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Crowe Healthcare Summit 2019

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Top Care Delivery Risks That Could Jeopardize Your Organization

September 17

Presented by:
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Charlene Stinnett, MSN, CNS-BC, RN

Introducing Healthcare's Trusted Community:

The Crowe Hive Network

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Agenda

- Top Care Delivery Risks
- Clinical Risk Assessment
- Endoscope Reprocessing Risks
- Hospital Acquired Conditions
- Ligature / Suicide
- Questions

Objectives

- Discuss top clinical risks in healthcare
- Discuss how clinical assessments can positively impact the bottom line
- Describe risks that can be mitigated by performing a clinical assessment to identify deviations from standard practice

Your Presenters

Anita Jackson

is a Clinical Operations Consultant for the clinical team at Crowe. She is a Clinical Nurse Leader with 20 years of experience in acute health care and public health. Areas of expertise include: sepsis, process improvement, patient quality and safety, suicide and ligature risk, and clinical best practice.

Charlene Stinnett

is a Clinical Operations Consultant for the clinical team at Crowe. She is an Advanced Practice Nurse, with 18 years' experience in medical-surgical and perioperative nursing, teaching, and quality. She is the Surgery Subject Matter Expert for Crowe.

Care Delivery Risks

What are the top risks?

How to identify risks at your facility

2019 Top Care Delivery Risks *

- Mishandling Flexible Endoscopes
- Hospital Acquired Conditions (HACs)
- Violent Incidents in Hospitals – Ligature / Suicide
- Care Coordination
- Telemedicine / Telehealth
- Alarm Fatigue
- Emergency Preparedness
- Process Reliability (Clinical Variation – Standardization)
- Sepsis
- Opioid Management

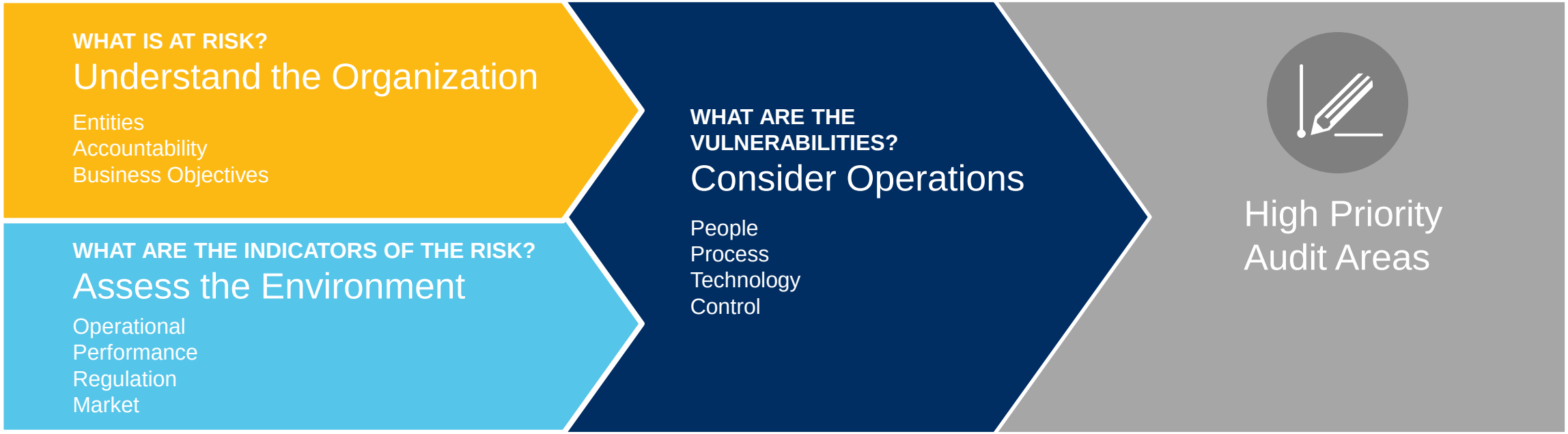
* ECRI Institute Top Ten Patient Safety Risks (2019); ECRI Institute Top Ten Health Technology Hazards (2019); Beecher Carlson Top Ten Emerging Risks in Healthcare (2019); Crowe Healthcare Risk Consulting.

Clinical Risk Assessment

Clinical Risk Assessment

A robust clinical risk assessment:

- Focuses on understanding the business and strategic objectives of the organization
- Leverages data wherever possible to gain an objective view of risks
- Includes the right skillsets, including individuals with deep clinical expertise
- Helps Management and Governance improve their Risk Management process



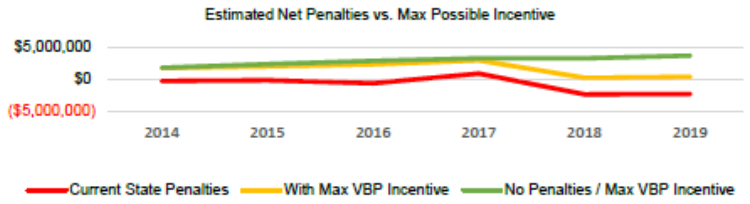
Common Clinical Risk Assessment Starting Point

Crowe

Estimated CMS Pay For Performance Penalties
(2014 - 2019)*
[redacted]
Estimated CMS Pay For Performance Penalties

Health System	Facility	Address	City	State	Zip	Provider ID
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Estimated Penalties by Year	2014	2015	2016	2017	2018	2019	Penalty Trend
Total Estimated Revenue Impact	($315,013)	($196,920)	($694,034)	$833,940	($2,411,608)	($2,325,621)	
Estimated Readmissions Penalty	($27,924)	($352,577)	($547,088)	($321,816)	($241,362)	($127,392)	
Estimated VBP Adjustment *(Including Max Possible Incentive)*	($287,088) *$1,745,277*	$155,657 *$2,299,413*	($146,947) *$2,815,892*	$1,155,756 *$3,218,163*	$627,217 *$3,218,163*	$975,742 *$3,639,783*	
Estimated HAC Penalty *(Started 2015)*	--	$0	$0	$0	($2,797,463)	($3,173,971)	
Where to Focus							Good



Total Estimated Readmissions Penalty	($1,618,159)
Total Estimated VBP Adjustment	$2,480,337
Total Estimated HAC Penalty	($5,971,434)
Net Penalties 2014 - 2019	($5,109,256)
Mid Range: Readm/HAC Penalties w Max VBP Incentive	$9,347,097
Top Range: No Penalties / Max VBP Incentive	$16,936,690
Total Penalty-Incentive Spread (Opportunity Cost)	$22,045,946

* Source: https://dag.advisory.com/2013_G[redacted]Gmap/Home/MapView?mapname=p4nf[redacted]

CMS Value Based Purchasing Scoring

Person/Community Engagement:

- HCAHPS

Safety:

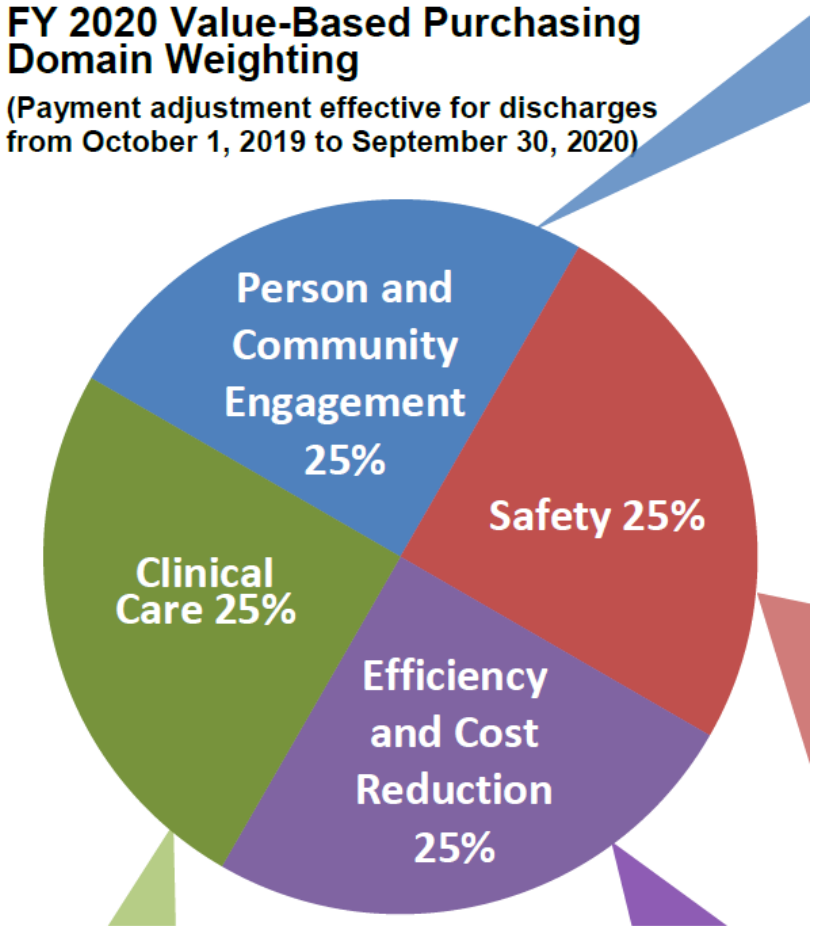
- Perinatal events
- Healthcare Associated Infections

Clinical Care:

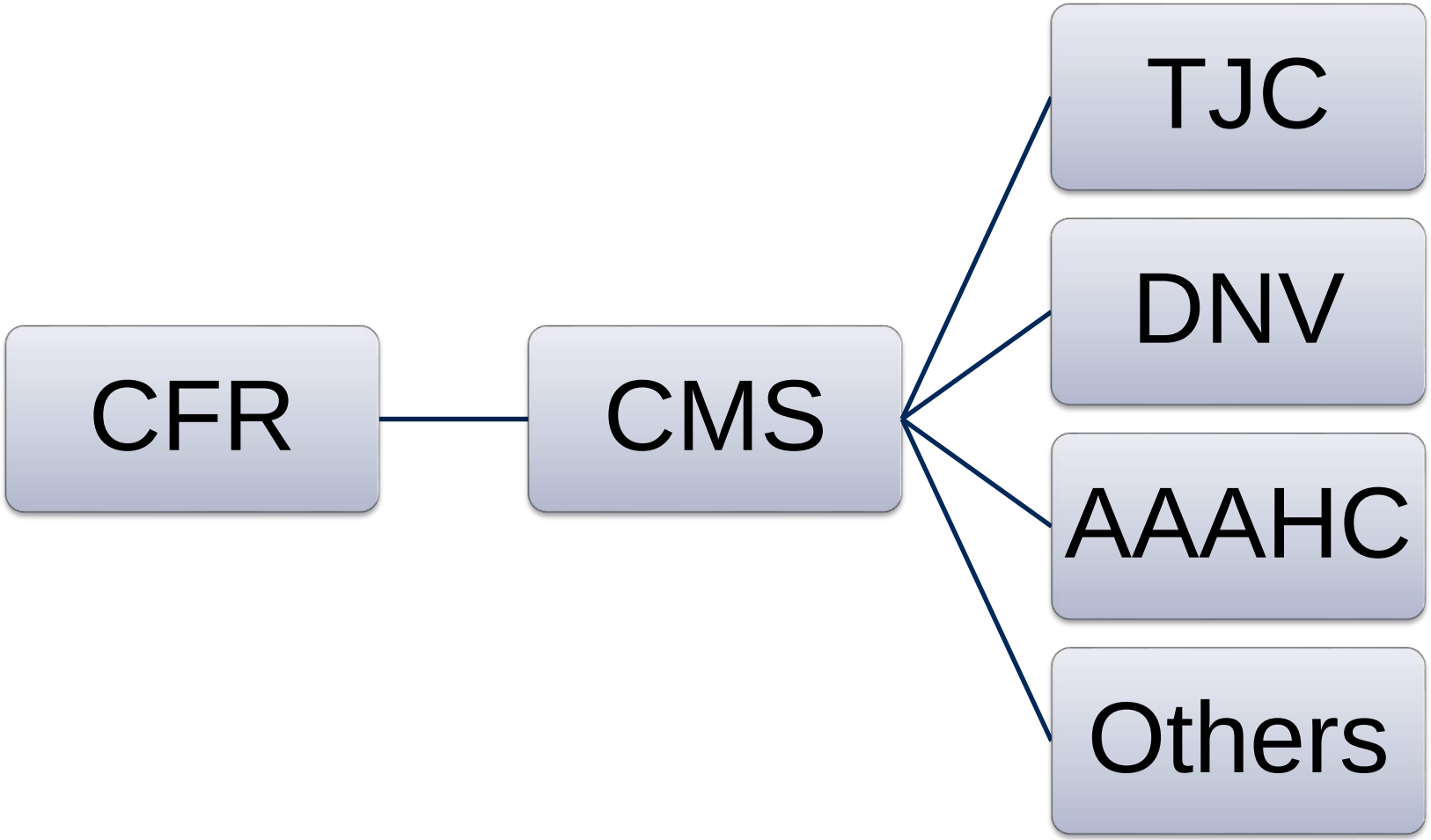
- Mortality
- THA/TKA Complications

Efficiency & Cost Reduction:

- Hospital-Acquired Condition (HAC) Program



Other Authorities with Jurisdiction



Take-away Points

- Clinical risk assessments can provide focus to a facility's top clinical risks.
- Many clinical areas have requirements designated by CMS, and are surveyed to be in effect by an accrediting body (e.g., TJC, DNV, etc.).
- The inability to meet national standards could result in penalties, loss of revenue, patient harm, litigation, and loss of reputation.
- A review of one's internal risk assessment by an independent third party could assist in validating and prioritizing one's clinical risks.

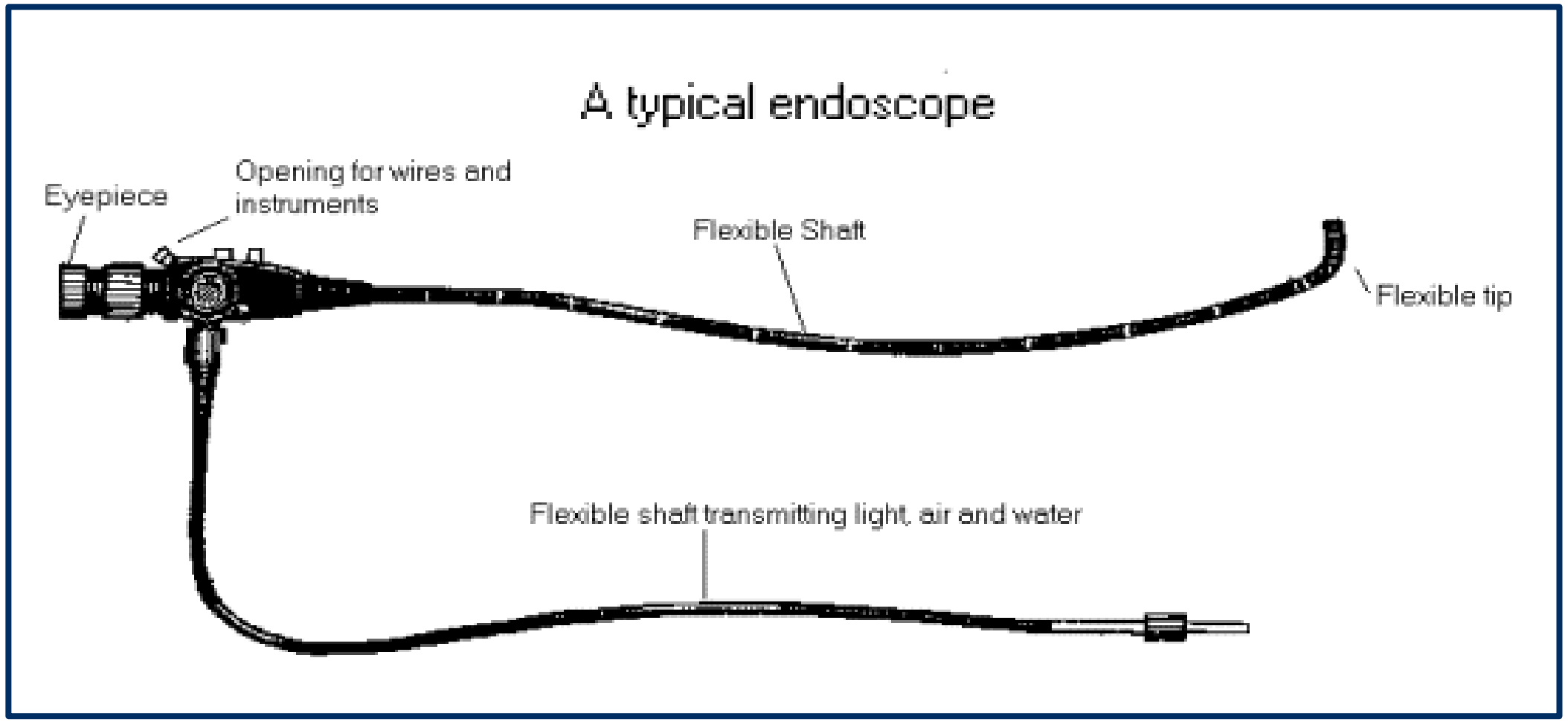
Endoscope Reprocessing Risks

What is an Endoscope?

- An instrument which can be introduced into the body to view its internal parts, and diagnose a variety of conditions / abnormalities that might otherwise go undetected.

- Endoscopes are not only used for GI procedures, but other types of endoscopes are used in the following specialties:
  - OB / GYN
  - Ear / Nose / Throat (ENT)
  - Urology
  - Pulmonology

GI Endoscope Example



Ripped from the Headlines

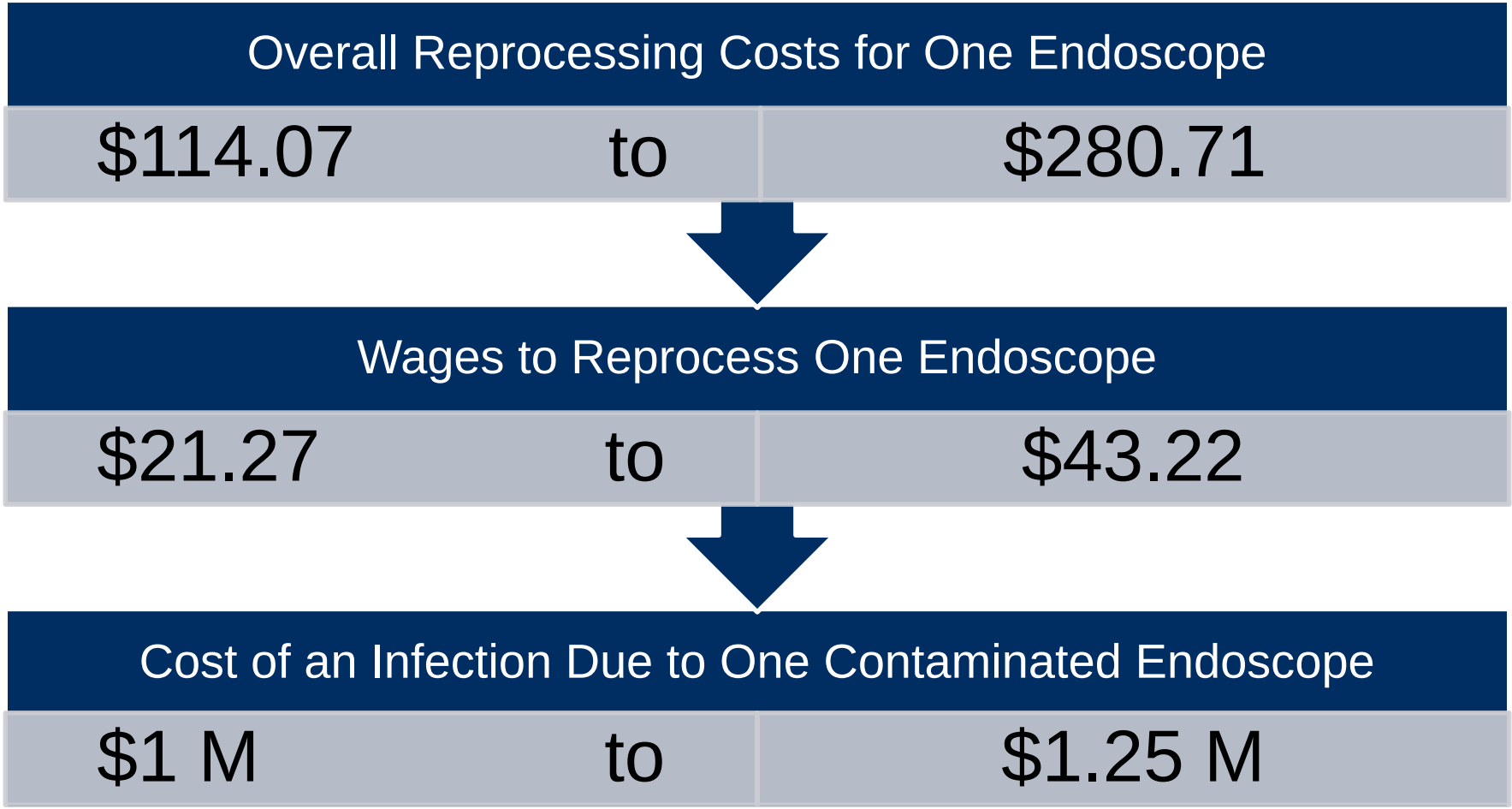
Deadly superbug infections from tainted scopes greater than thought (CNN, 2016)

35 deaths linked to scope infections after Olympus told execs not to warn hospitals (CNBC, 2016)

VA medical center warning 526 patients of infection risk from scopes (The Buffalo News, 2017)

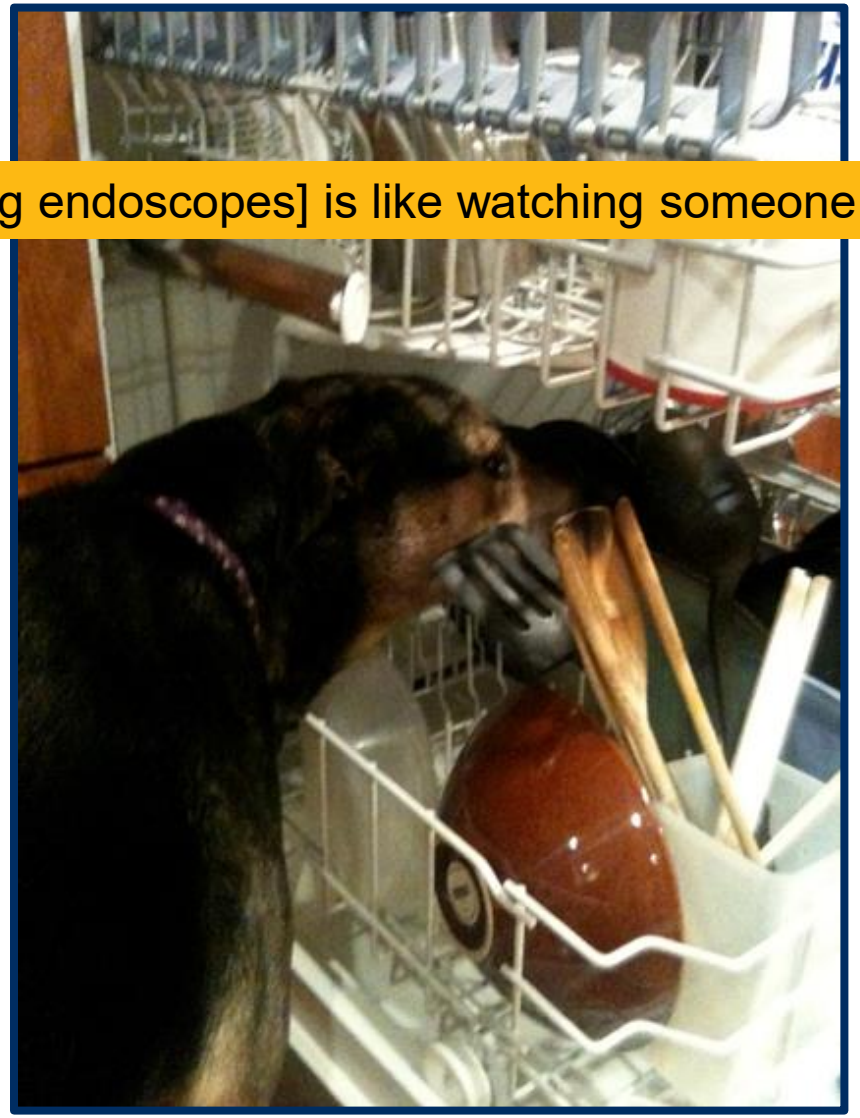
Hospitals and device makers still struggle to rid medical scopes of infectious bacteria (LA Times, 2018)

The Financial Costs of Endoscopes



Where’s the Breakdown? (aka “How hard can it be?”)

“[Reprocessing endoscopes] is like watching someone wash the dishes”



Where’s the Breakdown? (aka “How hard can it be?”)

- Testing to standards requires over 100 steps to observe for adherence; these steps are often performed by different people with varying levels of education and/or training.

“CLEANR” Study Findings:

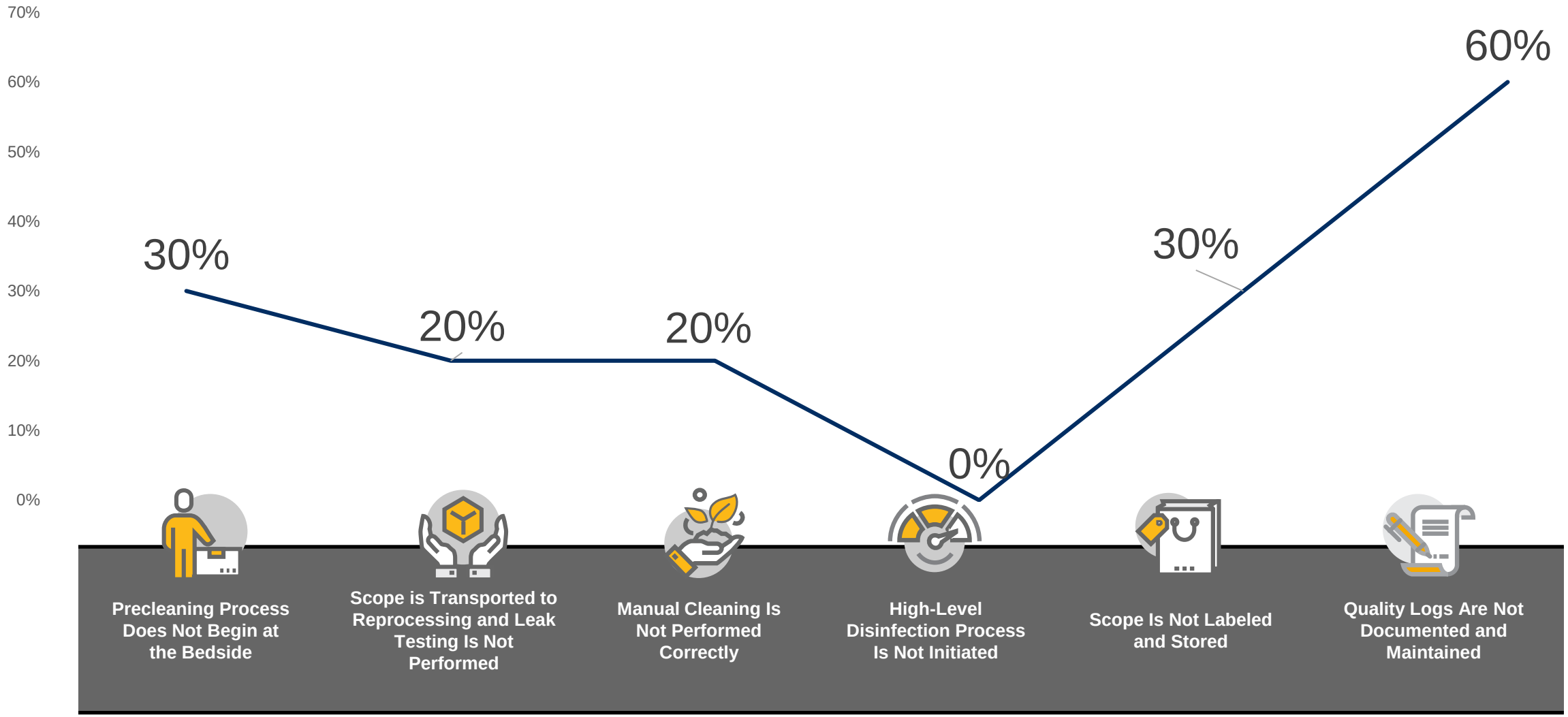
- 50% of technicians don’t like manual cleaning
- 75% felt pressure to work quickly while reprocessing
- 53% felt physical discomfort when reprocessing scopes (breathing difficulties, bothered by fumes, physical aches / pains)
- **99% of manually cleaned scopes had one or more steps skipped or done incorrectly**.

Where’s the Breakdown? (aka “How hard can it be?”)

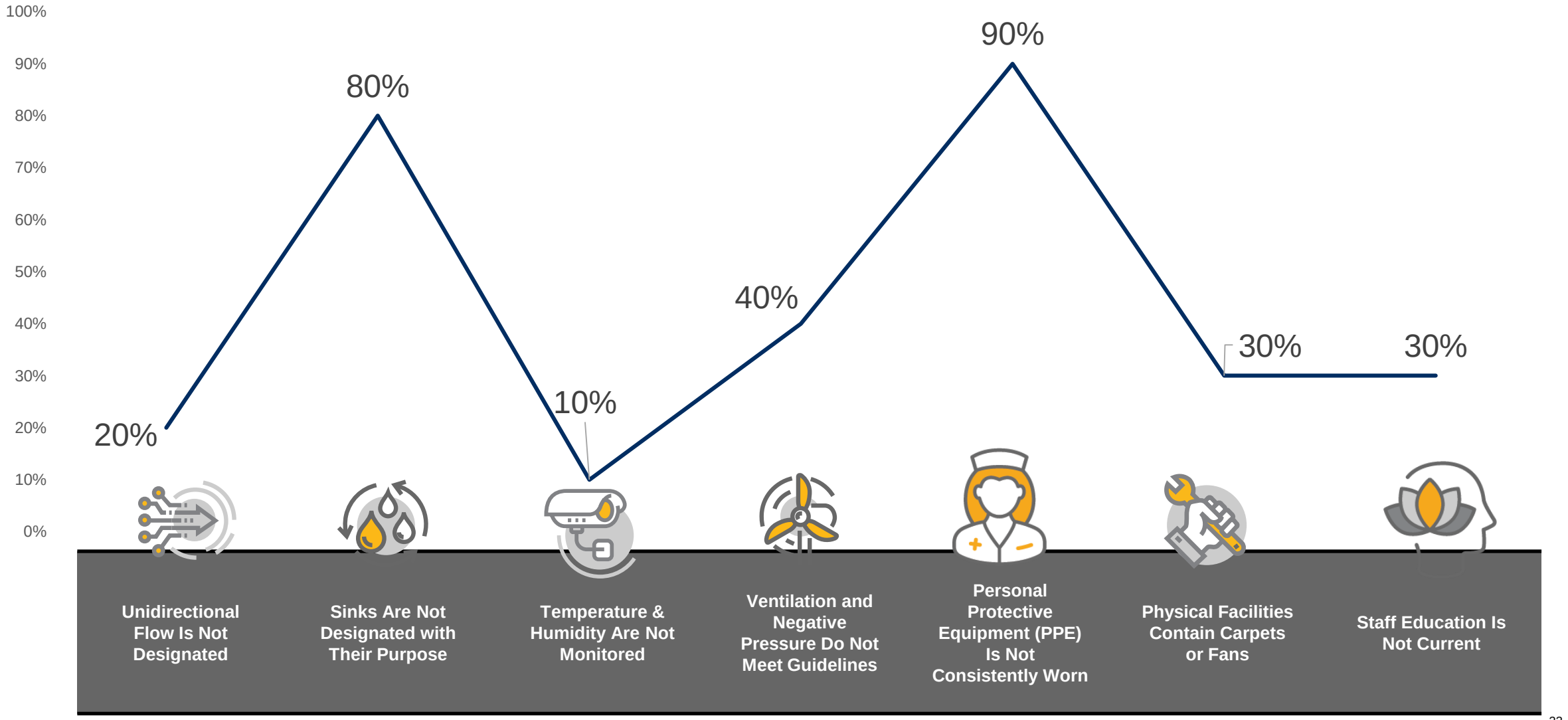
- In a study conducted by Ofstead et al., ATP was present on 66% of ports and channels after manual cleaning, along with protein and blood.

- “Meticulous cleaning must precede any sterilization or high-level disinfection of these instruments. **Failure to perform good cleaning can result in sterilization or disinfection failure**, and outbreaks of infection can occur.” (CDC)

Common Gaps in the Reprocessing Steps



Common Gaps in the Reprocessing Steps, Continued



Take-away Points

- Endoscope reprocessing is multi-faceted, and missing steps could result in harmful bacteria being transmitted to other patients.
- External consultation can provide feedback, resources, and increase compliance to expected national standards.

Hospital Acquired Conditions (HACs)

Types of HACs

- Hospital Acquired Conditions (HACs) are conditions that a patient develops while in the hospital being treated for something else. These conditions cause harm to patients and are often preventable.
- Centers for Medicaid and Medicare Services (CMS) tracks 14 distinct HACs
- Hospital Acquired Infections (HAIs)
  - Central Line Associated Blood Stream Infection (CLABSI)
  - Catheter Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI)
- Non-infection Hospital Acquired Conditions
  - Falls with injury
  - Pressure ulcers
  - Embolisms
  - Poor glycemic control
  - Incompatible blood products
  - Foreign objects left in the body during surgery

Costs of HACs

In 2016 there were almost 50,000 HACs resulting in:

- $2 billion in excess hospital operational costs
- 3,200 potentially avoidable deaths
- 8.17 additional days per patient to average length of stay
- 72% increased mortality risk per patient
- Harm to patients, physically, emotionally, financially
- Loss of hospital reputation

CMS HAC Reduction Program

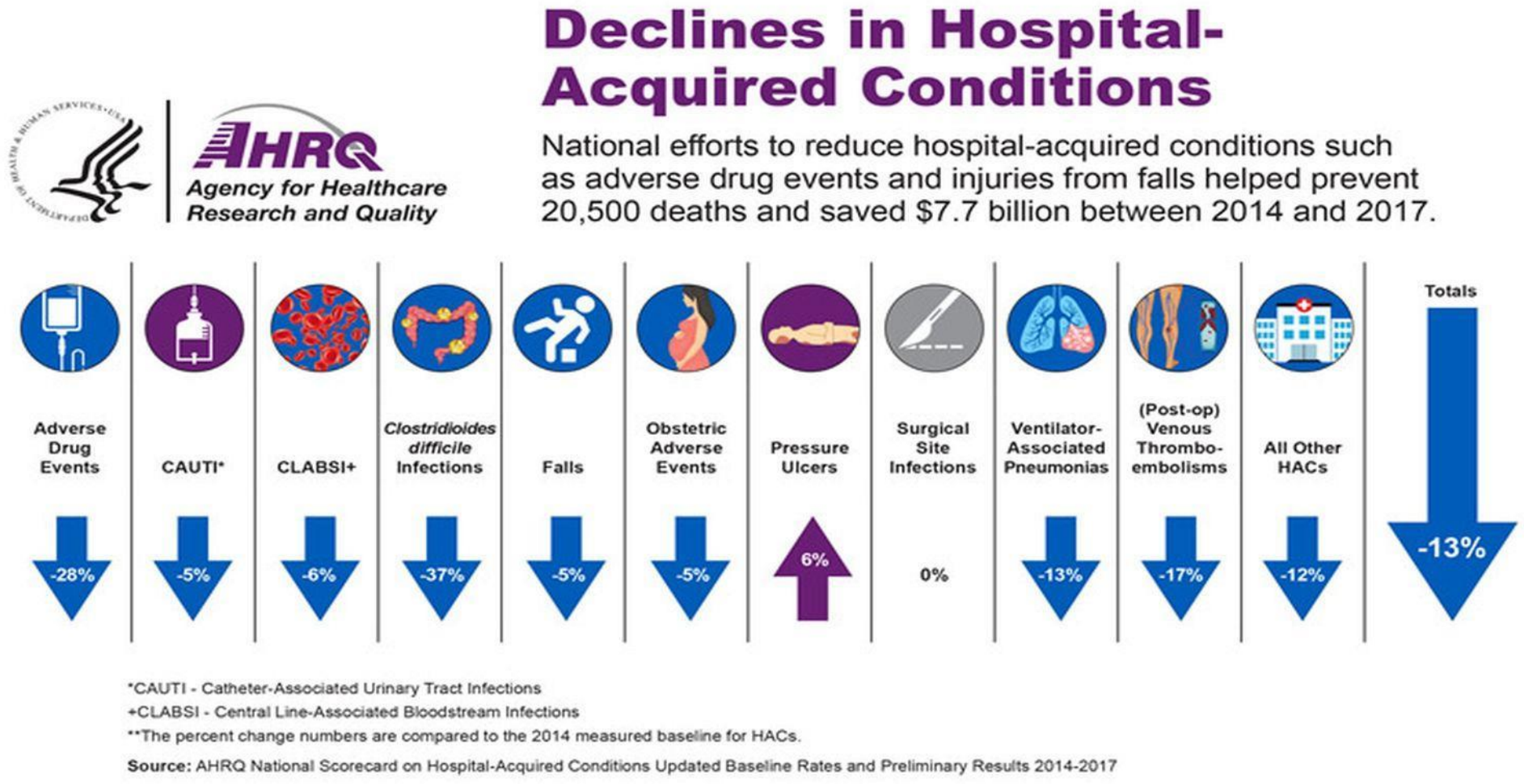
- Six HACs are part of the HAC Reduction Program
  - *Clostridioides difficile* (*C.diff*)
  - CAUTI
  - CLABSI
  - Methicillin-Resistant *Staphylococcus aureus* (MRSA)
  - SSI - Colon
  - SSI - Hysterectomy
- The HAC Reduction Program penalizes hospitals that perform in the bottom 25% of participating facilities
- The penalty is a 1% payment reduction from the Secretary of Health and Human Services (HHS)
- Examples of penalties in 2018:
  - Yale New Haven Hospital (CT), -$2,877,816
  - Mount Sinai Medical Center (NY), -$2,379,489

HACs are Preventable

Guidelines and evidence-based practices are established to guide care to prevent most HACs

- Centers for Medicare and Medicaid Services (CMS)
- Centers for Disease Control (CDC)
- Joint Commission (JC)
- Leapfrog Group

Decrease in HACs



Previous Crowe HAC Assessments

Crowe has performed numerous clinical assessments related to HACs

- CAUTI
- CLABSI
- SSI
- Sepsis
- Falls
- Pressure Ulcers
- Scope Processing
- Hand Hygiene
- Serious Safety Events

According to CDC, On average, healthcare providers clean their hands less than half of the times they should.

Crowe HAC Assessment - Findings

CAUTI

- Policies / Procedures not aligned with evidence-based guidelines
- Maintenance and care of catheter not documented
- No reason for catheter
- No nursing protocol
- No monitoring of processes

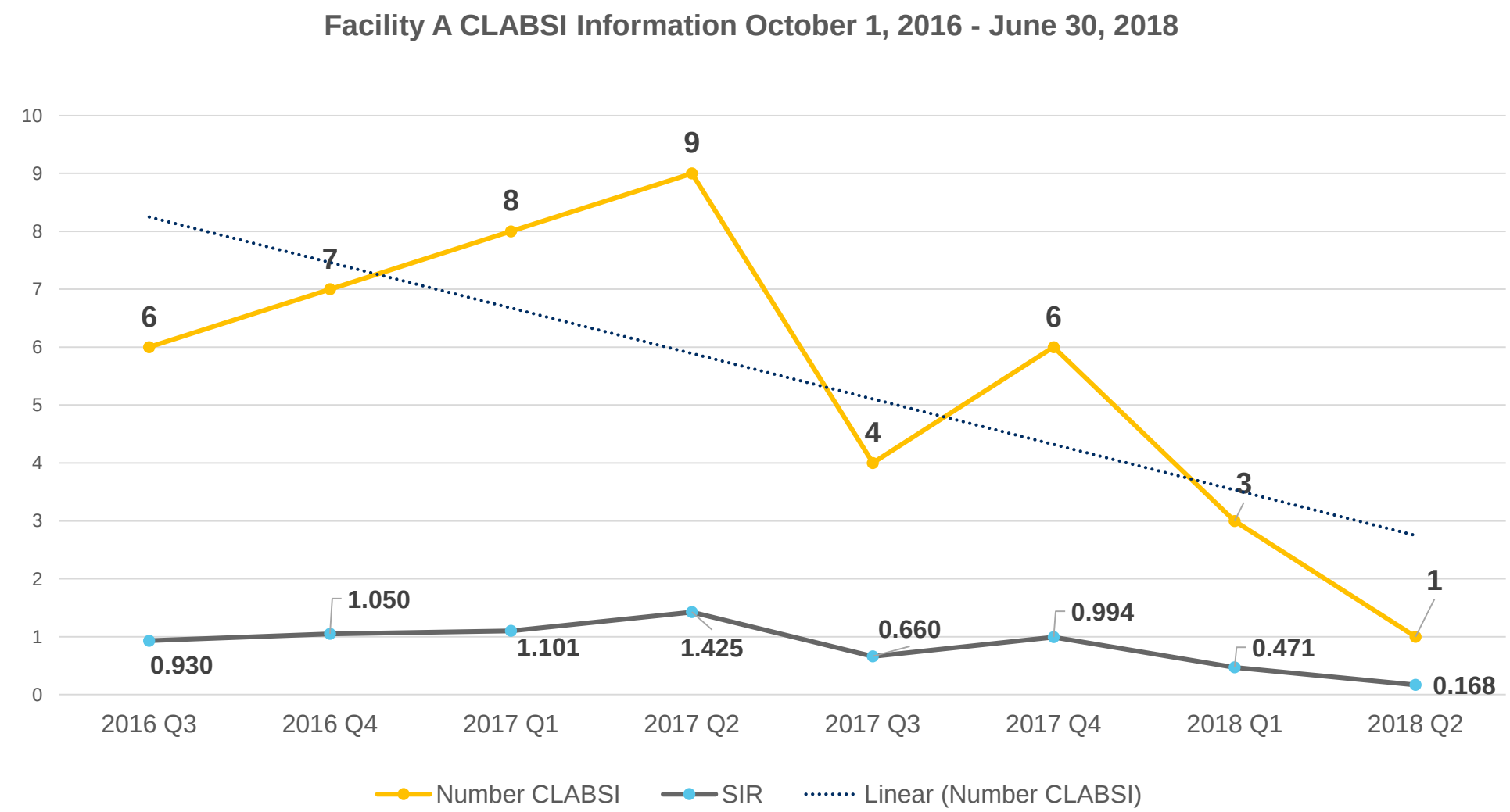
SSI

- Policies / Procedures not aligned with guidelines
- Operating rooms (OR) out of acceptable temperature and humidity range
- Timing / choice of antibiotic
- No monitoring

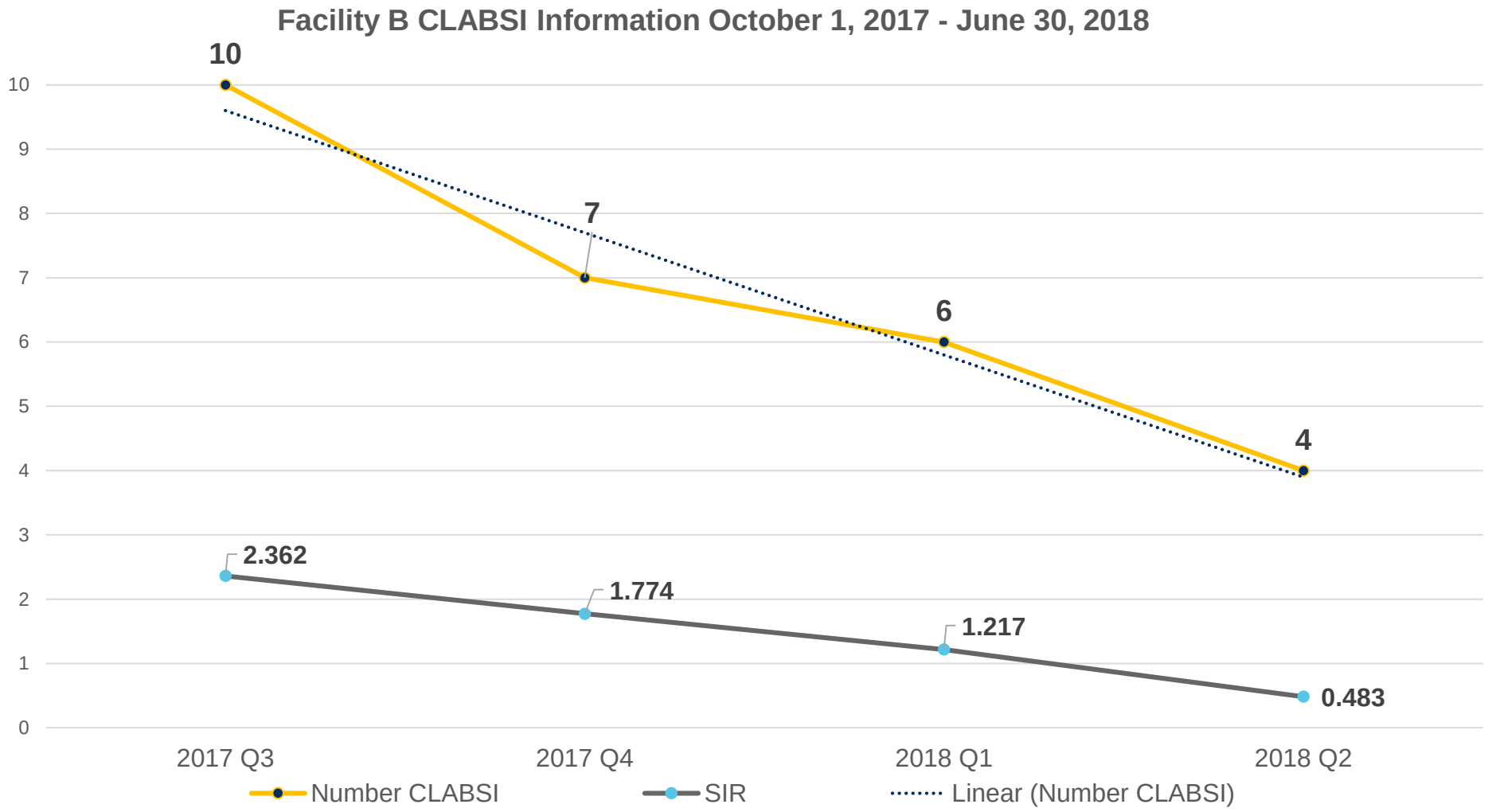
Crowe CLABSI Assessment

- Through observation and medical record testing, Crowe discovered deviations from expected standards:
  - Maintenance elements not documented as complete
  - Standards for Central Line care were not followed
  - Patient education was not documented
  - Orders for insertion, use, continued need, and removal were not documented
  - Daily rounds were not conducted
  - A standard hand-off communication tool (to report on Central Lines) was not in place

Crowe CLABSI Assessment



Crowe CLABSI Assessment



Take-away Points – HACs

- HACs are preventable and cost hospitals millions of dollars each year in penalties, reduced reimbursement, extended length of stay, and readmissions

- CMS requires hospitals to publically report HACs which can lead to loss of reputation

- Following best-practice guidelines reduces HACs

Ligature / Suicide Risk in Hospitals

Headlines

Chicago psychiatric hospital fails to protect suicidal patients. Modern Healthcare, September 18, 2018

[redacted] **hospital temporarily closes mental health units amid safety concerns.** The Chicago Tribune, May 31, 2019

Patient who killed himself in Naples was man, 76; hospital representatives discuss security measures. Naples Daily News, January 18, 2019

Two Georgia veterans died by suicide at VA hospitals this past weekend. Military Times, April 9, 2019

Mom's suicide at [redacted] came 12 hours after transfer. Forrest Park Review, September 23, 2013

Suicide Statistics

- Suicide is the 10th leading cause of death in the US
- Almost 45,000 Americans die by suicide every year
- Twice as many suicides as homicides
- Females attempt suicide three times as often as males
- Suicide rates for males is four times higher than female
- For females the suicide rate was highest for those 45-54 years old
- For males, the suicide rate was highest for those 65 and older
- Firearms are the most common method among males
- Poisoning is most common method among females
- Highest suicide rates are in Montana, Alaska, and Wyoming

Suicide Statistics

- Suicide is rarely caused by a single factor
- Depression, mental illness, addiction, and suicide are associated
  - Depression affects 20-25% of Americans
  - Only half seek treatment for major depression
  - 20% of Americans have a mental illness
  - 90% of suicides had an underlying mental illness

Inpatient Facility Suicide Statistics

- About 49 to 65 hospital inpatient suicides yearly
- 75% to 80% were psychiatric inpatients
- Over 70% occurred by hanging
- About half occurred in bathrooms, one-third in patient's rooms
- In over half, the ligature point was a door, door handle, or door hinge

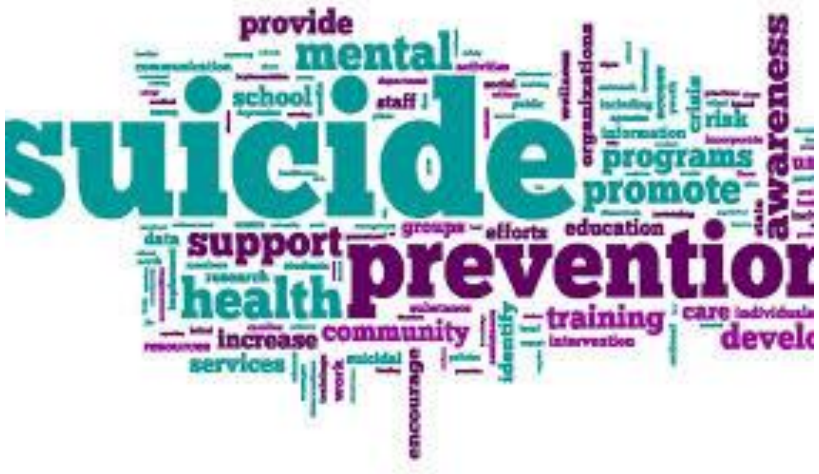
Inpatient Facility Suicide Costs

- Emotional and financial toll on family and friends
- Emotional toll on health care providers
- Fines from regulatory agencies
- Loss of hospital reputation
- Lawsuits
- Issuance of an Immediate Jeopardy (IJ) by CMS
  - CMS defines IJ as “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”
  - Once a hospital receives an IJ rating, it’s given a time frame to address the deficiency. If not, CMS will terminate the facility’s Medicare and Medicaid funding.
  - The loss of accreditation can be devastating for a hospital
  - Hospital insurance rates are negatively affected

Guidelines for Reducing Suicide in Healthcare

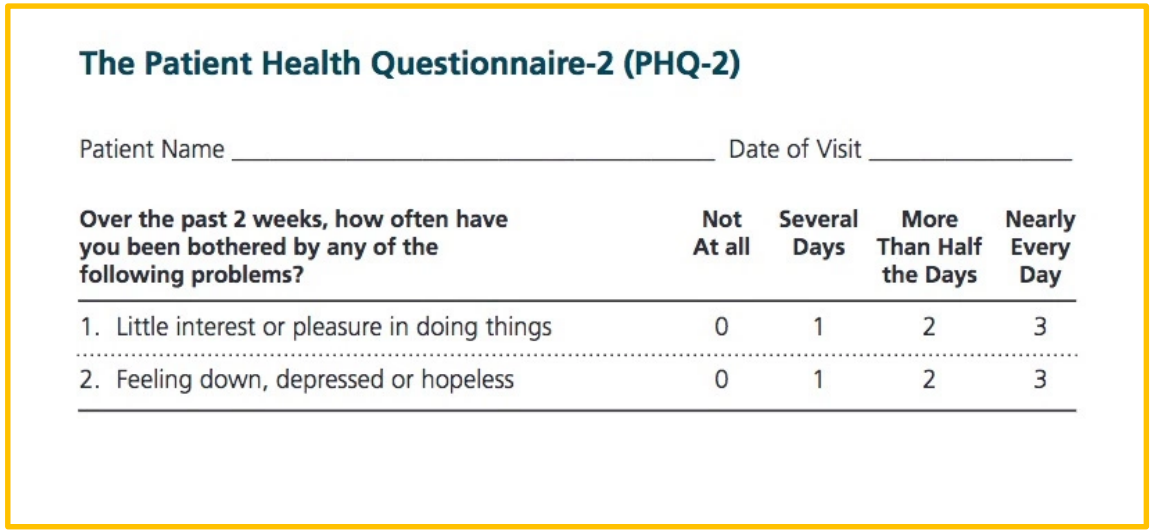
- The Joint Commission, Sentinel Event Alert, Issue 56, February 2016
- The Joint Commission, Perspectives, Volume 37, November 2017
- The Joint Commission, National Patient Safety Goals, January 2019
- National Action Alliance for Suicide Prevention, Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe, 2018

- General inpatient facilities, and emergency departments and behavioral health facilities have different guidelines



Sentinel Event Alert, Issue 56, February 2016

- Conduct risk assessment to identify characteristics that may increase risk of suicide
- Review patient and family history for suicide risk factors
- Screen all patients using a brief evidenced based tool
- If screen shows increased risk, conduct a thorough secondary screening
- If patient is high risk, check patients and visitors for unsafe items and monitor patient 1:1
- Give every patient screened Suicide Hotline information
- Restrict access to lethal means
- Educate all staff regarding identification and response to patients with suicidal ideations



The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Perspectives, Special Report: Suicide Prevention in Health Care Settings, Volume 37, November 2017

- Focus on environmental hazards specific to Inpatient Psychiatric Units, General Acute Care Settings, and Emergency Departments
- Discusses:
  - Hazards that must be corrected
    - Drop ceilings, ligature-resistant hardware in patient rooms
  - Mitigation strategies acceptable when hazards cannot be removed
    - Environmental risk assessments, protocols, monitoring, patient hand-off, policies
  - Staff education
    - *"expert panelists all emphasized the critical importance of well-trained, vigilant, compassionate staff who rigorously follow procedures for protecting patients. Health care organizations should focus as much on* ***staff training and monitoring compliance with protocols*** *as they do on detecting and correcting specific environment hazards."*

Behavioral Health National Patient Safety Goals 2019

- NPSG.15.01.01 Reduce the risk for suicide
  - Rationale: Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

  - Elements of Performance

1. Conduct an environmental risk assessment and act to minimize suicide risks
2. Use a validated screening tool to assess patients at risk
3. Use evidence-based process for conducting suicide risk assessment for patients who screen positive for suicidal ideation
4. Document the patients' risk and plan to mitigate
5. Develop policies/procedures addressing care of patients who are at-risk
6. Develop policies/procedures for counseling and follow-up care at discharge
7. Monitor processes for effectiveness, and take action as needed

Crowe Suicide/Ligature Risk Assessments

- Policies and Procedures: not aligned with industry standards, not being following by staff
- Screening: lack of consistent initial and secondary screening
- Monitoring: lack of 15-minute rounding, 1:1 monitoring, and visitor monitoring
- Education: lack of staff education, education materials did not align with policies and standards
- Documentation: lack of required documentation
- Hand-off: lack of nurse to nurse hand-off when transferring patient care
- Environmental issues: failure to remove unsafe items, ligature points, long cords, high shelves where contraband could be hidden, loop anchor attached to floor, hand rail in unmonitored location, hard plastic trash cans, isolation cart unlocked, unnecessary furniture in patient rooms

Take-away Points – Suicide/Ligature Risk

- Suicide in a health care setting is a NEVER EVENT
- CMS and state health departments can issue an IJ if hospitals are noncompliant and do not act to keep patients safe from serious injury, harm, impairment, or death
- Clinical consultation can provide assessment and feedback regarding hospitals compliance with standards and requirements

Questions?

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Simplify your busy workday. Register today to continue the Healthcare Summit conversations: **crowehive.com.**

Thank you

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