MAINE AHQ
Maine Association for Healthcare Quality

MAHQ MONTHLY JULY 2014

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MHA SUMMER FORUM AND MAHQ EDUCATION PROGRAM

By Jeff Gregory

Once again, the Maine Hospital Association had a stellar line up of speakers at their Annual Summer Forum at the Samoset Resort in Rockport June 18-20th. The theme for this year's forum was *Patients at the Heart of Everything We Do.*

During the morning session on the 19th, Paul Keckley, PhD. spoke about the current state of the Affordable Care Act and potential changes that will impact all of us. According to Dr. Keckley, there are two main catalysts for disruption in the current law including employers seeking value and healthcare consumers forced to engage directly in their coverage and care. This will pose challenges for both physicians and hospitals as the focus increasingly shifts to cost containment, evidenced-based medicine and business relationship transparency.

Probably the best known speaker of the day was Quint Studer, founder of the Studer Group and patient experience expert who spoke about achieving greater quality at lower costs. With the rapid pace of change, Studer argues that this will require the use of different skills and creating a whole new level of urgency within healthcare. Hospitals and providers will need to confront the new reality by avoiding self-delusion. For example, Studer warned that using the excuse that your market is different than others will not help providers in this new healthcare environment. He also cautioned that mergers and acquisitions that deliver only size and press headlines but no long term value will suffer.

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MAHQ President Trudy O'Bar (left) with Rhonda Lanzara-Dalfonso at the MHA Allied Professional Society Recognition Luncheon

2014 MAHQ Distinguished Member

On June 19, 2014 Rhonda Lanzara-Dalfonso from Mercy Hospital was recognized as MAHQ's 2014 Distinguished Member during the Allied Professional Society Luncheon at the Maine Hospital Association's Summer Forum.

Rhonda has been a member of both the Maine Association for Healthcare Quality (MAHQ) and National Association for Healthcare Quality for several years and currently serves as the MAHQ Treasurer. Rhonda has a nursing background and has spent her entire career at Mercy Hospital in Portland in various roles. Rhonda currently is a Senior Quality Specialist who is responsible for the oversight, education and implementation of quality improvement and patient safety initiatives. In this capacity, Rhonda also submits data to regulatory agencies.

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Studer referred to 'motivating the elephant' by responding to the felt needs, speaking to emotions and helping leaders manage an increasing complex process. Studer also advocates showing the bright spots, lessening ambiguity and showing a clear path to improvement. He recommends greater mentoring for 'middle managers', having an operational dashboard, 90 day action plans and helping employees understand the 'why' or need for change.

Finally, Patient Advocate Jennifer Page reminded us that patients are truly at the heart of what we do, as she described her experience with the healthcare system during her son Max's multiple surgeries for a congenital heart defect. She not only touched on the many challenges faced by her family but also those in healthcare including patient care, conflicting provider information, and navigating an often confusing payment structure. She invited the audience to set the tone for their organizations by being more patient and family centered.

MAHQ SUMMER SESSION

Dr. Akindele Majekodunmi, MD, the Chief Medical Officer of the Northeast Health Care Quality Foundation addressed the MAHQ session on the afternoon of June 19th. Dr. Majekodunmi spoke about the National Quality Strategy, specifically around reducing readmissions. Since October 2013, the Centers for Medicare and Medicaid Services have reduced payments to 2,225 hospitals for a total of $227 million in fines. Hospitals will need to perform 50% better than an average hospital that admitted similar patients with similar risk factors for readmissions, such as age and co-morbidities.

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Congratulations Rhonda for being MAHQ's 2014 Distinguished Member of the Year!

Rhonda Lanzara-Dalfonso accepts the 2014 MAHQ Distinguished Member Award from Steven Michaud of the Maine Hospital Association at the MHA Allied Recognition luncheon in Rockport

"We can no longer tolerate a healthcare industry that markets non-existent excellence."

— Dr. Marty Makary, Johns Hopkins Medical Center

Dr. Akindele Majekodunmi, MD, MBA spoke to attendees of the MAHQ Summer Program at the Samoset in Rockport

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CMS uses the Excess Readmission Ratio to determine reimbursement rates as part of the Hospital Readmission Reduction Program (HRRP). The Hospital Specific Reports will show the excess readmission ratios for the 30 day 'All-Cause' Unplanned Risk-Standardized Readmission measures for AMI, HF, and PN.

One important note under the 'All-Cause' Admission category is that transfers between two or more applicable hospitals with patients readmitted in the 30 days following the final hospitalization, the readmission will be attributed to the hospital that discharged the patient to a non-acute care setting. There are certain admissions that are classified as 'planned readmissions' such as maintenance chemotherapy, transplant care and rehabilitation to name a few.

Are these initiatives to reduce readmissions having an impact? According to Dr. Majekodunmi they are as reflected in the drop in 2012 readmissions to 17.8% from 19% the previous five years. This would mean that there were over 70,000 fewer readmissions in 2012. He emphasized the importance of the first two weeks after discharge and providing needed follow-up with the patient.

Finally, Quality Reporting may look different in the near future as CMS looks to combine the function of QIO from individual states to a regional, or even national, organization. More information should be available sometime in August!

Use of RCA Tool for Rapid Cycle Improvements

By Susan Curtis, RN, CPHQ, Patient Safety Specialist Maine Medical Center

Most organizations are familiar and have experience with using the Root Cause Analysis (RCA) process for investigating Sentinel Events. The RCA process includes a detailed timeline of the event, a brainstorming session to come up with possible contributing causes, a deeper dive into identifying root causes, and development of an action plan with owners, due dates, and measurements. For serious reportable events this process typically requires a minimum of two 2 hr. team meetings with an experienced facilitator and the team members with the most knowledge about the event.

The RCA tool can also be used effectively to examine other challenging quality and patient safety problems and come up with solutions. CLABSI is one example.

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RCA Tool

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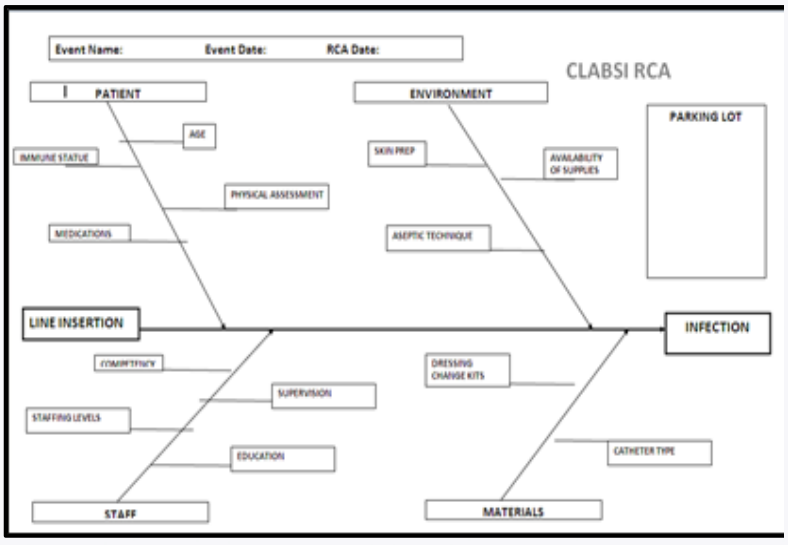
When a patient has been identified as having suffered a central line associated blood stream infection this event is communicated to a team leader who requests that an RCA be performed. The goal is to convene the team of interdisciplinary caregivers and the microsystem (unit/dept) leaders within 7 days. A knowledgeable person is assigned to develop a detailed timeline that includes line insertion, maintenance, access, and other important details such as any noted problems with the site or elevated blood sugars.

The team meets for a 1 hour session. A standard fishbone diagram (Fig 1), drawn on exam table paper, is displayed on the wall.

FIGURE 1



CLABSI RCA Agenda

1. Review the timeline-10 min
2. Go through the wall fishbone, add potential contributing causes-20 min
3. Identify likely root causes-10 min
4. Draft an action plan for addressing the root causes-20 min

Patient Safety Academy

September 5, 2014

Where: Abromson Center, University of Southern Maine, Portland
When: 9 am - 4 pm on Friday September 5th
Cost: $50, with a discounted rate of $25 for students. Nursing & Pharmacy CEUs available.

The microsystem leaders would then be responsible for carrying the plan forward and ensuring lessons learned are shared throughout the organization. This example of utilizing the RCA process as a rapid improvement cycle when a patient experiences a preventable adverse event, regardless of whether it is reportable, supports a culture of safety and a continual journey to a highly reliable organization.

SAVE THE DATE
MAHQ Fall Program
Friday October 17, 2014
Maine Health
110 Free St
Portland