Crowe Horwath

CHAN Healthcare
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Beyond the Business Side of Healthcare

Internal Audit Impact on Patient Outcome Processes

Crowe® Healthcare Webinar Series

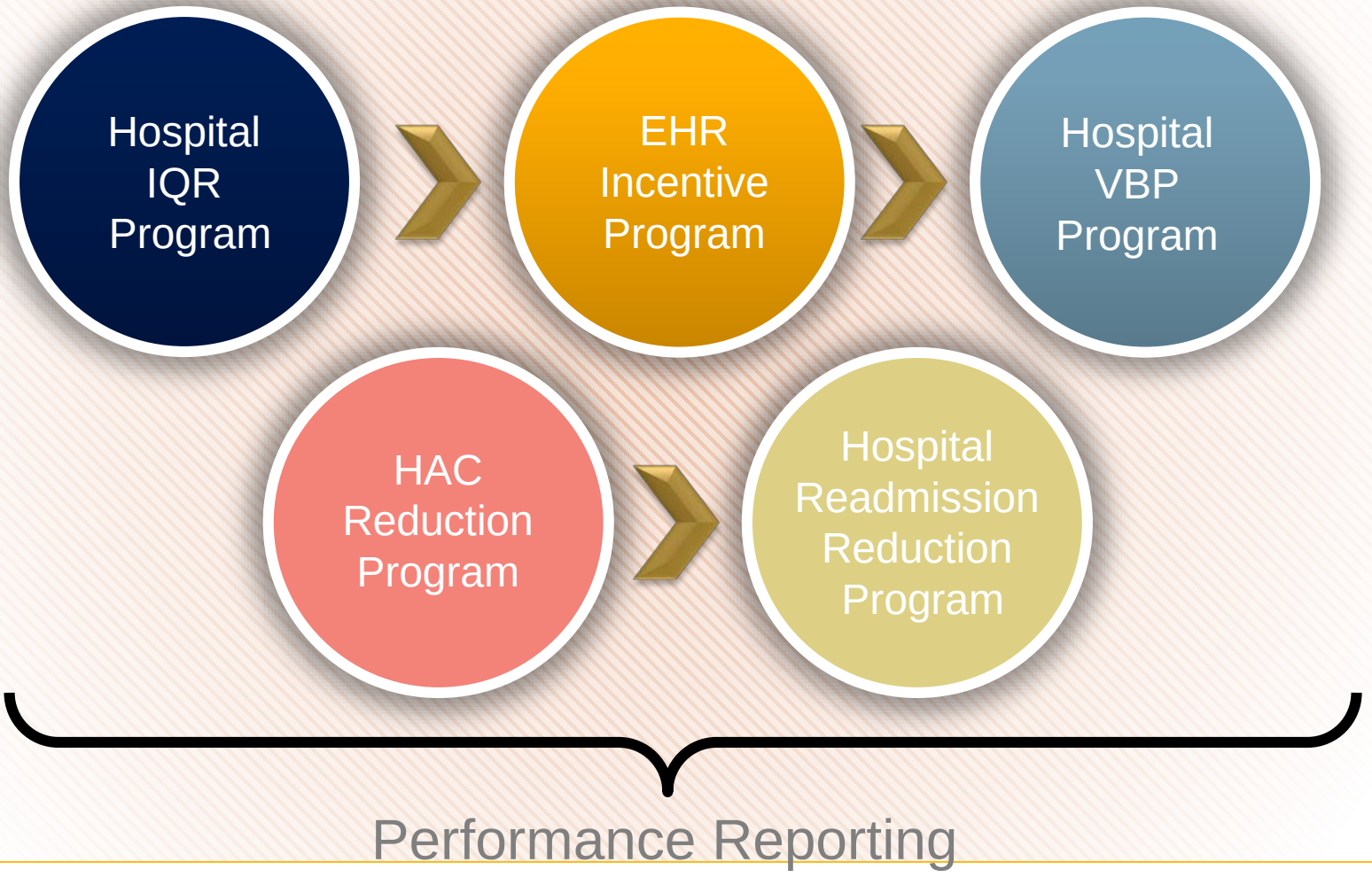
Learning Objectives

As a result of participating in this session, you should be able to:

- Identify how healthcare internal audit has evolved in response to the healthcare environment
- Recognize the growing importance of quality outcomes reporting, performance improvement and how internal audit can support these critical goals for healthcare providers
- Anticipate future internal audit assistance based on evolving healthcare needs

Improving Healthcare Quality, Safety, Efficiency & Effectiveness

Affordable Care Act (ACA) Initiatives Designed to Measure and Compensate Hospitals for Performance



The History of Publicly Reporting Quality in Healthcare

Hospital IQR Program

Voluntary Hospital Quality Initiative

- 2002 “Hospital Quality Alliance (HQA): Improving Care Through Information”.
- Supported by The Joint Commission (TJC)), the National Quality Forum (NQF), the Centers for Medicare & Medicaid Services (CMS), and the Agency for Healthcare Research and Quality (AHRQ)

Pay for Reporting (IQR)

- 2003 Medicare Modernization Act (MMA)
  - Submit 10 quality measures / Non-submission would result in a 0.4 percentage point reduction in APU
- 2005 Deficit Reduction Act (DRA)
  - Inpatient Quality Reporting Program (IQR)
  - Requires hospitals to report on additional quality measures in order to receive annual payment updates
  - Non-submission would result in a 2.0 percentage point reduction in APU

Pay for Performance

- Pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures
- Reduces Medicare reimbursement to hospitals that score below national performance benchmarks on selected quality measures
- Under section 1886(b)(3)(B)(viii) of the Social Security Act (SSA), beginning with FY 2015, the reduction in the applicable percentage increase for hospitals that fail to submit quality information under rules established by the Secretary, is one quarter of the applicable percentage or one quarter of the applicable market basket update.

www.hospitalcompare.hhs.gov

EHR Incentive Program

EHR Incentive Program

The Medicare EHR Incentive Programs

- Also known as “Meaningful Use”
- Provides Medicare and Medicaid incentive payments to qualifying physicians, healthcare professionals, and hospitals when they adopt and meaningfully use Certified Electronic Health Record Technology (CEHRT)

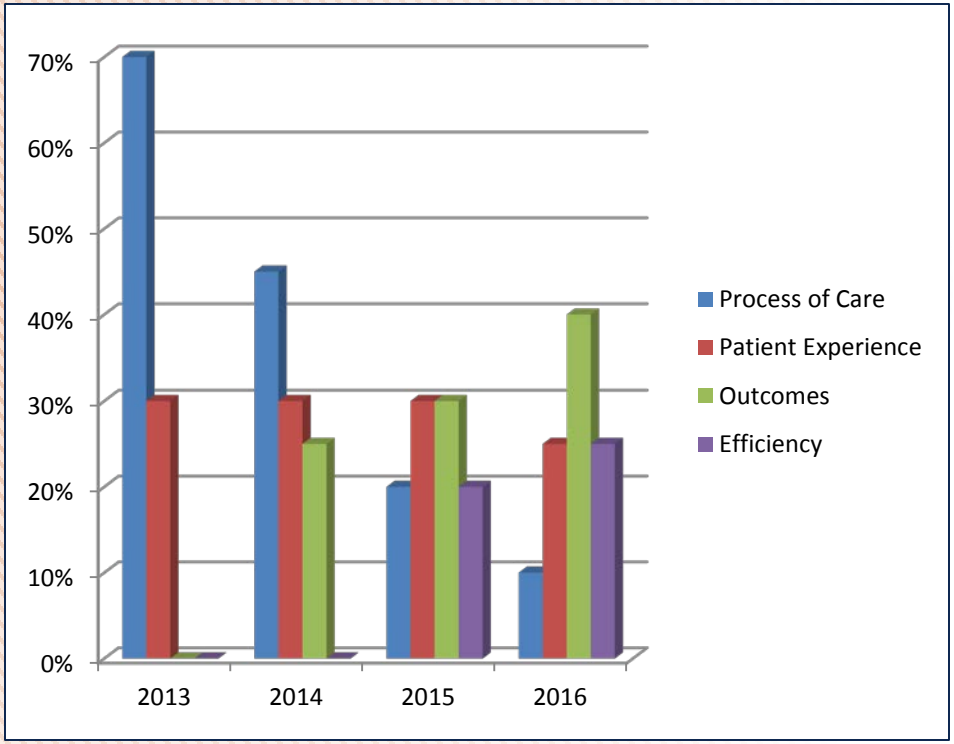
CMS’ Vision

Simplify and streamline quality reporting by collecting and reporting data through health information technology (HIT).

Value Based Purchasing

Hospital VBP Program

- Measures fall under four domains of care
  - Clinical Process of Care Domain – 12 quality measures already being reported to Medicare under IQR Program
  - Patient Experience of Care Domain (HCAHPS)
  - Outcome Domain – 5 quality measures assessing healthcare activities that affect patients' well-being
  - Efficiency Domain - measures cost of care per-beneficiary episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge



Hospital-Acquired Condition (HAC) Reduction Program

HAC Reduction Program

- Section 3008 of the Patient Protection and Affordable Care Act (ACA) established the HAC Reduction Program to incentivize hospitals to reduce hospital-acquired conditions (HACs)
- The program began last year with payment adjustments to discharges beginning October 1, 2014
- Payment adjustments occur for hospitals that rank in the lowest performing quartile with respect to HACs.
- Applies to hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS)
- Data for HAI measures is submitted to the CDC through the NHSN

Hospital Readmission Reduction Program

Hospitals with a readmissions performance worse than the national average for any one of the conditions are subject to a payment adjustment.

- Payment adjustment applies to all Medicare discharges for that year, not just a hospital's readmissions.
- Payment adjustment is applied to a portion of a hospital's payments.

Fiscal Year (FY)	Number of Hospitals Subject to Adjustment	Estimated Savings for Medicare
FY 2013	2,214	$280 million (0.2% of payments)
FY 2014	2,225	$227 million (0.2% of payments)
FY 2015*	2,638	$428 million (0.4% of payments)
FY 2016	TBD	TBD

Financial Impact

Fiscal Year	Hospital IQR Program	EHR Incentive Program	Hospital VBP Program	HAC Reduction Program	HRRP
2013	2.0 Percentage Point Reduction to Market Basket Update (MBU)	N/A	1.00% withhold to base-operating DRG Payment Amount	N/A	1.00% maximum reduction to base-operating DRG Payment Amount
2014	2.0 Percentage Point Reduction to MBU	N/A	1.25% withhold to base-operating DRG Payment Amount	N/A	2.00% maximum reduction to base-operating DRG Payment Amount
2015	¼ reduction to the applicable MBU	¼ reduction to the applicable MBU	1.50% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2016	¼ reduction to the applicable MBU	½ reduction to the applicable MBU	1.75% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2017	¼ reduction to the applicable MBU	¾ reduction to the applicable MBU	2.00% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount

Care Delivery Change Requirements

- **Reduce Waste and Redundancy**
- **Slow Historical Growth Rate in Healthcare Costs**

- **Increase Care Coordination**
- **Strengthen Transparent Exchange of Healthcare Information**

- **Improve Patient Outcomes**
- **Adhere to Evidence Based Standards**

- **Improve Professional Credibility & Market Perception**
- **Compete for Populations Served**

Clinical Performance Improvement

482.21 Medicare Conditions of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program

Initiatives must reflect the complexity of the hospital's organization and services;

- Involve all hospital departments and services (including those services furnished under contract or arrangement);
- Focus on indicators related to improved health outcomes and the prevention and reduction of medical errors;
- Focus on high-risk, high-volume, or problem-prone areas;
- Consider the incidence, prevalence, and severity of problems in those areas; and
- Improve health outcomes, patient safety, and quality of care

Clinical Performance Improvement Tied to Accreditation

The Joint Commission E-dition

PI.03.01.01 The hospital improves performance on an ongoing basis.

Standard Introduction and Rationale

Nbr	Elements of Performance (EPs)	CMS
1	Leaders prioritize the identified improvement opportunities. (See also PI.02.01.01, EP 8; MS.05.01.01, EPs 1-11)	§482.21(c)(1)(ii) §482.21(d)(4)
2	The hospital takes action on improvement priorities. (See also MS.05.01.01, EPs 1-11)	§482.21 §482.21(c)(3) §482.21(d)(4)...
3	The hospital evaluates actions to confirm that they resulted in improvements. (See also MS.05.01.01, EPs 1-11)	§482.21 §482.21(c)(3) §482.21(d)(3)...
4	The hospital takes action when it does not achieve or sustain planned improvements. (See also MS.05.01.01, EPs 1-11)	§482.21 §482.21(c)(3) §482.21(d)(3)...
11	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following: - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services	

Key Objectives Related to Performance Improvement

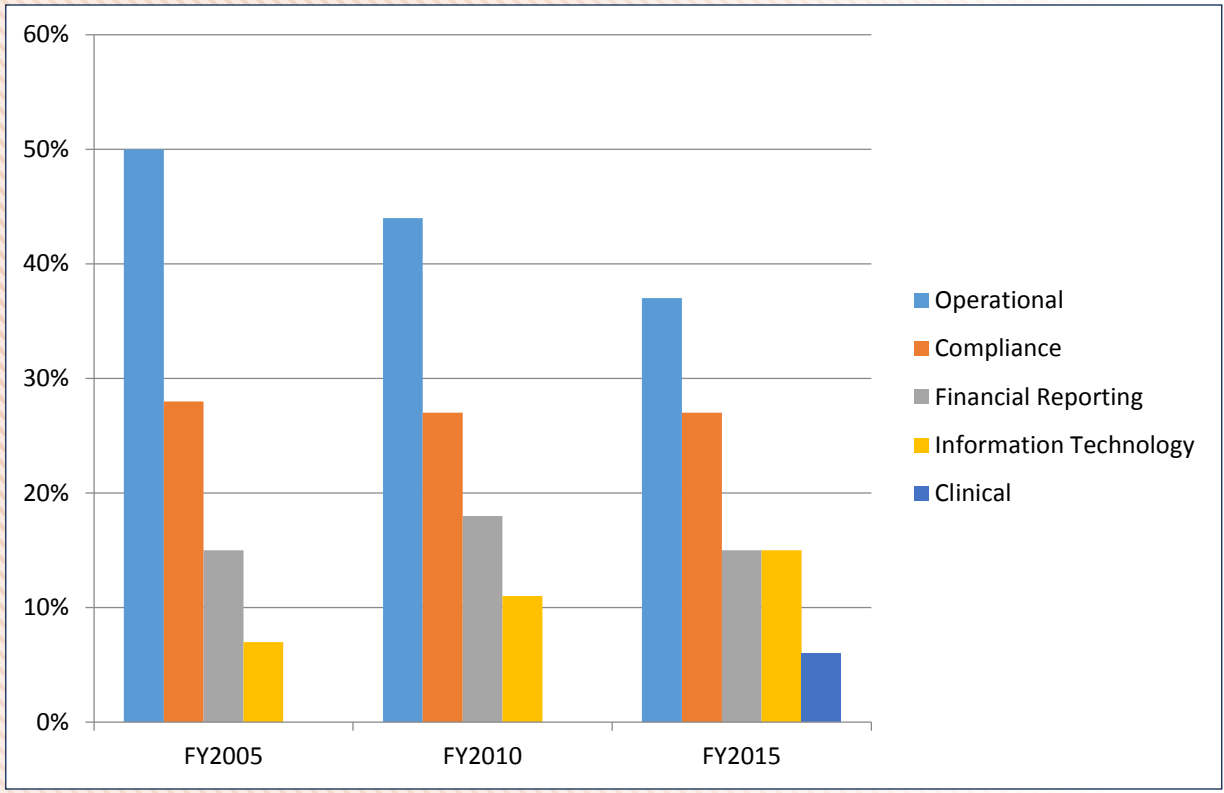
- Implement Practices and Measures to Improve Quality and Patient Safety
- Maintain Compliance with Joint Commission and the Centers for Medicare and Medicaid Services (CMS) Requirements
- Conduct Operations in Compliance with Professional Standards
- Provide Hospital Governance, Leadership, Personnel and Physicians Quality and Patient Safety Information to make Informed Decisions

Performance Improvement Program Priorities

- Fully integrated automated information systems for data management
- Prioritization of performance improvement efforts with strategic goals
- Methods are in place to ensure clear, frequent and open communication
- Training for all staff in QI/PI, team group, data collection and statistical processes
- Accountability for staff monitoring activities with meeting agendas and clear objectives
- Oversight or PI teams to assure coordination of function, process and process steps
- Professional certification of all staff
- Reporting structures assure dissemination of information to key stakeholders
- Active leadership and coordination of staff roles in performance improvement activities
- Ongoing support of governing body, administration, physicians
- Development and roll-out of strategic quality initiatives
- Accurate data collection to monitor improvement
- Policies and Procedures align people, process and technology

Internal Audit's Role in Process Improvement

- Compliance
- Financial Reporting
- Information Technology
- Operational
- Clinical



Traditional Audit Focus

Business Side

- Accounts Payable
- Business Related Expenses
- Cash Controls
- Compliance Program
- Construction
- Contract Administration
- Financials – Balance Sheet
- General IT Controls
- Mergers & Acquisitions
- Payroll
- Supply Chain
- Revenue Cycle

Bedside

- Adverse Events
- EHR Implementation
- HIPAA Security/Privacy
- Patient Safety
- Peer Review
- Quality Reporting
- Risk and Claims Management
- Throughput
- Utilization Review

The Changing Healthcare Environment

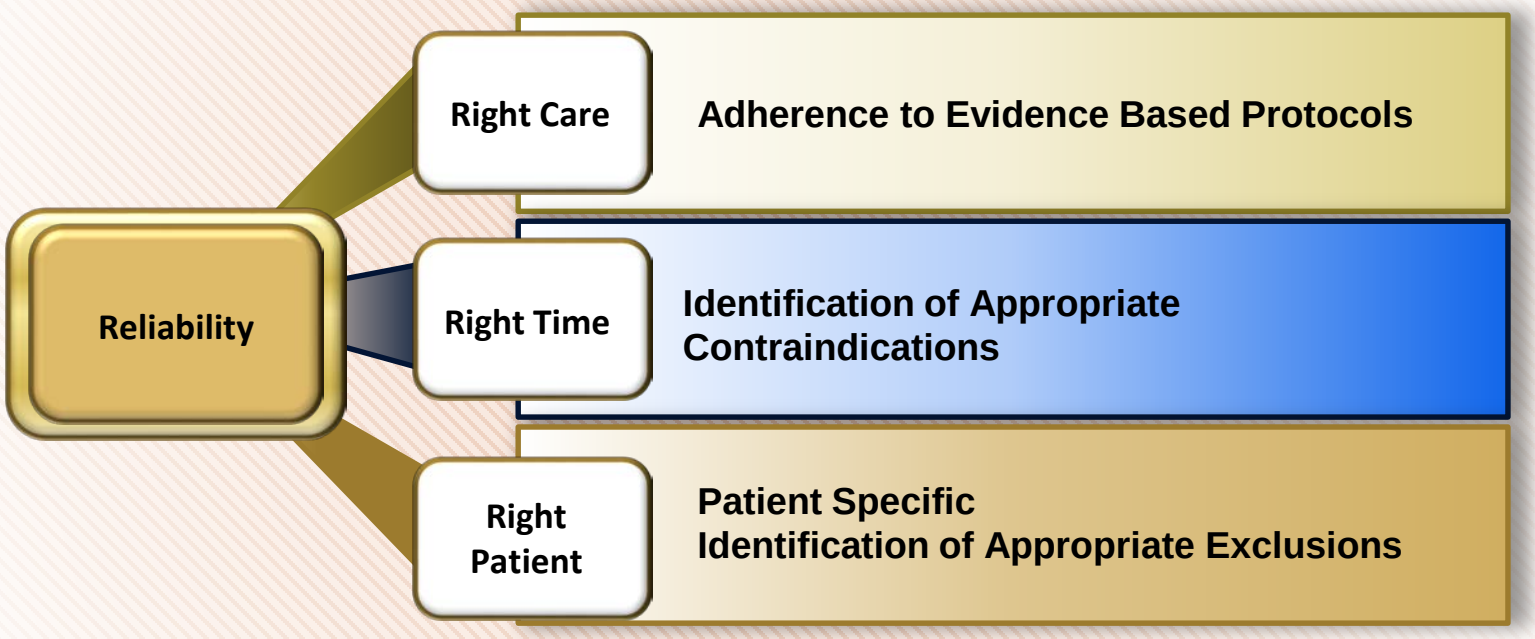
Business Side

- 340B – HRSA Readiness
- Accountable Care Organizations
- Complex Provider Arrangements
- Data Management
- Health Information Exchange
- Information Security
- Regulatory Readiness
- Third Party Risk
- Value Based Purchasing

Bedside

- Documentation Impacting Continuity of Care
- Evidence Based Care Delivery
- Patient Engagement and Experience
- Patient and Staff Safety
- Population Management/Care Coordination
- Process Redesign and Improvement
- Quality/Performance Measures
- Readmission Reduction
- Staffing Models
- Telemedicine

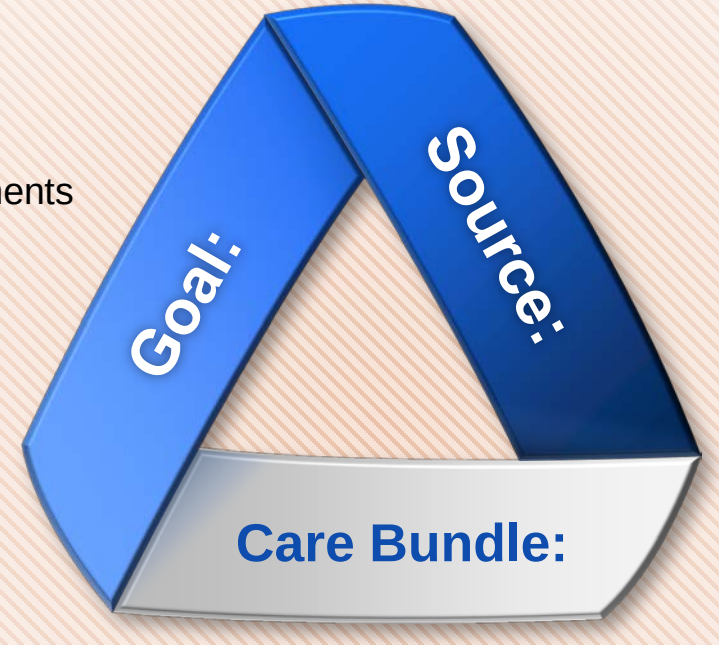
Delivery of Safe Reliable Care



Safe, Effective, Patient-Centered, Timely, Efficient, Equitable

Evidence Based Care Bundles: More than a Check-List

Reliable delivery of the best possible care to patients undergoing particular treatments with inherent risks



Developed by the Institute for Health Care Improvement (IHI)

- Small but critical set of processes all determined by Level 1 evidence when performed collectively and reliably, have been proven to improve patient outcomes
- Ensuring care action is safe, effective and efficient
- Cohesive unit of steps that must *all* be completed to succeed
- All-or-nothing measurement

Early Identification and Treatment of Sepsis Saves Lives

6.5 million hospital discharges

10.4% mortality for sepsis patients vs. 1.1% non-sepsis

52% of all hospital deaths were result of sepsis

22% of all hospital charges

83% of patients already had sepsis at the time of hospital admission

Source:
Physician Executive Council, *10 Imperatives for Reducing Sepsis Mortality*, Washington, DC; The Advisory Board Company,
Kaiser Permanente Northern California013

What You Don't Know Could Hurt You

Figure 1: The Surviving Sepsis Campaign Care Bundles.

Surviving Sepsis Campaign Bundles

TO BE COMPLETED WITHIN 3 HOURS:

1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30 mL/kg crystalloid for hypotension or lactate ≥4 mmol/L

TO BE COMPLETED WITHIN 6 HOURS:

5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥65 mm Hg
6) In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate ≥4 mmol/L (36 mg/dL):
   -Measure central venous pressure (CVP)*
   -Measure central venous oxygen saturation ($Scvo_2$)*
7) Remeasure lactate if initial lactate was elevated*

*Targets for quantitative resuscitation included in the guidelines are CVP of ≥8 mm Hg. $Scvo_2$ of ≥70%, and normalization of lactate.

1 Hour Delay in Antibiotics → 7.6% Increase in Mortality

Audit Objectives

- Operational Audit Steps
  - Policies and procedures are in place to support EBP care delivery
  - Staff education is consistent with care and documentation requirements
  - Implementation of evidence based Sepsis prevention toolkits
  - Implementation of quality monitoring programs
  - Oversight at all levels of the organization
- Clinical Audit Steps
  - Adherence to Sepsis bundle protocols
  - Evaluate performance over baseline

Clinical Process Reliability Trending

3 Hour Bundle Statistics

Month Reviewed	COUNT OF CASES REVIEWED	LACTATE OR LACTIC ACID MEASURED UPON RECOGNITION OF SEPSIS ELEMENT MET	BLOOD CULTURES BEFORE ANTIBIOTICS ELEMENT MET	EARLY ADMINISTRATION OF ANITBIOTICS UPON RECOGNITION OF SEPSIS ELEMENT MET	BLOOD CULTURES BEFORE ANTIBIOTICS ELEMENT MET	EARLY ADMINISTRATION OF ANITBIOTICS UPON RECOGNITION OF SEPSIS ELEMENT MET
Oct	46	54% (25/46)	83% (38/46)	52% (24/46)	83% (38/46)	52% (24/46)
Nov	40	63% (25/40)	78% (31/40)	63% (25/40)	78% (31/40)	63% (25/40)
Dec	29	55% (16/29)	76% (22/29)	48% (14/29)	76% (22/29)	48% (14/29)
Jan	50	60% (30/50)	92% (46/50)	62% (31/50)	92% (46/50)	62% (31/50)

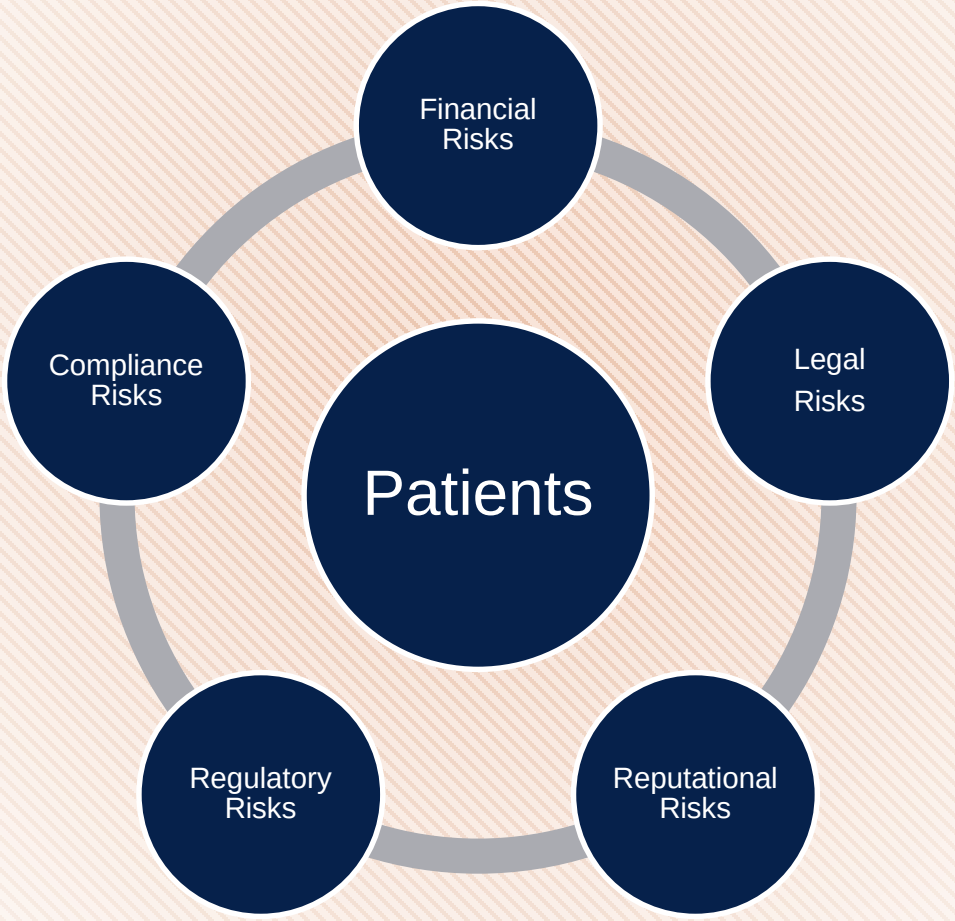
Results – Adherence to Drive Performance Improvement

- Improvements Achieved
  - Exception Based Performance Improvement Initiatives Based Upon Care Gaps
  - Closed Loop of Communication and Action Based Upon Aggregate Data Analysis
  - Identification of Gaps and Opportunities for Documentation Improvement and Completeness of the Medical Record
    - Improved order sets
    - Documentation tools enhanced
  - Standardized Abstraction Requirements Incorporating Definitions and Guidelines for Ongoing Use
  - Education and Skills Competencies Developed

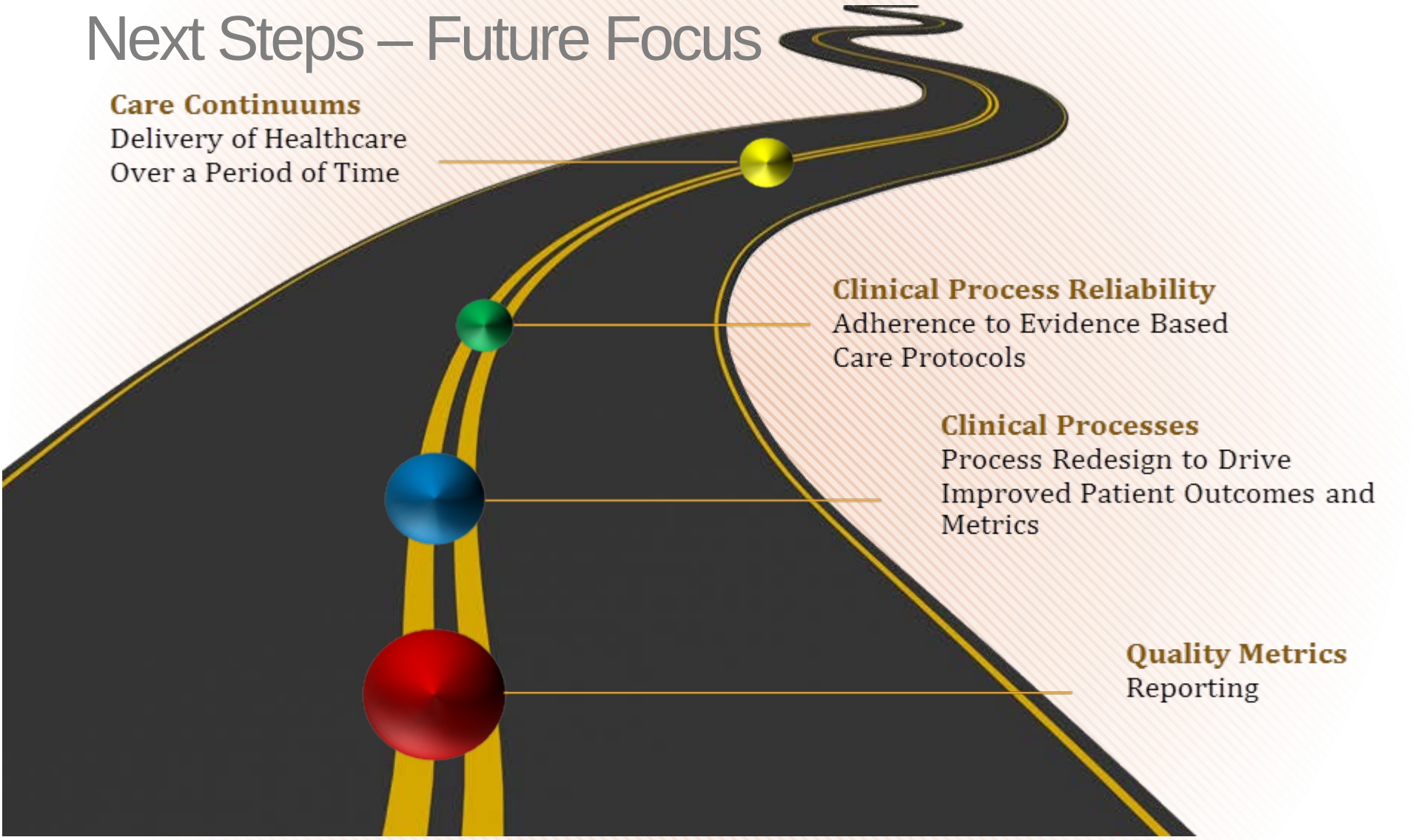
Sepsis Reporting Added to IQR Program Requirements

On 04/01/15, CMS and TJC released the National Hospital Quality Measures (NHQM) Specifications Manual, v5.0 that is effective with October 1, 2015 discharges. Included in this manual were the new specifications for the Sepsis Bundle which will be a requirement for hospitals currently being reimbursed by the Inpatient Prospective Payment System (IPPS) beginning with October 1, 2015 discharges

Bringing It All Together



Next Steps – Future Focus



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