AHRQ Common Formats and the Role of the Patient Safety Organization

NDNQI Data Use Conference - *Rhythms in Quality*
January 20-22, 2010
New Orleans, Louisiana

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Agenda

- Patient Safety Act
- PSO Operations
- Common Formats
- NDNQI: Pressure Ulcer, Falls, and Healthcare Associated Infections
- Q & A

The Patient Safety and Quality Improvement Act of 2005

- Creates "Patient Safety Organizations" (PSOs)
- Establishes "Network of Patient Safety Databases" (NPSD)
- Authorizes establishment of "Common Formats" for reporting patient safety events
- Requires reporting of findings annually in AHRQ's National Health Quality / Disparities Reports

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The Patient Safety Act

- Aims to improve safety by addressing
  - Fear of malpractice litigation
  - Inadequate protection by state laws
  - Inability to aggregate data on a large scale
- Amends AHRQ's enabling legislation
  - AHRQ administers the program
  - Office for Civil Rights handles enforcement
  - Program is voluntary

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PSO Operations

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Listing PSOs

- AHRQ began listing PSOs under Interim Guidance - Oct 2008
- Final rule published in the Nov 21st, 2008 Federal Register; effective Jan 19th, 2009
- 78 PSOs "listed" by AHRQ as of January 20th, 2010; complete list at www.pso.ahrq.gov

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Who Can be a PSO?

- Eligible organizations
  - Any public or private entity / component
  - Any for-profit or not-for-profit / component
- Ineligible organizations
  - Health insurance issuers or their components
  - Accrediting & licensing bodies
  - Entities that regulate providers, including their agents (e.g., QIOs)
  - Mandatory public reporting systems

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PSOs: Becoming a PSO

- Entities seeking listing must complete a "Certification for Initial Listing" form
  - Available on AHRQ's PSO Web site http://www.pso.ahrq.gov/index.html
- Application: a simple process of attestation
  - Compliance with requirements ensured by spot checks
  - Entities subject to penalties for false statements
- Listing: for 3-year renewable periods
- Funding: no Federal funding from AHRQ, but technical assistance without charge
- Provider Choice of PSO: voluntary, marketplace assessment

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PSO Activities

- Collect, analyze patient safety (PS) data
- Assist providers to improve quality & safety
- Develop & disseminate PS information
- Encourage culture of safety & minimize patient risk
- Provide feedback to participants
- Maintain confidentiality & security of data

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How Do Providers Benefit From Working With A PSO?

- Receive uniform Federal confidentiality & privilege protections
- Gain protection for analysis beyond the initial report (e.g., root cause analysis)
  - In provider's patient safety evaluation system or the PSO's
  - Shared learning within the provider's system
- Benefit from aggregation
  - PSO level
  - PSO to PSO analysis & sharing
  - NPSD

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Common Formats

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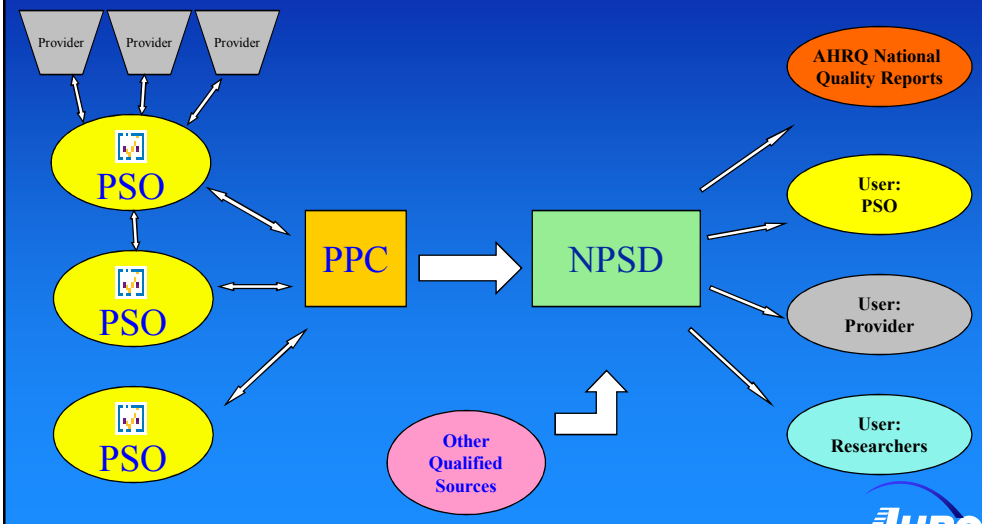
Data Flow: Provider to PSO to NPSD to User



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PSO Requirements

- PSOs & providers analyze patient safety data
  - PSOs are required to collect information that allows comparison of "similar events among similar providers"
  - "Common Formats" have been made available by AHRQ, acting for the Secretary of HHS, to assist PSOs to meet this requirement
  - At recertification, PSOs will be required to state how they meet the requirement

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AHRQ's Common Formats

- Standardize the patient safety event information collected
  - Common language & definitions
  - Standardized rules for data collection
- Allow aggregation of comparable data at local, PSO, regional, & national levels
- Facilitate exchange of information, learning

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Design Goals

- Be driven by envisioned uses
  - First use at point-of-care
  - Roll up to PSO, regional, national levels
- Based on evidence; scientifically supportable
- Practical, intuitive, & useful
- As short & simple as possible
- Conform, where possible, with accepted wisdom (e.g., CDC for HAIs, WHO-ICPS)

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Framework and Scope

- Limit initial scope to safety: preventing harm to patients from the delivery of health care
- Develop for specific delivery settings; begin with hospitals
- Start with first phase of improvement cycle – the initial report
- Construct in modules

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Common Formats Scope

- Common Formats apply to all patient safety concerns
  - Incidents – patient safety events that reached the patient, whether or not there was harm
  - Near misses (or close calls) – patient safety events that did not reach the patient
  - Unsafe conditions – any circumstance that increases the probability of a patient safety event

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Common Formats: Revising and Refining

- Common Formats 0.1 Beta released August 2008 (prior to listing of first PSOs)
- National Quality Forum (NQF) process established to solicit comments & provide advice
  - Over 900 comments received by NQF
  - NQF Expert Panel analyzed comments, provided advice to AHRQ
- AHRQ revised & refined Common Formats based upon advice from NQF & DHHS agencies; Version 1.0 released on September 2, 2009
  - NQF currently completing review of Version 1.0
  - Version 1.1 scheduled for release March 2010

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Common Formats 1.0 Highlights

- Components
  - Available at: www.psoppc.org
    - Event Descriptions
    - Paper forms to allow immediate implementation
    - A Users Guide and Quick Guide
  - Version 1.1 in development- anticipated release March 2010
    - Revisions based upon NQF input
    - Technical specifications for vendor systems
    - Patient safety population reports

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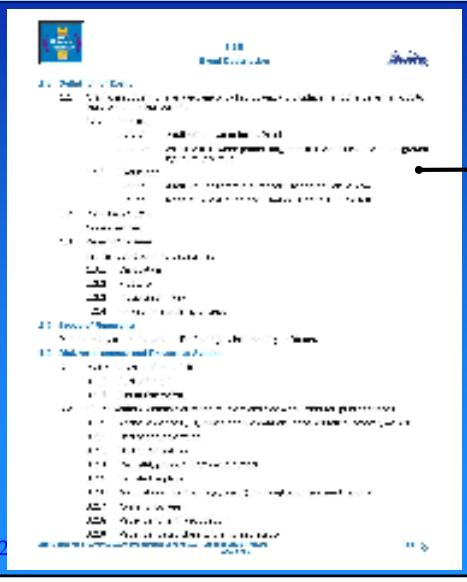
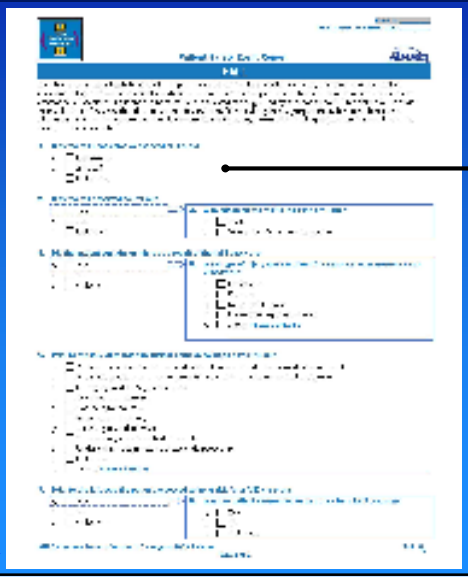
Sample Event Description



1.1 A fall is a sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object.
- 1.1.1 Inclusions
  - 1.1.1.1 A fall not known to be assisted
  - 1.1.1.2 Assisted fall - when patient begins to fall and is assisted to the ground by another person
- 1.1.2 Exclusions
  - 1.1.2.1 A fall resulting from a purposeful action or violent blow
  - 1.1.2.2 Near fall – loss of balance that does not result in a fall

Sample Paper Form



1. Was the fall unassisted or assisted? CHECK ONE
   a. Unassisted
   b. Assisted
   c. Unknown

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Common Formats 1.0

- Event Specific Categories
  - Blood or Blood Product
  - Device or Medical / Surgical Supply
  - Fall
  - Healthcare-Associated Infection
  - Medication or Other Substance
  - Perinatal
  - Pressure Ulcer
  - Surgery or Anesthesia

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AHRQ Common Formats and NDNQI Nursing Sensitive Indicators

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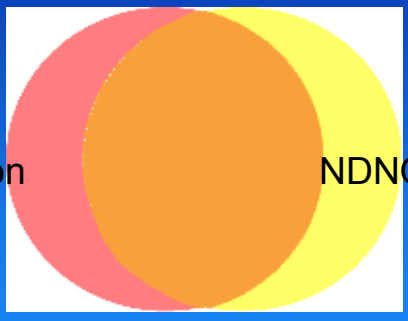
AHRQ Common Formats and NDNQI

AHRQ Common Formats



NDNQI Participants

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AHRQ Common Formats and NDNQI

- Different histories, background, sponsors, scope of data collected, and reasons for participation
- Common Goal:
  - Safe, high-quality patient care
- Common Goal (eventually):
  - Common clinical definitions
  - Electronic interoperability

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AHRQ Common Formats and NDNQI

- Similar:
  - All hospital types – all 50 states and DC
  - Voluntary
  - Process and Outcome data
  - Local and national aggregate data
    - Pressure Ulcer, Falls and HAI
  - Data collected at point of care
  - Reports by location (unit type)

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Differences: Common Formats and NDNQI

AHRQ Common Formats

- Voluntary, spontaneous patient safety event reporting
- NQF expert panel guidance and stakeholder feedback
- User submits to PSO→NPSD
  - Used for local reports
  - PSO analysis and feedback
  - Regional and national learning
- Data sent to PSO receives Federal confidentiality and privilege protection
  - All settings and topics

NDNQI Measures

- Point prevalence and surveillance
- NQF Definitions
- User submits directly to national database
  - Used for Magnet applications
  - Quality Initiatives
  - RN retention and recruitment

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AHRQ Common Formats and NDNQI

AHRQ Common Formats

Blood or Blood Product
Device or Medical / Surgical
Supply
Fall
Healthcare-Associated Infection
Medication or Other Substance
Perinatal
Pressure Ulcer
Surgery or Anesthesia

NDNQI Participants

Nurse Turnover
Falls
Pressure Ulcers
Physical/ Sexual Assault
Pain
IV Infiltration
Physical Restraints
Healthcare Associated Infections
Staff Mix
Nursing Care Hours
RN Education/Certification
RN Survey

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Falls

Common Formats

- Number of falls
- Harm level and related injury
- Fall assisted by employee
- Risk assessment prior to fall
- Patient at risk for falls
- Fall prevention protocol
  - Prevention interventions
- Patient activity prior to fall
- Observation of fall by staff
- Contributing factors:
  - Role of medication

NDNQI

- Number of falls, with or without injury on care unit / calendar month, patient days, year
- Injury level
- Optional data elements:
  - Fall assisted by employee
  - Fall prevention protocol
  - Risk assessment prior to the fall
  - Fall risk assessment score
  - Patient at risk for fall
  - Physical restraint
  - Prior falls this month
  - Time since last risk

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Pressure Ulcer

Common Formats

- Presence of a stage 3 or 4 pressure ulcer
  - Newly acquired (including unstageable)
  - Advancement of pre-existing ulcer by two or more stages
- Exclusions:
  - Stage 1 or 2 ulcers
  - Present on admission with no advancement
  - Unstageable or Deep tissue injury present on admission

NDNQI

- Patients on eligible unit with at least 1 pressure ulcer on day of study / number of eligible patients on the unit
- Exclusions:
  - Stage 1 ulcers
  - Ulcer present on admission

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Pressure Ulcer

Common Formats

- Admission skin assessment
- Risk assessment performed
  - Admission
  - Prior to discovery
  - After discovery
  - Formal (i.e., Braden) vs. clinical
- Pressure ulcer risk
- Prevention protocol in place
- Prevention Intervention
- Risk factors
  - Device/appliance association

NDNQI

- Optional:
  - Admission risk assessment
  - Pressure ulcer risk
  - Prevention protocol in place
  - Braden score breakdown, creatinine, BUN, albumin, pre-albumin, other risk assessment score

Healthcare Associated Infections

Common Formats

- Consistent with CDC NHSN
  - Central Line Associated Bloodstream Infections
  - Catheter Associated UTI
  - Ventilator Associated Pneumonia
  - Surgical Site Infections

NDNQI

- NQF definitions - CDC NHSN guidelines
  - Central Line Associated Bloodstream Infections
  - Catheter Associated UTI
  - Ventilator Associated Pneumonia

Common Formats and NDNQI
Conflict vs. Convergence

- Problems:
  - Lack of harmonization of clinical definitions
  - Duplicate data entry vs. incomplete databases
- Opportunities:
  - Goal of harmonization of clinical definitions
  - Work towards one time data entry for common areas of inquiry

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Next Steps

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PSOs: Next Steps

- Continue to list new PSOs
- Provide technical assistance
- AHRQ and PSO activities
  - Web Forum
  - Quarterly calls
  - Next Annual Meeting
- Begin PSO Compliance Reviews

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Common Formats: Next Steps

- Version 1.1
  - Vendor technical specifications
  - Includes population reports
- Future expansion to other settings (e.g., long term care)
- Future extension to other improvement cycle phases (e.g., root cause analysis)
- Continuing NQF assistance

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Feedback Process for Common Formats Evolution

- AHRQ seeing feedback to refine Common Formats
- The National Quality Forum
  - Online tool to gather comments from users and public

    www.qualityforum.org
  - Expert panel to provide advice
- Process will be a continuing one, guiding periodic updates of the Common Formats

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NPSD: Next Steps

- Information will be submitted using the Common Formats (PSOs & other sources)
- Non-identifiable PSWP scheduled to be accepted in early 2011
- Findings from NPSD will be published in AHRQ's annual National Healthcare Quality & Disparities Reports

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Your questions?

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