



June 7, 2013

DATA TRANSPARENCY AND QUALITY IMPROVEMENT: DEVELOPING IRF-SPECIFIC BENCHMARKS



EQUADRSM
Exchanged Quality Data for Rehabilitation

Objectives

- Provide context to the need for IRF-specific quality and safety data
- Describe the purpose and creation of Patient Safety Organizations
- Summarize the key elements essential to driving quality improvement in rehab
- Provide a facility's perspective on how data transparency and benchmarking facilitates improvement



Carolinas HealthCare System

- Largest healthcare system in the Southeast
- Second largest public, multi-hospital system in the nation
- 38 hospitals, 8 rehab hospitals/units, 10 nursing homes, and over 600 outpatient service locations
- 1,900 integrated physicians and over 300 residents
- 60,000 employees



Carolinas Rehabilitation

- Operate 192 IRH/U beds in the Charlotte area, 13 OP Therapy Centers and 9 Physician Clinics
- 3000 Inpatient Rehab Discharges per Year
- CARF accredited in 17 programs - SCI, BI, CVA, CIIRP, Pediatrics
- Teaching and research center - 24 PM&R faculty, 13 PM&R Residents



Background

- Quality outcomes measurement, reporting, and benchmarking in rehabilitation has lagged behind the acute care hospital sector
- Historically, rehab only had acute care to benchmark against
- Inpatient Rehabilitation Facilities (IRH/Us) exempted from mandatory HAC reporting and payment penalties until FY2013
- Traditional measures of quality in rehab not longer adequate to meet the changing paradigm of healthcare delivery
- Increasing patient complexity, increasing demands for value over volume



Creating an IRF Quality Network

- How do we know where we're going if we don't know where we are?
- Legal barriers to sharing of data and practices
- Identified need for a formal process and structure for sharing
- Opportune timing – PSO legislation



EQUADRSM Network

- Exchanged Quality Data for Rehabilitation
- Designated as a Patient Safety Organization (PSO) by AHRQ in 2010 – “Carolinas Rehabilitation Patient Safety Organization”
- Only PSO dedicated to rehabilitation care
- 23 IRFs currently members

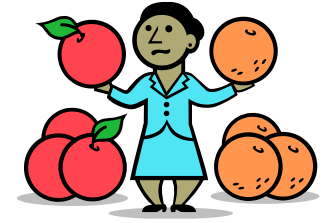


Member Facilities

- Rehabilitation Hospital of Indiana
- WakeMed Rehab
- Southern Indiana Rehab Hospital
- Reid Hospital and Health Care Services
- Cone Health Rehabilitation Center
- National Rehabilitation Hospital
- Roper Rehabilitation Hospital
- Brooks Rehabilitation Hospital
- Magee Rehabilitation
- Methodist Rehabilitation Center
- Mary Free Bed Rehabilitation Hospital
- University of Utah Rehabilitation
- Baptist Health Rehabilitation Institute
- Cottage Rehabilitation Hospital
- Rehabilitation Institute of Michigan
- Sunnyview Rehabilitation Hospital
- Vidant Health Medical Center - Regional Rehabilitation Center
- TIRR Memorial Hermann
- Miller-Dwan Rehabilitation
- Burke Rehabilitation Hospital
- Rehabilitation Institute of Chicago
- Carolinas Rehabilitation
- New Hanover Regional Medical Center Rehabilitation Hospital



Comparing Apples and Oranges



Acute Care Hospital

- All diagnoses, problems, injuries, illnesses
- Purpose is to treat, cure, or stabilize acute condition rapidly
- Length of Stay around 3 days - get to the next level of care
- Severity of illness requires around the clock nursing care, respiratory care, and/or physician supervision
- Treatment varies from intensive medical to surgical
- Patient spends the majority of time in a single room

Inpatient Rehab Hospital

- Select RICs make up the majority of cases – must have an expectation of gaining function
- Purpose is to restore maximal independent function
- Length of Stay roughly 2 weeks
- Requires round-the-clock nursing care – outpatient therapy not an option
- Treatment involves managing medical conditions plus therapy to address functional limitations
- Patient is encouraged to be mobile and moves about the facility



Defining Quality

- Very limited options for NQF-endorsed measures for IRF setting
- Must balance accuracy, clarity, data collection burden
- Do the measures reflect quality of care delivered? Can they be impacted by improvement efforts? Are they reflective of the institution's priorities for quality?

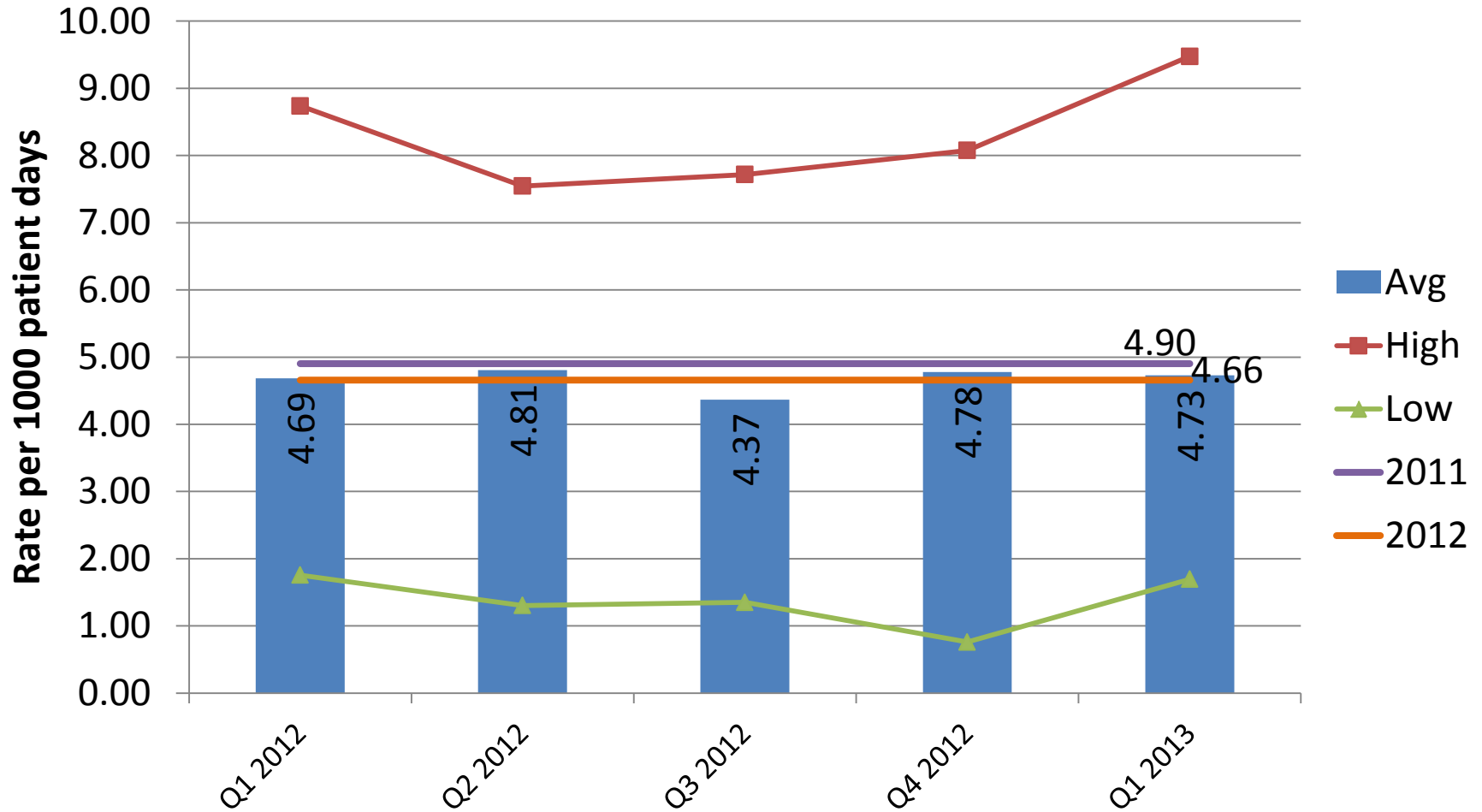


Example: Unassisted Falls

- “An unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient that occurs during the patient’s admission to the rehabilitation facility. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Do NOT include assisted falls – A fall in which any staff member (whether a nursing service employee or not) was with the patient and attempted to minimize the impact of the fall by easing the patient’s descent to the floor or in some manner attempting to break the patient’s fall. ‘Assisting’ the patient back into a bed or chair after a fall is not an assisted fall. A fall that is reported to have been assisted by a family member or visitor counts as a fall, but does not count as an assisted fall.”



Unassisted Falls

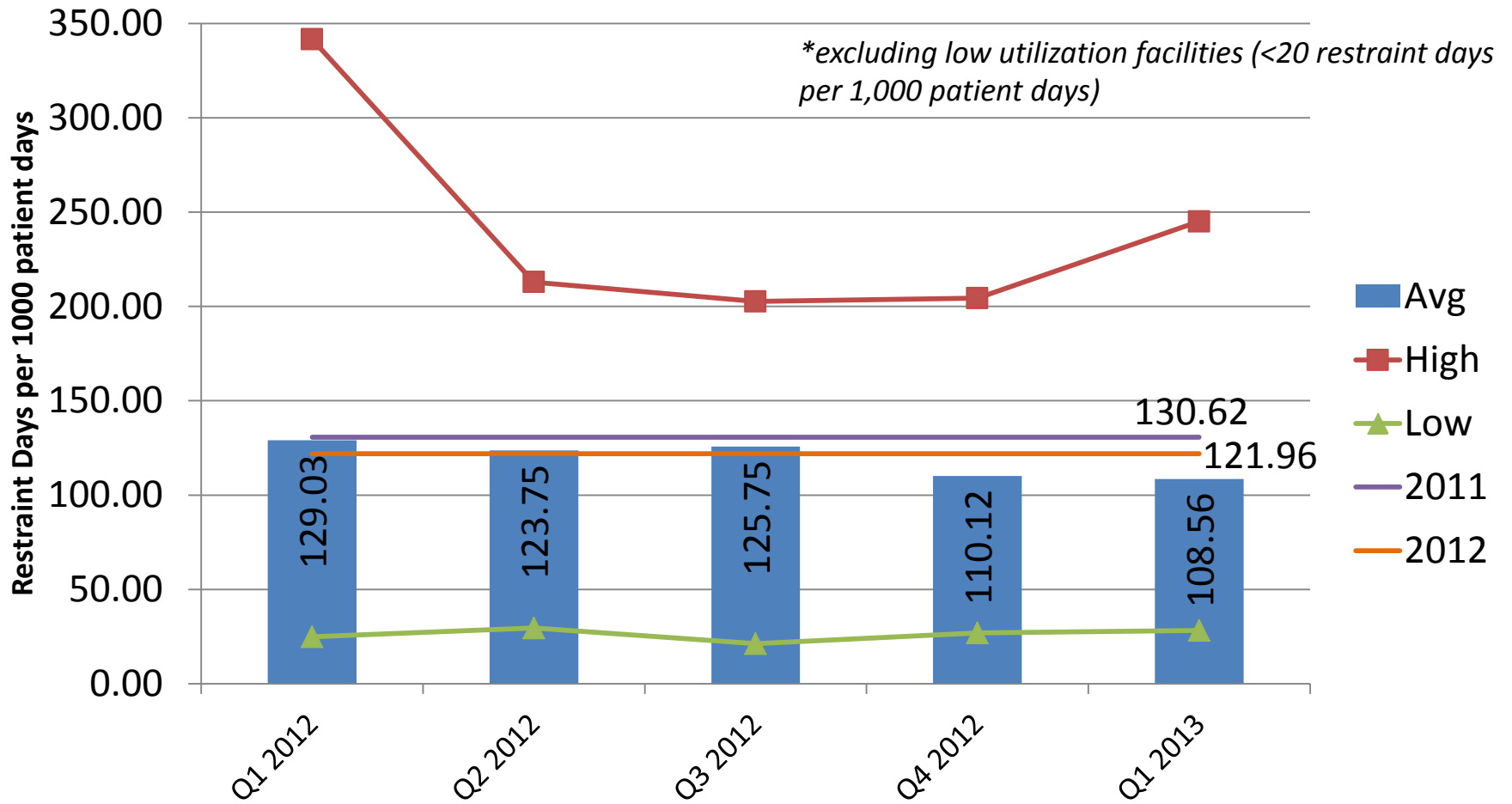


Example: Restraint Utilization

- Physical restraints are defined by CMS as, “Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).” (CMS, Final Patient Rights Rule).



Restraint Utilization*



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Why a PSO?

- Patient Safety Organizations (PSO) were created by the Patient Safety and Quality Improvement Act of 2005.
- Designed to promote patient safety and quality of care by attaching privilege and confidentiality protections to a provider's confidential quality/patient safety information.
- Members can share information and conduct open discussions about quality and safety with other PSO members without fear that the information will be shared externally or be subject to legal discoverability.
- **Purpose:** encourage the expansion of voluntary, provider-driven initiatives to improve the quality and safety of healthcare; to promote rapid learning about the underlying causes of risks and harms in the delivery of healthcare; and to share those findings widely, thus speeding the pace of improvement
 - Key concepts: **PROTECTION** and **AGGREGATION**



Leading Quality and Safety

- Tremendous opportunities through the PSO structure to collaborate among Inpatient Rehab Facilities

“The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year.”

– John Foster Dulles

“Success teaches us nothing; only failure teaches...Develop the capacity to learn from experience.”

- Admiral Hyman G. Rickover



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QUESTIONS?



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