10 codes. This transition is more complex and pervasive for hospital organizations that the Y2K migration.

VPQHC is collaborating with the State Office of Rural Health (SORH) to coordinate training, team building, project implementation (using an external content expert source) and to develop on line education and support discussions to share best practice. This project will also align efforts with DVHA, VMS and VDH to ensure distribution of education and training for all stakeholders across the State.

3. Focused Improvement Projects - LTC NHSN MDRO Infection Reporting Specialist

The third category representing focused improvement project efforts describes Vermont's proactive response in addressing Multi-Drug Resistant Organism (MDRO) infection reporting in long term care facilities.

Five million Americans will be residing in Long Term Care Facilities by 2030. With this knowledge Health and Human Services (HHS) has included Long Term Care Facilities in the National Action Plan to prevent Healthcare-associated Infections: Roadmap to Elimination. A priority goal in this plan is the enrollment of LTCFs into the National Healthcare Safety Network (NHSN). VPQHC has hired a grant-funded NHSN Project Specialist to work closely with the VDH HAI program to:

- Assist LTCF Infection Preventionists with enrollment and reporting of MDRO and C. difficile infections in NHSN LTC Component.
- Compile data to estimate the prevalence of MDRO and C. difficile infections in the State of Vermont.

To date of the 30 participating LTCFs there are 19 LTCFs that are now enrolled and 5 LTCFs in the process of enrollment.

4. **Routine Deliverables**

The fourth and final area of today's presentation briefly addresses elements of on-going support VPQHC routinely administers including:

- Technical Advice & Support – robust website, web "blasts"
- Peer Review Portal
- Annual Quality Report

Technical Advice and Support includes the production and maintenance of our website and monthly distribution of "web blasts" to a diverse group of hospital managers. The email "blasts" have a theme for the month, and conveys the most current available publications, toolkits, and resources available on the particular topic.

VPQHC maintains a statewide peer review pool from which to draw physicians to conduct or assist in peer review. This information is available through our website and offers information sharing of best practice regarding peer review and credentialing. This resource provides the tools for routine review of patient charts for provider performance evaluation during CoPs reviews and for other regulatory requirements.

The annual Quality Report provides an easy-to-read summary of year's activities that hopefully serves as an informational reference document for professionals and laymen alike. This year's Quality Report includes a scan code that will enable a smart phone to directly connect to our website home page to access the posted information and tools.

Conclusion

I would like to conclude this formal testimony by sharing a valuable regional conference announcement; the "Creating a Culture of Safety Best Practices in Implementation Science" Patient Safety Conference will be held on Tuesday May 7, 2013 at the Grand Summit Resort Hotel and Conference Center at Mt. Snow, Vermont. It is sponsored by the Southwestern Vermont Medical Center, Dartmouth Hitchcock Medical Center, and Fletcher Allen Medical Center. This conference will feature Dr. Peter Pronovost as the keynote speaker and will highlight the implementation of best practices for patient safety.

Thank you again for this valuable opportunity and introduction. I would like to extend VPQHC as a resource to the committee and please feel free to reach out to us in that capacity as you work to support the health care delivery systems that care for all Vermonters.

Respectfully submitted,
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