CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

Promoting Safest Health Care Through Agency Collaboration: AHRQ, CDC and CMS












Speakers

Michelle Schreiber, MD - CMS

Arjun Srinivasan, MD – CDC

Erin Grace - AHRQ

AGENDA

- CMS National Quality Strategy Safety Initiatives
- CDC Patient Safety Initiatives
- AHRQ Patient Safety Initiatives
- Aligning Across Agencies

We Are Better Together

- *"The more complex the world becomes, the more difficult it is to complete something without the cooperation of others."*

  Alexander Fleming

- We all know that meaningful advances in patient safety will take close collaboration from a host of groups.
- We in the government are committed to deepening our collaboration, not only with each other, but with all of you.
- Tell us what we can do with you!

Health Care Safety during the Pandemic and Beyond – Building a System That Ensures Resilience

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Health Care Safety during the Pandemic and Beyond — Building a System That Ensures Resilience

Lee A. Fleisher, M.D., Michelle Schreiber, M.D., Denise Cardo, M.D., and Arjun Srinivasan, M.D.

As we emerge from this public health emergency, we at CMS and the Centers for Disease Control and Prevention (CDC) are committed to a renewed focus on patient safety. We seek to join leaders from throughout the health care ecosystem in reviewing safety practices and seeking better and more deeply embedded solutions that also help to close health disparities, since there is no true health care quality and safety without equity.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Safety Lessons Learned from Covid

- Safety metrics significantly worsened
- 40% rise in healthcare associated infections
- Rise in complications such as falls, pressure injury
- Reporting declines in error reporting and safety practices
- Organizations with deeply embedded safety practices and reliability plus well developed systems tended to do better (Veterans Administration)
- Some facilities and regions saw enhanced levels of cooperation and coordination (dialysis, some hospitals, LTCH)

Cross Agency Commitment to Safety

- CMS, CDC, AHRQ and FDA working collaboratively helped lead the HHS Patient Safety meeting November 2022
- CMS, CDC, AHRQ meet regularly to design Leadership Alliance for safety
- VA and DoD advancing High Reliability for safety
- Many components and levers for safety across HHS agencies, which when aligned/combined lead to strong advances for patient safety
  - Maternal Safety
  - Nursing Home Safety
  - Mental Health Integration
  - Equity Focus
- Rapidly growing technology for safety, including shared data through interoperability will also advance safety

CMS: Strategies for Advancing Safety

Michelle Schreiber, MD

Deputy Director – Center for Clinical Standards and Quality

Director, Quality Measurement and Value Based Incentives Group

CMS

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CMS National Quality Strategy
Goals

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

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

Advancement
Promote advancement in science, analytics, and technology

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Safety and Resiliency

Safety: Achieve Zero Preventable Harm

OBJECTIVE

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

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, and Conditions of Participation.

HIGHLIGHTED 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 data on safety indicators across programs, including data on key areas such as maternal health and mental health.
- Align across HHS to implement actions from the President's Council of Advisors on Science and Technology (PCAST) to further enhance patient safety.

CMS Levers for Safety

- Conditions of Participation – all CoPs are considered health and safety standards. Applies to 20 facility types. QAPI is the coordinated application of quality management systems and performance improvement
- QIO – quality improvement organizations – target safety especially in nursing homes and hospitals
- Leveraging value based quality programs for safety including new metrics: diagnostic accuracy, EMR safety, and electronic quality measures
- “return to basics” of culture of safety throughout entire organization
- Workforce safety – staffing levels, turnover

Recently Expanded Patient Safety Metrics

- Hyper and Hypo Glycemia*
- Opioid Safety* (including e-prescribing of Opioids)
- Acute Kidney Injury*
- Pressure Ulcers*
- Radiation Safety*
- Maternal Safety*
- Use of SAFER guidelines
- Nursing Home Staffing

- Future Considerations
  - Diagnostic Excellence
  - Suicide Prevention
  - Falls with Injury
  - Updated Healthcare Acquired Conditions (Hospital Onset Bacteremia)
  - Structural Safety Measure

*Denotes Electronic Clinical Quality Measure – eCQM Goal to Align with CDC NHSN

Future Safety Measure Considerations

- Diagnostic Excellence
- Suicide Prevention
- Falls with Injury
- Updated Healthcare Acquired Conditions (Hospital Onset Bacteremia)
- Structural Safety Measure
- Ambulatory Safety
- Workforce Safety

Other Safety Program Considerations

- Evaluation of Safety in Hospital Stars and other Value Based Programs (safety weighting, inclusion of safety metrics in all VBP)
- Payment/non-payment for error
- QIO network of support for assistance with best safety practices
- Conditions of Participation, QAPI, survey & certification
- Promoting Patient and Caregiver Engagement – patient reporting of error, use of Communication and Resolution Programs
- Promoting Best Practices of High Reliability
  - Safety Huddles and Rounding
  - Culture of Safety
  - Engagement of Leadership and Governance
  - Teamwork and Communication

CDC's Role in Patient Safety

Capt. Arjun Srinivasan, MD
Director of Healthcare Quality Promotion
CDC

Division of Healthcare Quality Promotion

- The mission of the Division of Healthcare Quality Promotion (DHQP) is to protect patients; protect healthcare personnel; and promote safety, quality, and value in both national and international healthcare delivery systems.

Areas of Focus- What We Do

- Healthcare associated infections
- Antibiotic resistance, including improving antibiotic use (“stewardship”)
- Healthcare strengthening/healthcare preparedness, including training
- Medication safety
- Blood, organ and tissue safety
- Immunization safety
- Sepsis

National Healthcare Safety Network: The Nation's Healthcare Surveillance System

Standards-based, vendor-neutral, surveillance program

The trusted healthcare surveillance program for patient-safety events, and healthcare preparedness with best-in-class data automation and user interfaces

- Combines facility-level, clinical performance measurement with national-level, public health surveillance & healthcare quality improvement
- Based on rigorously-defined, validated metrics of clinical care
  - NHSN measures are NQF endorsed
- Supports CMS' large pay-for-performance/value-based purchasing programs
  - CMS publicly posts NHSN data at the facility level for hospital, nursing homes
- Provides simultaneous data to states, facilities, & other users
- More than 130,000 users in more than 37,000 facilities of all types.

Data as of March 2022

National Healthcare Safety Network A broad suite of measures

- Many related to healthcare associated infections and antibiotic resistance.
- Healthcare personnel vaccination rates: influenza and COVID
- Adverse events in outpatient surgery: falls, burns
- Blood safety events
- Medication safety- hypoglycemia events (under development)
- Other safety events under development, e.g. venous thromboembolism

NHSN: Data For Action

- Healthcare facilities use NHSN data to find locations where infection rates are high.
- Healthcare systems use NHSN data to find facilities where rates are high.
- State health departments have access to NHSN data and use it to follow up with facilities with high infection rates.
- There are hundreds of quality improvement efforts that have created their own "groups" within NHSN to use the data for action.
- CMS Quality Improvement Networks have been using the vaccination data to work directly with nursing homes with low vaccine uptake.

Defining Risk Factors For Action

- CDC uses multiple data sources to assess risk factors for infections and adverse outcomes to inform where we need to focus prevention efforts:
  - Which types of healthcare facilities struggle the most with prevention?
  - Which patients are at the highest risks?
- We are increasing our efforts to identify important **facility** and patient disparities and health equity issues that are **drivers** of poor outcomes, not just associated with them.
  - Very little has been done to address facility level disparities.
- The Emerging Infections Program, a collaboration between CDC and 10 state health departments and academic partners, is a critical part of this work.

Knowing Is Not Enough…

- The Targeted Assessment for Prevention (TAP) Strategy is a feature of NHSN for quality improvement designed to use data for action to prevent healthcare-associated infections.
- Users can run reports to find locations with opportunities for improvement.
- They can access gap assessment and improvement resources from the same site.

The Targeted Assessment for Prevention (TAP) Strategy

Implementation: Informing Practices

- Division of Healthcare Quality Promotion supports the Healthcare Infection Control Practices Advisory Committee (HICPAC), which produces comprehensive, gold-standard guidelines for infection prevention and control.
- Interim infection control guidance for emerging threats- Ebola, COVID, COVID, COVID.
- Setting specific guidance on infection prevention practices in specific settings- dialysis, neonatal intensive care units, dentistry
- Practice specific guidance- improving antibiotic use through stewardship

Implementation: Improving Practices

- We learned during the pandemic that providers wanted more training and support on implementing optimal infection prevention practices.
- CDC launched Project Firstline in response
  - https://www.cdc.gov/infectioncontrol/projectfirstline/index.html
- A collaborative of diverse healthcare and public health partners that aims to provide engaging, innovative, and effective infection control training for millions of frontline U.S. healthcare workers as well as members of the public health workforce.
  - Focus on equity and addressing disparities

Implementation: Partnerships
If you want to go far, go together.

- Who do we partner with? Yes!
- Providers, payors, industry, professional organizations, health departments, patients
- State health departments are a key partner for CDC.
- We fund staff who work specifically on healthcare associated infections and antibiotic resistance in every state.
- Find yours: https://ww.cdc.gov/hai/state-based/index.html
- Our state colleagues built relationships with providers and facilities before the pandemic - those connections were hugely important during COVID.
- State health departments did more than **18,000** consultations with facilities over the past 2 years.

Partnerships: Patients Are At the Center of What We Do

- DHQP has an active patient engagement effort with a variety of patients advocates and organizations.
- They make our work better (and more meaningful).

Finding My Voice as a *C. diff* Patient

At the age of 31, I knew nothing of patient advocacy; having a voice for my own healthcare simply hadn't crossed my mind. I've since learned that it is essential to include patient voices in the healthcare system. When I was prescribed a preventive antibiotic for a root canal I, like most Americans, thought nothing Read More >

October 27, 2021 by Christina Fuhrman

6 Comments

Antibiotic Resistance and Antibiotic Use (Stewardship), Healthcare-associated infections

Antibiotic Resistance and Antibiotic Use (Stewardship), C. difficile, Healthcare-associated Infections, Survivors

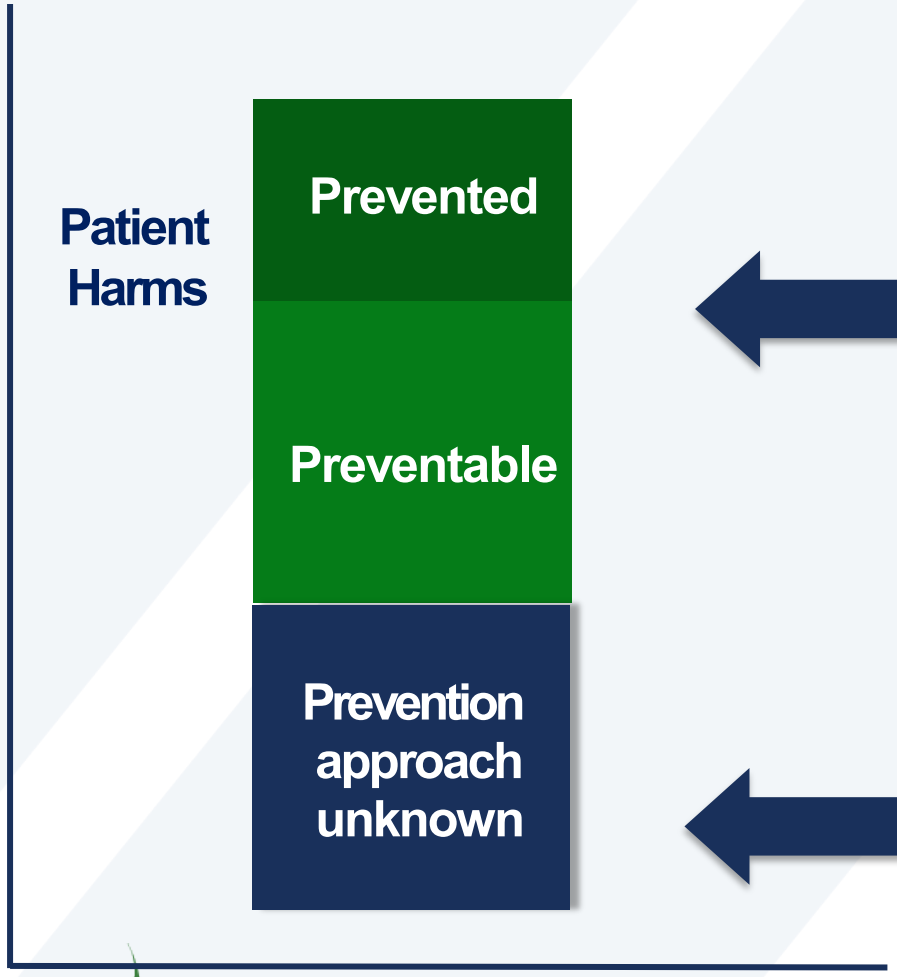
Patient Safety Representatives Unite to Implement Global Patient Safety Action Plan in the United States

Preventable harm in the healthcare system is an urgent public health challenge, internationally and in the United States. Globally, more people die now from medical errors or other breakdowns in the quality and safety of healthcare services than from lack of access to them. (1) Researchers estimate that medication errors, preventable infections, venous thromboembolism, falls, Read More >

Implementation: Communications
It Doesn't Matter What You Do If No One Knows

- DHQP issues regular reports on our work- healthcare associated infections, antibiotic use and resistance, sepsis.
- We have a variety of patient resources.
- We're making more data directly available to the public and researchers.
- Antibiotic Resistance and Healthcare Associated Infections Patient Safety Portal (https://arpsp.cdc.gov/) is an interactive databases that lets users create their own data searches and graphs.

Innovation- Expanding Our Abilities to Protect Patients



- **Data**
  - Outcomes, practices, risk factors, and pathogens
- **Implementation**
  - Practices
  - Programs
  - Policies and communications
- **Innovation**
  - Intramural
  - Extramural

Healthcare Innovation Portfolio

- CDC supports a variety of investigative efforts to learn more about:
- Novel prevention approaches
- Better ways to implement prevention strategies
- New ways to measure performance
- Some of that work is more directed "please answer this question"
- Some of that work is more investigator drive "what questions need to be answered"
- All of that work is collaborative.

Developing Healthcare Safety Research (SHEPheRD)

CDC PREVENTION EPICENTERS
innovative research to protect patients

Erin N. Grace, M.H.A

Deputy Director
Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality

AGENDA (2)

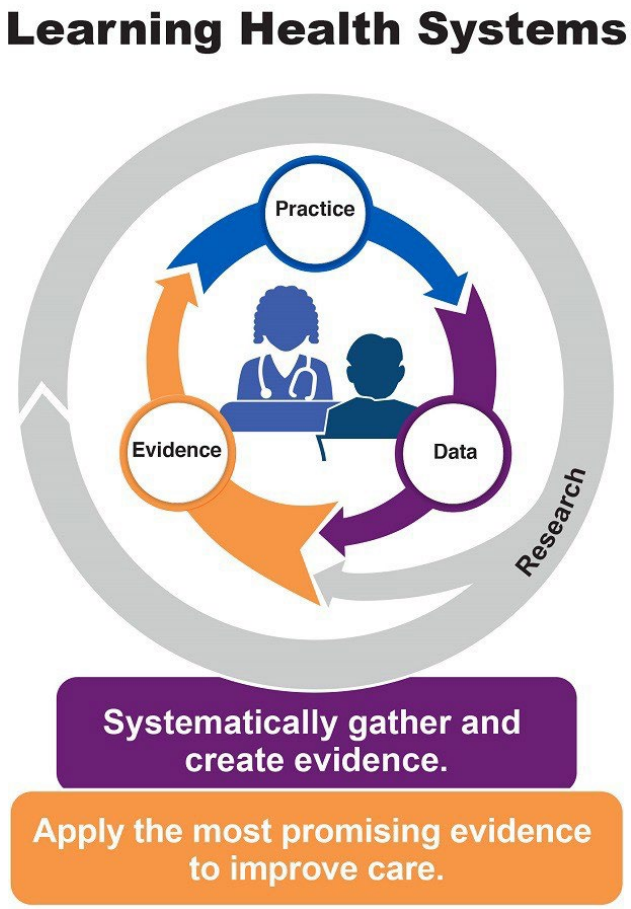
- AHRQ's Patient Safety Programs – Including focus on improving diagnosis in healthcare
- HHS Patient Safety Convening and Co-creation of National Action Alliance
- Information, Action, Innovation – Together

AHRQ Safety Programs

- Patient Safety Program
- Patient Safety Organizations Program
- Healthcare-Associated Infections Program
- Measurement Programs
  - National Healthcare Quality and Disparities Report (NHQDR)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
  - Surveys of Patient Safety Culture (SOPS)
  - Quality Indicators
    - Patient Safety Indicators (PSIs)

Integrating Research, Practice, and Data for Patient Safety Improvement

- Research
  - Generate scientific evidence about how to improve safety
  - Translate evidence into information that can actually be used
- Practice*
  - "Technical" aspects of care
    - To prevent events such as medication events, HAIs, VTE, etc.
  - Foundational factors
    - Just culture, team-based care, patient & family engagement, workforce safety, CUSP
- Data, Analytics, and Measurement
  - Information to support improvement where care is delivered
  - Becomes "Knowledge" to perpetuate the improvement cycle



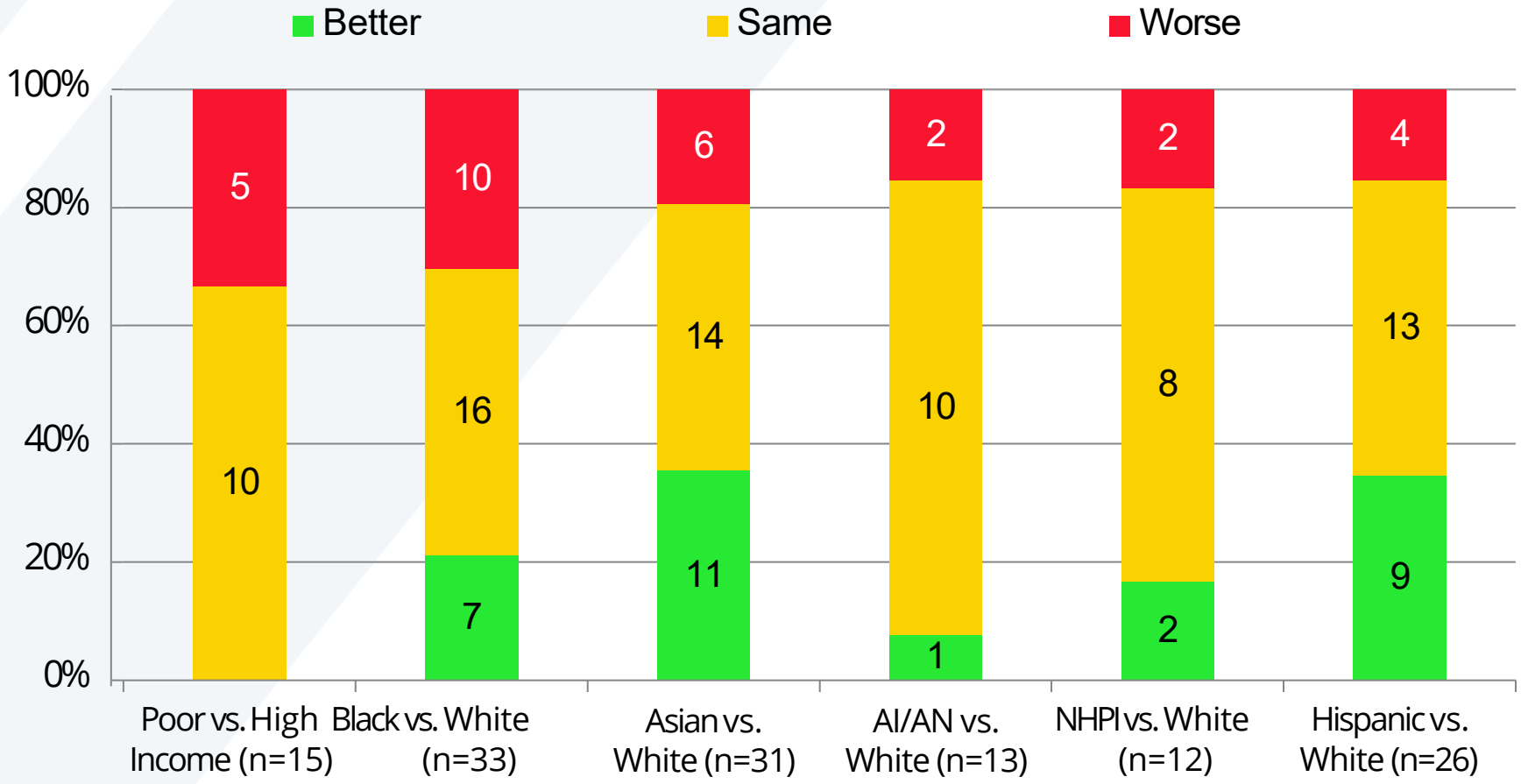
*Evidence demonstrates that improvement depends on both technical aspects of care AND foundational factors

AHRQ Patient Safety Priorities

- Understand causes of patient harm
  - ***All settings of care and transitions between them***
  - ***Advance Diagnostic Safety and Quality***
- Apply knowledge to accelerate improvement
- Improve organizational culture, teamwork, and communication
- Support patient and family engagement
- Integrate patient safety improvement with clinical workflow
- Strategies to prevent many different harmful events, including:
  - Hospital-acquired conditions (HACs)
  - **Diagnostic errors**
  - Healthcare-associated infections (HAIs)
  - Medication safety events, etc.

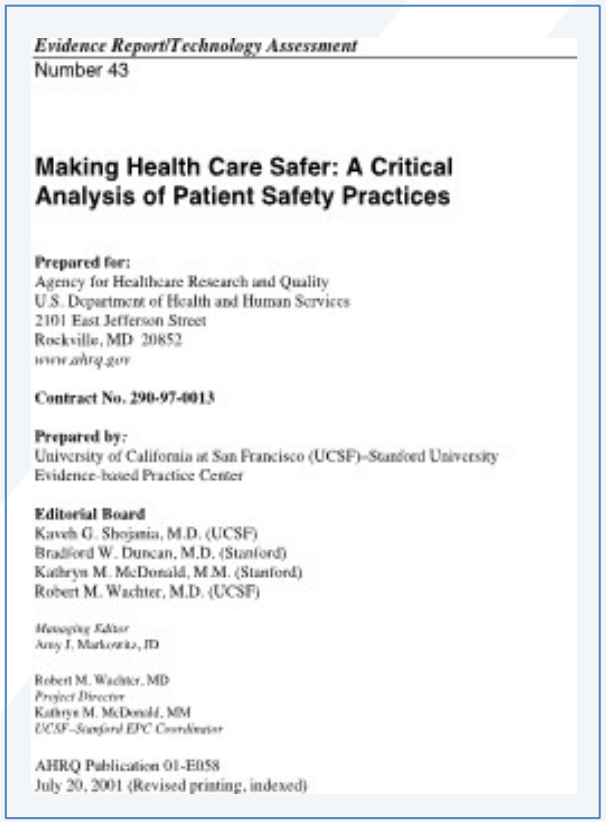
Equity and Patient Safety: Some Patient Harms Place Higher Burdens on Different Groups

Number and percentage of NHQDR patient safety measures for which members of select groups experienced better, same, or worse quality of care compared with reference group, 2016, 2017, or 2018



Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander; n = number of measures.
Note: Poor indicates family income less than the Federal poverty level. High Income indicates family income four times the Federal poverty level or greater.

Making Health Care Safer Evidence Reports on Safe Practices


Evidence Report/Technology Assessment
Number 43

Making Health Care Safer: A Critical Analysis of Patient Safety Practices

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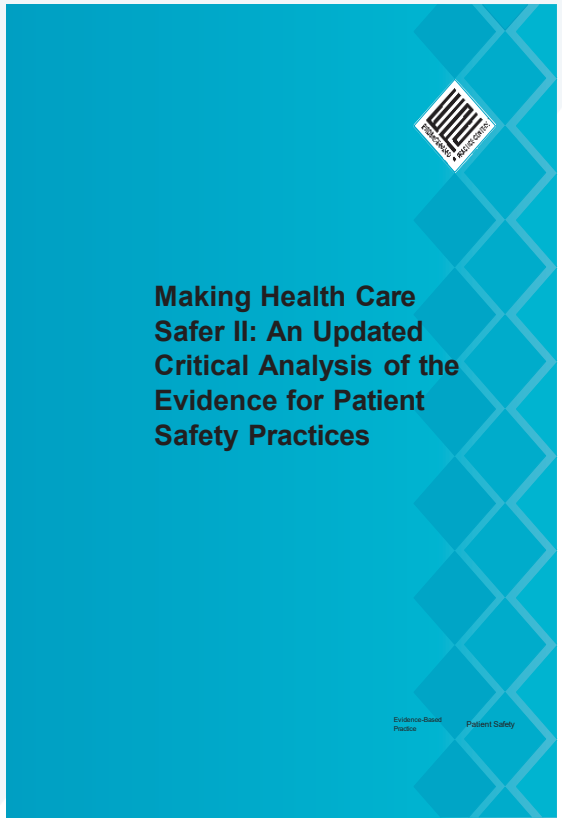
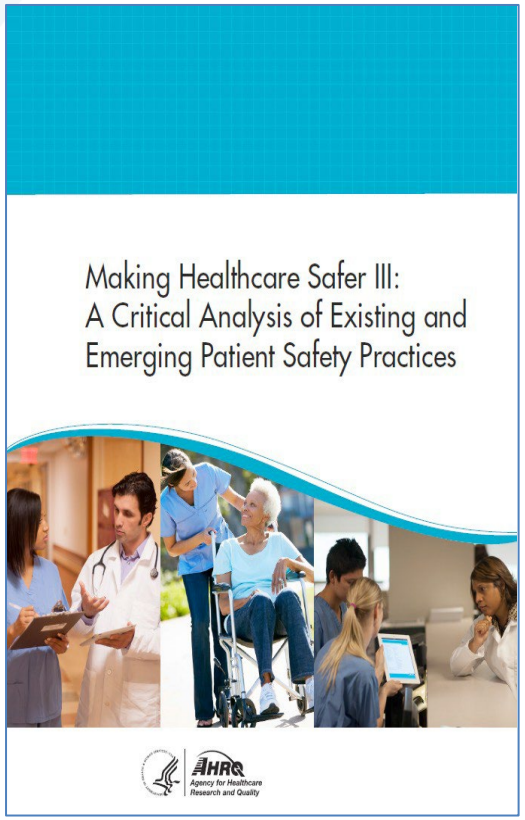




First report: July 2001

Second report: March 2013

Third report: March 2020

Tools for Practice Improvement

- Evidence-based resources that apply the “how” to the “what” of quality improvement
- Apply across settings and to a variety of professions (doctors, nurses, pharmacists, etc.,)
- Focus on improving safety and quality at the front lines of care

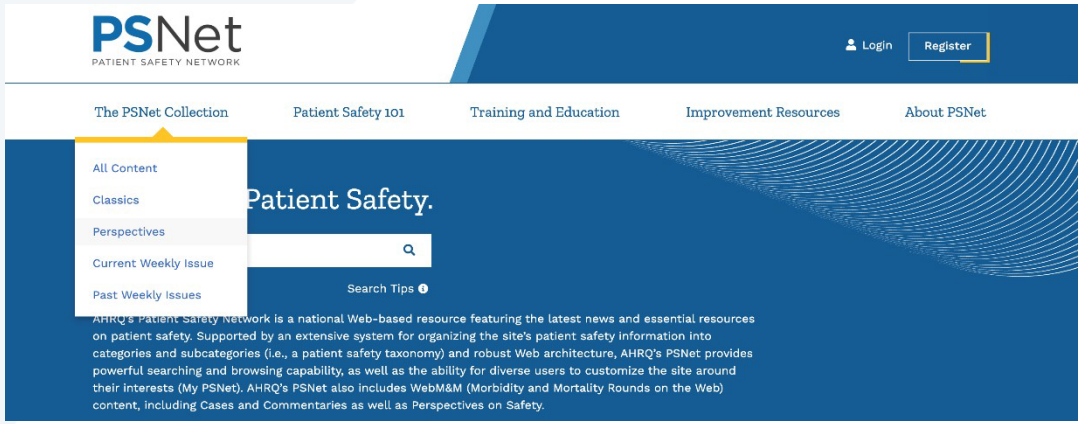
https://www.ahrq.gov/patient-safety/resources/pstools/index.html

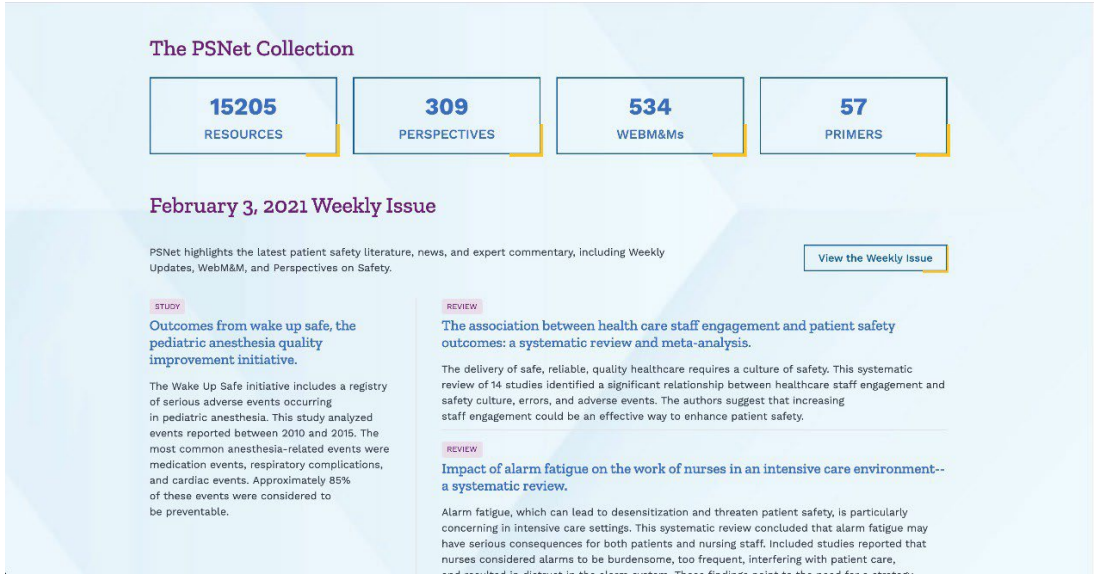
https://www.ahrq.gov/topics/diagnostic-safety-and-quality.html

More than 3 dozen tools that translate research into practice improvement in a variety of settings

AHRQ Patient Safety Network

- AHRQ Patient Safety Network (PSNet) synthesizes and disseminates patient safety information across the entire field.
- The site serves as a “one-stop-shop” for PS information, and includes:
  - Primers
  - Journal articles
  - Training and educational resources
  - Tools and guides for improvement
  - “Web M&M” cases with continuing education opportunities
  - And more…





HHS Patient Safety Convening

- Secretary Becerra hosted a Health System Patient Safety Convening in fall of 2022
- Convening followed by Request for Information
- ~ 100 responses
  - Closed in late January 2023
  - Analysis will shape form and content of Action Alliance

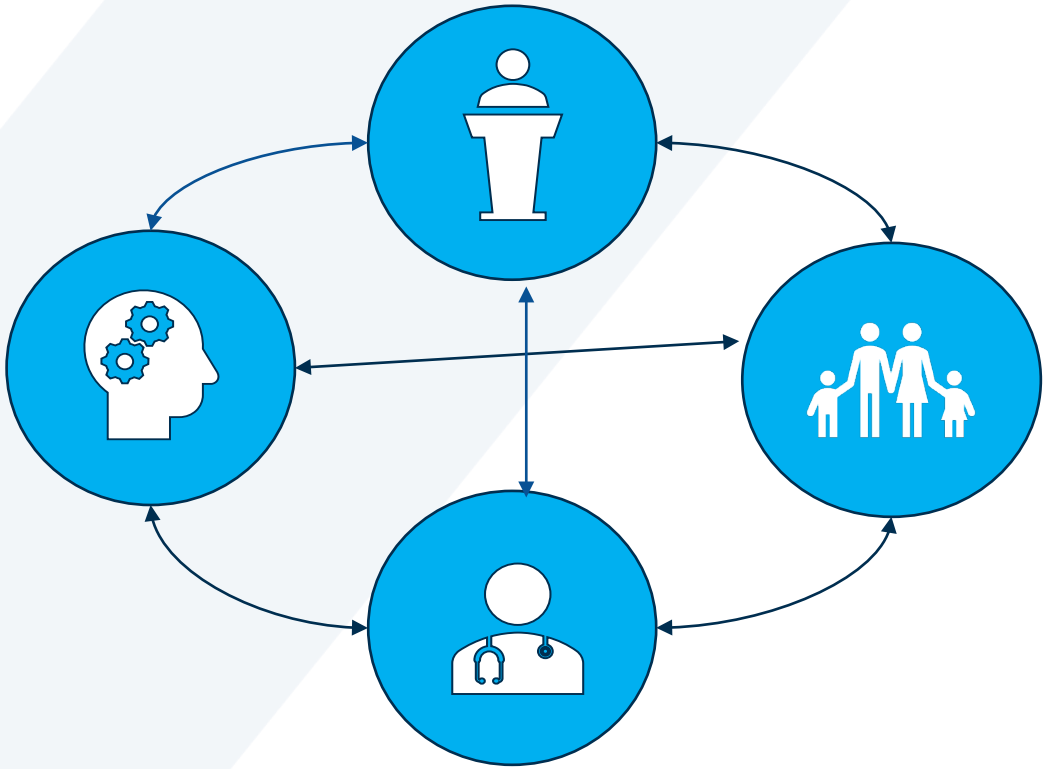
The National Healthcare System Action Alliance to Advance Patient Safety (Action Alliance)

- The National Action Alliance brings together public and private sectors to recommit to patient and workforce safety
- HHS goal is to co-create the Action Alliance to have the greatest impact
- Build a broad learning community for sharing solutions to common barriers
  - Multi-directional learning
    - Assist HHS in coordinating and aligning resources
    - Peer-to-peer learning around successes and challenges
    - Commitment to engaging patient and families
  - Built around the four foundational areas of the National Action Plan to Advance Patient Safety and other existing frameworks and resources

Four Foundational Areas to Advance Patient Safety

Culture, Leadership, and Governance

Learning System



Patient and Family Engagement

Workforce Safety

There are recognized interdependencies across each of the foundational areas

www.ihi.org/SafetyActionPlan

Information, Action, Innovation - Together An "All of Healthcare" Response

- Federal partners – including AHRQ, CDC, CMS
- Federal partners providing direct care – including DoD, VA, IHS
- State and Local partners – including health departments, healthcare organization associations, professional organizations
- Healthcare organizations – including providers, payors, industry, healthcare quality and safety organizations, PSOs
- We also need to engage patients and the healthcare workforce while ensuring they are safe

Information, Action, Innovation - Together

- Information
  - Public reporting
  - Voluntary reporting that is aggregated and shared for learning
  - Local surveillance to inform improvement
- Action
  - Public-sector (including Federal) action
  - Private-sector action
  - Individual action
- Innovation – needs to be shared
  - Public-sector (including Federal) innovation
  - Private-sector innovation
  - Individual innovation

Safety - Summary

- Although safety gains had been made pre-pandemic, safety performance metrics have declined since Covid-19 PHE
- Many strategies to re-commit to patient safety and Zero Preventable Error
- Collaboration and cooperation across multiple federal agencies in support of safety – AHRQ, CDC, CMS, FDA, ONC, VA, DoD and others
- Join us in collaborative efforts to reduce preventable harm and ensure healthcare achieves highest quality, safety and equity for all individuals.