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SoW News

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Identified Participant Groups (IPGs) in the 8th SoW

As part of the 8th Scope of Work (SoW) (2005–2008), the Centers for Medicare & Medicaid Services (CMS) has asked its Quality Improvement Organizations (QIOs) to work with leading hospitals in each state to transform health care to higher levels of quality through participation in national projects, referred to as Identified Participant Groups (IPGs). These new projects will continue the work initiated in the 7th SoW on public reporting of quality measures and pay-for-performance initiatives, but they will also include new areas of focus, such as organizational safety culture and use of advancing technologies.

Health Services Advisory Group (HSAG, the QIO for Arizona) will work intensively with a limited number of hospitals that are interested in aligning the strategic priorities of their organization, their resources, and their support mechanisms to achieve the transformational change goals relevant to the 8th SoW. This work will ultimately lead to improved processes and outcomes, as well as enhanced patient care and economic savings.

Each IPG has unique criteria for participation. CMS, in conjunction with HSAG, will determine which hospitals are eligible and invited to participate. The 8th SoW IPGs include:

- Appropriate Care Measure (ACM)
- Surgical Care Improvement Project (SCIP)
- Systems Improvement and Organizational Culture Change (SIOC)
- Rural Organizational Safety Culture Change (ROSC)

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HQA and RHQDAPU Data Available

The preview data for the Hospital Quality Alliance (HQA) and Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) are now available for review for each participating provider and QIO on http://qnetexchange.org. The hospital performance rates are based on data submitted and successfully accepted into the QIO Clinical Warehouse. The Preview Report will reflect discharge data from 2nd through 4th quarter 2004 and 1st quarter 2005, depending upon the measure. It is anticipated that the data will be posted on the Hospital Compare Web site on December 1, 2005.

Appropriate Care Measure (ACM)

The ACM is composed of the 10 quality measures (5 AMI, 2 HF, and 3 PN) as defined in the Medicare Modernization Act (MMA) and associated with the hospitals' Annual Payment Update (APU). Unlike past quality efforts, in which each indicator was measured separately, the ACM is *patient-centered*. It answers the question: "Did the patient receive ALL the care he or she should have received, based upon his or her clinical condition?" Teams will focus on reducing the gap between care the patient *should have* received and care the patient *did* receive.

Surgical Care Improvement Project (SCIP)

SCIP is a national effort to reduce preventable complications related to surgical infections and thromboembolic events. These complications take a toll, not only on the patients, but also on the overall cost of health care through increased length of stay and hospital costs. The project quality measures have been developed in association with nationally recognized professional associations. Teams will participate in learning sessions and implement interventions designed to improve surgical processes and reduce surgical complications.

Systems Improvement and Organizational Culture Change (SIOC)

SIOC addresses issues related to use of advancing technology for health care and patient safety. Arizona is nationally recognized for its excellent telehealth network through the work of the Arizona Telehealth Program (ATP). Teams will use a CMS survey to assess their hospitals' current telehealth status, develop a business case for use or further advancement of telehealth, implement interventions to support the work, and conduct a second survey to determine improvement.

Rural Organizational Safety Culture Change (ROSC)

ROSC is designed to assist rural and critical access hospitals (CAHs) in assessing their organizations' safety climate through a survey developed by the Agency for Healthcare Research and Quality (AHRQ)—the *Hospital Survey on Patient Safety Culture*. Teams will assess their hospitals' current culture using the survey, identify opportunities for improvement, implement interventions, and conduct a second survey to determine improvement.

IPG FAQs (Frequently Asked Questions)

Q: How will HSAG assist hospitals to achieve transformational change?

A: QIOs will work with providers to achieve transformational change in health care and to deliver the right care for every person, every time. They will employ four strategies to help providers transform the care they deliver:

- ***Measuring and reporting performance***—QIOs laid the foundation for public reporting of provider quality in the 7th Scope of Work. Reporting helps providers to identify opportunities for improvement, track the progress of their changes, and compare their performance against others.
- ***Adopting and effectively using information technology***—Research strongly suggests that technologies such as electronic medical records, computerized physician order entry (CPOE) systems, and medication barcodes reduce errors and assist providers in making appropriate point-of-care decisions. QIOs will help providers select and best use these tools to improve patient outcomes.
- ***Redesigning care processes***—QIOs will assist the health care community in placing patients at the center of their own care using strategies borrowed from other industries. These changes will eliminate redundancies in care, allowing the system to redirect resources to areas requiring extra support.
- ***Changing organizational cultures***—QIOs will work with providers to foster an environment in which senior leaders orient teams to quality through specific goals and performance assessment, employees are empowered to look for potential problems and immediately fix mistakes, and management teams that effectively recruit and promote successful teamwork continually seek to clarify roles and constantly learn from past experiences.

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Q: How will HSAG assist IPG-participating hospitals to improve?

A: HSAG will provide evidence-based interventions, supplementary resources, information, and resources to assist IPG hospitals.

Q: Does every hospital have to participate in all of the IPGs?

A: No, CMS has specific criteria for determining which hospitals will be eligible to participate in an IPG. The Chief Executive Officer (CEO) of each eligible hospital has been invited to participate via a letter from HSAG's CEO, Herb Rigberg, MD. Hospitals that indicate a willingness to participate in an IPG will have their applications reviewed by CMS and HSAG.

Q: Does that mean that even though a hospital wants to participate in an IPG, it may not be selected to participate?

A: Yes, there are a limited number of available openings for participation in each IPG. However, HSAG will work with every hospital that wants to participate in IPG-related activities. IPG hospitals may receive more intensive assistance from HSAG.

Q: My CEO received a packet of information that included an Application/Fax Back Form. What is the purpose of that form?

A: HSAG needs to determine which hospitals are interested in participating in an IPG. The form was for hospitals to use to indicate their interest.

Q: We are not sure if we want to participate in an IPG. Should we complete the Application Form?

A: Yes, completing the Application Form does not commit a hospital to participate in an IPG. Hospitals completing an Application Form will receive additional information about the IPG to assist them with determining if they would like to participate.

Q: The Application Form was due back to HSAG by October 7. Is it too late to inform HSAG of our interest?

A: No, interested hospitals should complete the form and fax it back to HSAG.

Q: The CEO packet also contained a Participant Contact List. What is the purpose of that form?

A: To be successful in implementing system-level changes, hospitals will need to form a multidisciplinary team that includes a physician champion. Gaining administrative support for the team will help to assure the team's success. The form was designed to assist hospitals in identifying their teams and champions. The completed form does not need to be returned to HSAG until after the hospital has been officially notified of acceptance into the IPG.

Q: After we submit the application form, what happens? When will we be notified of our selection to participate in an IPG?

A: HSAG is required to submit the list of interested hospitals to CMS for its approval. Once CMS reviews and approves the hospital's application, HSAG will notify the hospitals' CEOs. This process should be completed by December 15, 2005.

Q: When will the hospitals be required to begin working with their selected IPG?

A: IPGs have variable timelines. Included with the HSAG notification of acceptance to the hospital will be information about starting dates for the IPG.

Q: Whom do I contact for additional information?

A: You can contact the HSAG clinical quality specialist (CQS) assigned to your hospital or to the project for additional information. They are:

- Susan Sumwalt—Appropriate Care Measure (ACM); Systems Improvement and Organizational Culture Change (SIOC)
- Suzanne Anders—Surgical Care Improvement Project (SCIP)
- Judith Richard—Rural Organizational Safety Culture Change (ROSC)

Nurses Lead Tobacco Control Interventions at the Point of Care

A growing number of Arizona hospitals and health care systems have taken advantage of the free Continuing Education Brief Tobacco Intervention Skills Certification and Basic Skills Instructor Workshops taught by The University of Arizona HealthCare Partnership faculty. The workshops are funded by the Arizona Department of Health Services Office of Tobacco Education & Prevention.

There are many opportunities for clinicians and nonclinicians to learn the methods and techniques to provide a life-saving intervention. For the HealthCare Partnership calendar of events, visit http://research.sbs.arizona.edu/hcpcalendar/month.php or e-mail hcpinfo@u.arizona.edu.

To access more information on Arizona Department of Health Services continuing education and certification programs, visit http://www.azteppdata.org/hcp.

To learn about the Arizona Department of Health Services free resources and service to help people quit tobacco, visit http://www.azdhs.gov/phs/tepp/index.htm.

"If the 2.2 million working nurses in the United States each helped one person per year quit smoking, nurses would triple the U.S. quit rate."

—Tobacco Free Nurses

Use the Correct Dictionary for Validation

Use the appropriate version of the data dictionary located within the *CMS/JCAHO Specification Manual* or run the risk of failing validation. The specification manual can be found at: http://qnetexchange.org/public/hdc.do?hdcPage=hosp_quality_manual.

HSAG Acute Care Team Contact Information

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Charlie A. Chapin, MS, CHCA Director, Decision Support cchapin@azqio.sdps.org 602.665.6107	Susan Sumwalt, RN, MA, CPHQ Clinical Quality Specialist ssumwalt@azqio.sdps.org 602.665.6176	Hospital Quality Improvement Web Site **http://acute.hsag.com**

Upcoming Events

October 26, 2005 11:00 a.m. to 12:30 p.m.	**Arizona Rural Quality Network Group** For information, contact hospodar@u.arizona.edu.
November 10, 2005 10 a.m. to 2 p.m.	**Arizona Hospital Workgroup (HoW)** For information, contact Suzanne Anders (sanders@azqio.sdps.org).

This material was prepared by Health Services Advisory Group, Inc. (HSAG), the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Information for Health Care Improvement

ACM Summary

CMS Appropriate Care Measure (ACM) Project

Background

The methodology used in the Centers for Medicare & Medicaid Services (CMS) 7th Scope of Work (SoW) (2002–2005) reported hospital performance on each of the 10 core measures separately. During the 8th SoW (2005–2008), the Appropriate Care Measure (ACM) will be introduced. The ACM is a composite measure of the 10 core measures starter set defined by the Medicare Modernization Act (MMA) and used by the Hospital Quality Alliance (HQA) for public reporting. The ACM is patient-centered and designed to answer the question: "Did the patient receive ***all*** the care he or she should have received, based upon his or her clinical condition?" Teams will focus on reducing the gap between the care the patient ***should have*** received and the care the patient ***did*** receive.

Eligibility

PPS hospitals in the state that have submitted data on the 10 core measures are eligible to participate in the project. A limited number of hospitals will be selected by Health Services Advisory Group (HSAG) and CMS to participate in the ACM project. The selected hospitals will be known as the ACM Identified Participant Group (IPG).

Quality Indicators

The ACM is based on the publicly reported quality indicators for the following clinical conditions:

- **Acute Myocardial Infarction** (AMI)—aspirin at arrival, aspirin at discharge, beta-blockers at arrival, beta-blockers at discharge, and ACE-I/ARBs for left ventricular systolic dysfunction (LVSD)
- **Heart Failure** (HF)—left ventricular function assessment and ACE-I/ARBs for LVSD
- **Pneumonia** (PN)—antibiotics received within four hours of arrival, oxygenation assessment, and pneumoccoccal vaccination

Methodology

Hospital teams will focus on clinical performance measurement, including reporting and reducing the gap in the appropriate care of patients admitted with AMI, HF, or PN.

Participation Process

The chief executive officer (CEO) of each hospital eligible to participate will receive an invitation letter from HSAG. This letter will contain a request for participation that is to be signed by the CEO. HSAG will respond with a confirmation letter.

HSAG Contact

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Appropriate Care Measure Project

— *Frequently Asked Questions (and Their Answers)* —

What is the ACM?

The Appropriate Care Measure (ACM) is a composite measure that comprises the 10 quality measures familiar to most hospitals. They are the same core measures (5 acute myocardial [AMI], 2 heart failure [HF], and 3 pneumonia [PNE]) defined by the Medicare Modernization Act (MMA) and used by the Hospital Quality Alliance (HQA) for public reporting. The ACM is patient-centered and designed to answer the question: "Did the patient receive ***all*** the care he or she should have received, based on his or her clinical condition?" Teams will focus on reducing the gap between the care the patient ***should have*** received and the care the patient ***did*** receive.

Why use the ACM?

The ACM reinforces CMS's commitment to the right care for every patient, every time. It encourages organization-wide improvement by demonstrating your organization's commitment to quality improvement through administrative support and communication.

How is the ACM rate calculated?

All patients eligible for care in at least 1 of the 10 measures are counted in the denominator. However, only the patients receiving ***all*** the care they are eligible for are counted in the numerator.

AMI Example:

A patient is only eligible for aspirin and beta-blocker at arrival (excluded from aspirin and beta-blocker at discharge and ACE-I/ARBs for LVSD):

- Receives aspirin-at-arrival only—fails ACM
- Receives beta-blocker-at-arrival only—fails ACM
- Receives both aspirin and beta blocker at arrival—passes ACM

What will be the data collection sample size and methodology?

To be determined, based on the IPG's need to assess the success of implemented interventions

What are the 10 quality measures?

Acute Myocardial Infarction	Heart Failure	Pneumonia
Aspirin at arrival	LVF assessment	Oxygenation assessment
Aspirin at discharge	ACE-I/ARBs for LVSD	Pneumococcal vaccination
ACE-I/ARBs for LVSD		Antibiotic within 4 hours
Beta-blocker at arrival		
Beta-blocker at discharge		

How will my hospital benefit from participation?

Hospitals will have the opportunity to:

- Gain recognition as a leader in the region and in Arizona.
- Have opportunities to network with peers and learn best practices.
- Track change over time.
- Have access to educational workshops, WebEx presentations, and cross-state teleconferences.
- Raise awareness of core measures.
- Get a head start in preparing for pay-for-performance.
- Improve patient outcomes.
- Increase efficiency and reduce costs.
- Receive assistance from Health Services Advisory Group (HSAG) in quality improvement efforts.

What does a hospital need to do to participate in the ACM IPG?

In order to participate in the ACM IPG, the hospital will need to:

- Submit a request to participate signed by the CEO.
- Be selected to be in the Identified Participant Group by HSAG and CMS.
- Demonstrate senior leadership support and commitment to systems improvement.
- Designate an ACM Team.
- Complete a self-assessment tool (provided by HSAG).
- Actively participate in project activities.
- Participate in intra-state teleconferences.
- Meet with and maintain contact with the HSAG project coordinator throughout the duration of the project.
- Share information and ideas with HSAG and the other IPG participants.
- Collect and submit timely data and activity reports.

What support will HSAG provide to hospitals participating in the ACM IPG?

HSAG will:

- Plan, implement, and support the project by providing expert faculty, learning materials, and meeting facilities.
- Support participants by providing teleconferences, consultative services, and communication structure and support.
- Provide resource information on evidence-based interventions and methods for process improvement.
- Provide communications venues for shared learning.
- Maintain and safeguard the confidentiality of privileged data and information—whether written, photographed, or electronically recorded, and whether generated or acquired by the team—which can be used to identify an individual patient, hospital, facility, health plan, or patient population.
- Provide recognition of participating hospitals.

Who is eligible to participant in the ACM IPG?

PPS hospitals in the state that have submitted data on the 10 core measures are eligible to participate in the project. A limited number of hospitals will be selected by HSAG and CMS to participate in the ACM project.

Is participation in ACM mandatory?

Participation in ACM is voluntary at this time. However, the composite measure consists of the same 10 measures hospitals are required to report in order to obtain additional Medicare reimbursement through the Annual Payment Update (APU).

Who can I contact if I have additional questions?

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SCIP Summary

CMS Surgical Care Improvement Project (SCIP)

Background

Of the more than 42 million surgeries performed in the United States each year, up to 40 percent have associated postoperative complications, such as infection, thromboembolic events, respiratory complications, and adverse cardiac events. These complications take a toll not only on the patients, but also on the overall cost of health care—increasing length of stay and hospital costs. A significant percentage of these complications are preventable.

During the national surgical infection prevention collaborative, in which 44 hospitals participated, surgical infections were reduced by 27 percent. A SCIP collaborative is just one intervention planned to assist hospitals in reducing surgical complications and preparing the hospital for pay-for-performance.

Eligibility

Participating hospitals must:

- Perform at least 300 major surgical procedures per year.
- Be willing to collect data on the surgical site infection and venous thrombolembolism quality measures.
- Be willing to actively participate in statewide interventions.

Quality Measures

See **reverse side** of this handout for the SCIP Quality Measures.

Methodology

Participating hospitals will work to achieve a 25 percent reduction in failure rate on surgical site infections (six measures) and venous thromboembolism (two measures).

Participation Process

Hospitals interested in participating in SCIP must complete a Participation Application and fax it to HSAG by October 21, 2005. Hospitals will be notified of their acceptance into the SCIP Identified Participant Group (IPG) by December 1, 2005.

Reference

American Academy of Orthopaedic Surgeons www.aaos.org

American College of Surgeons www.facs.org

American Society of Anesthesiologists www.asahq.org

American Society of Peri-Anesthesia Nurses www.aspan.org

Society of Thoracic Surgeons www.sts.org

Surgical Infection Society www.sisna.org

MedQIC www.medqic.org

HSAG Contact

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(Continued on reverse side.)

SCIP Summary

CMS Surgical Care Improvement Project (SCIP)

Quality Measures

Infections:

- SCIP INF 1: Prophylactic antibiotic received within one hour prior to surgical incision
- SCIP INF 2: Prophylactic antibiotic selection for surgical patients
- SCIP INF 3: Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients)
- SCIP INF 4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
- SCIP INF 5: Postoperative wound infection diagnosed during index hospitalization
- SCIP INF 6: Surgery patients with appropriate hair removal
- SCIP INF 7: Colorectal surgery patients with immediate postoperative normothermia

Venous Thromboembolism:

- SCIP VTE 1: Surgery patients with recommended venous thromboembolism prophylaxis ordered
- SCIP VTE 2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery
- SCIP VTE 3: Intra- or postoperative pulmonary embolism (PE) diagnosed during index hospitalization and within 30 days of surgery
- SCIP VTE 4: Intra- or postoperative deep vein thrombosis (DVT) diagnosed during index hospitalization and within 30 days of surgery

Cardiac:

- SCIP Card 1: Non-cardiac vascular surgery patients with evidence of coronary artery disease who received beta-blockers during the perioperative period
- SCIP Card 2: Surgery patients on a beta-blocker prior to arrival that received a beta-blocker during the perioperative period
- SCIP Card 3: Intra- or postoperative acute myocardial infarction (AMI) diagnosed during index hospitalization and within 30 days of surgery

Respiratory:

- SCIP Resp 1: Number of days ventilated surgery patients had documentation of the head of the bed (HOB) being elevated from recovery end date (day zero) through postoperative day seven.
- SCIP Resp 2: Patients diagnosed with postoperative ventilator-associated pneumonia (VAP) during index hospitalization
- SCIP Resp 3: Number of days ventilated surgery patients had documentation of stress ulcer disease (SUD) prophylaxis from recovery end date (day zero) through postoperative day seven
- SCIP Resp 4: Surgery patients whose medical record contained an order for a ventilator weaning program (protocol or clinical pathway)

Global:

- SCIP Global 1: Mortality within 30 days of surgery
- SCIP Global 2: Readmission within 30 days of surgery

Vascular:

- VA 1: Proportion of permanent hospital ESRD vascular access procedures that are autogenous AV fistulas

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Surgical Care Improvement Project

— *Frequently Asked Questions (and Their Answers)* —

What is SCIP?

SCIP, pronounced “skip,” is an acronym for the Surgical Care Improvement Project. SCIP is an ongoing quality improvement project for the Centers for Medicare & Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the American Hospital Association (AHA).

What is the goal of SCIP?

The primary goal of SCIP is to reduce surgical complications. There are more than 40 million inpatient surgical procedures performed in the United States each year. Despite advances in knowledge about surgical technique and perioperative management of patients, the health care system often falls short in its ability to translate this knowledge and technical skill into practice. For example, 2 percent to 5 percent of all patients undergoing clean extra-abdominal operations, and up to 20 percent of all patients undergoing intra-abdominal surgery, will develop a surgical site infection. Venous thromboembolism is a common complication of surgery, occurring in up to 65 percent of patients undergoing orthopedic surgery and 33 percent or more of patients undergoing general surgical operations. For each of these complications there are established evidence-based care practices that are not being consistently implemented, resulting in higher-than-necessary rates of complications and adverse events.

Participation in the SCIP project will help your hospital reduce the gap between known evidence-based care and actual surgical management of patients, resulting in improved patient outcomes and decreased costs. Participation will also help your hospital meet one of the recommendations made by JCAHO in its recent publication, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*—the need to encourage appropriate adherence to clinical guidelines to improve quality and reduce liability risk.

Why should we join SCIP?

During this 3-year project, actively participating hospitals will have the opportunity to learn and implement up-to-date evidence-based interventions to improve the quality of care provided to their surgical patients. Hospitals that

implemented SCIP interventions during the demonstration project had better outcomes for patients, reduced lengths of stay, and cost savings. Quality improvement strategies will be made available to active participants. These strategies have been shown to protect hospitals from malpractice litigation, encourage staff loyalty, support staff retention, promote teamwork, and improve efficiency.

What do you mean by actively participate?

Health Services Advisory Group (HSAG), Arizona's Medicare-contracted Quality Improvement Organization, has designed a 3-year program for surgical care quality improvement. This program is based upon the Institute for Healthcare Improvement's collaborative model. Active participation includes:

- Providing senior leadership support.
- Identifying a physician champion.
- Designating a team leader who will serve as a contact person throughout the project.
- Forming an interdisciplinary team.
- Participating in project activities.
- Collecting and submitting data.

Senior leadership support and an active physician champion are essential components of successful collaborative participation.

Senior leadership must have the authority to allocate the time and resources to achieve the team's aim, have ultimate authority over all areas affected by the change, and be willing to champion the spread of successful changes throughout the organization.

The ideal physician champion is a practicing provider (either a surgeon or anesthesiologist) who is an opinion leader respected by peers, understands the processes of care, has a good working relationship with colleagues, and wants to drive improvements in the system.

Successful hospitals often choose team leaders who are closest to the project-related work. The team leader should understand how changes would affect systems and have the time to keep the project moving forward.

An interdisciplinary team includes members from hospital departments potentially affected by system changes related to surgical-infection prevention.

Project activities will include learning workshops, telephone conferences, implementation of evidence-based interventions, quarterly data collection, and sharing with other SCIP-participating hospitals.

How will HSAG help us if we choose to actively participate in SCIP?

HSAG will assist all hospitals wanting to participate in SCIP. Those hospitals that apply and who are selected to participate in the SCIP Identified Participant Group (IPG) will receive more intensive assistance.

HSAG is prepared to assist hospitals by facilitating a SCIP collaborative. The collaborative will include principles of quality improvement, clinical education, and evidence-based interventions designed to improve the process of surgical care.

HSAG will also assist SCIP hospitals by:

- Facilitating telephone conferences among SCIP participants. Conference calls will address issues of data collection, clinical issues surrounding SCIP, best practices, and lessons learned.
- Providing SCIP participants with access to a national automated mailing list server. The "list serv" can be used as a source of information as to how other hospitals are implementing processes, a reference source, and a way to share tools.
- Offering technical support for data collection.
- Supplying references and tools that can be modified by the hospital to meet its unique needs.
- Making its Acute Care Team members available for hospital consultation.

How is the SCIP collaborative different from the SIP collaborative sponsored by HSAG three years ago?

The SIP collaborative three years ago was provided to address the issues of antibiotic selection, administration, and duration. The SCIP collaborative will be expanded to address additional issues designed to improve surgical care.

What national organizations are supporting SCIP?

The following national organizations support SCIP:

- Agency for Healthcare Research and Quality (AHRQ)
- American College of Surgeons (ACS)
- American Hospital Association (AHA)

- American Society of Anesthesiologists (ASA)
- Association of periOperative Registered Nurses (AORN)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Veterans Health Administration (VA)

Is participation in SCIP mandatory?

Participation in SCIP is voluntary. It is likely that the SCIP measures will become part of the publicly reported national hospital quality measures at a later date.

When is the deadline for joining SCIP?

Enrollment is limited. Hospitals that wish to join the SCIP IPG should complete the IPG Application / Fax Back Form and return it by October 21, 2005. Hospitals will be asked to complete a Contact List for their SCIP Team (Day-to-Day Leader, Senior Leader, System Leader, Physician/Clinical Champion, Other Team Members) after they are notified by HSAG of their acceptance to the SCIP IPG.

How will hospitals be chosen to participate in SCIP?

HSAG will submit a list of potential SCIP hospitals to CMS for final review and approval. Once that process is complete, HSAG will notify hospitals and share with them an up-to-date timeline of SCIP events.

What tools are available for data collection?

The CMS CART tool will be *FREE* and available for use by project participants. CMS plans to have the CART tool available by January 2006. HSAG will provide training for hospitals choosing to use the CART tool. Vendors will be developing tools to support SCIP. Contact your vendor to assure the most up-to-date information.

What is the surgery sample universe of SCIP?

SCIP procedures include: cardiac, colon, gynecological, orthopedic, neurological, and urological surgeries.

What is the volume of chart abstraction required for SCIP?

Information provided by CMS on September 20, 2005, stated that the total SCIP abstraction volume would be a random sample of 75 charts per quarter.

What is the approximate length of time required to abstract a medical record for SCIP?

There are many variables for abstraction times. In the demonstration project, hospitals with electronic medical records were able to abstract records more quickly than hospitals without electronic records. On average, abstraction may take about 40 minutes per record. Experienced abstractors and those that are comfortable and familiar with the data collection tool should be able to abstract the record more quickly.

Who should I contact if I have additional questions?

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SIOC Summary

CMS Systems Improvement and Organizational Culture Change (SIOC) Project

Background

During the Centers for Medicare & Medicaid Services (CMS) 8th Scope of Work (SoW) (2005–2008) Health Services Advisory Group (HSAG) will work with a select group of hospitals to foster transformational change via system improvement and organizational culture change. HSAG will assist hospitals to initiate and/or continue progress in telehealth systems implementation.

Telehealth technology can overcome geographic limitations and expand accessibility to specialized health care. It allows real-time consultation with medical specialists for people who live in rural America and who would otherwise have to travel great distances to have access to this level of care. This technology also permits continuing medical education for medical and nursing staff at convenient times and locations.

Eligibility

All acute care hospitals and critical access hospitals (CAHs) that submit the publicly reported 10-measure set are eligible to participate.

Improvement Indicator

The improvement indicator for SIOC is the hospital's readiness to adopt telehealth technology.

Participation Requirements

Hospitals that participate in the SIOC Identified Participant Group (IPG) will be required to:

- Involve senior leadership.
- Complete a readiness assessment survey for telehealth technology (survey provided by HSAG).
- Become educated about all aspects of telehealth technology (i.e., infrastructure requirements, funding opportunities, day-to-day staffing requirements, available applications, associated costs, and network partnership).
- Develop a telehealth strategy and implementation plan to advance telehealth readiness.
- Document progress by completing a remeasurement of the readiness assessment.

Note: HSAG, partnering with the Arizona Telemedicine Program, will offer and provide assistance in all of the above areas.

Participation Process

Hospitals interested in participating in SIOC must complete a Participation Application and fax it to HSAG by October 21, 2005. Hospitals will be notified of their acceptance into the SIOC IPG.

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CMS Systems Improvement and Organizational Culture Change (SIOC) Project

— Frequently Asked Questions (and Their Answers) —

What is the focus of the CMS 8th Scope of Work?

During the Centers for Medicare & Medicaid Services (CMS) 8th Scope of Work (SoW) (2005–2008) Health Services Advisory Group (HSAG) will work with hospitals to encourage systems improvement and organizational system-level change. Hospitals will be invited to collaborate as Identified Participant Groups (IPGs) in several CMS projects, each of which will have a different focus.

What is the Systems Improvement and Organizational Culture Change (SIOC) project?

SIOC addresses issues related to use of advancing technology for health care and patient safety. Arizona is nationally recognized for its excellent telehealth network through the work of the Arizona Telehealth Program (ATP). Teams will use a CMS survey to assess their hospitals' current telehealth status, develop a business case for use or further advancement of telehealth, implement interventions to support the work, and conduct a second survey to determine improvement.

What is telehealth?

Telehealth is the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.

What is telemedicine?

Telemedicine is the use of electronic communication and information technologies to provide or support clinical care at a distance. Included in this definition are patient counseling, case management and supervision, and/or preceptorship of rural medical residents and health professions students when such supervising and precepting involves direct patient care.

Will Health Services Advisory Group (HSAG) partner with any other organization for SIOC?

Yes, HSAG will partner with the Arizona Telemedicine Program (ATP).

What is the ATP?

The ATP is an award-winning, multidisciplinary, university-based program consisting of over 150 nodes that provide telemedicine services, distance learning, informatics training, and telemedicine technology assessment capabilities to communities throughout the Arizona and Nevada region.

Who is eligible to participate in SIOC?

All PPS hospitals that have submitted data on the 10 core measures and all critical access hospitals (CAHs) are eligible to participate in the SIOC IPG.

How will hospitals be selected to participate in SIOC?

HSAG will send an invitation to participate to the CEOs of eligible hospitals. The CEO of any eligible hospital interested in participating will need to submit a participation application in order for his or her facility to be considered for inclusion in SIOC.

Is participation limited?

Yes, participation in the Arizona SIOC IPG will be limited.

What does SIOC participation entail?

SIOC participants will be asked to assign a team to complete a baseline assessment survey to determine readiness for telehealth by December 15, 2005, and a remeasurement survey to be completed in 2007. Based on the initial survey, each hospital will be asked to develop a plan for the advancement of telehealth in its facility.

What will HSAG provide?

HSAG will supply the baseline and remeasurement survey, assist participants in taking the survey, provide hospital leadership with support to develop a business case for telehealth, and provide education on all aspects of telehealth. HSAG will also support the project by providing expert faculty, learning materials, meeting facilities, and teleconferences.

Who can I contact if I have additional questions?

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ROSC Summary

CMS Rural Organizational Safety Culture Change (ROSC) Project

BACKGROUND

Health care organizations must create an environment in which safety is a top priority. Patient safety is a system issue, and system changes are utilized to reduce the incidence of preventable medical errors and adverse drug events in a blame-free environment. This culture of safety means designing systems geared to preventing, detecting, and minimizing hazards and the likelihood of error, and to unmask underlying system failures that result in errors.

The Centers for Medicare & Medicaid Services (CMS) 8th Scope of Work (SoW) (2005–2008) contains an initiative specific to critical access hospitals (CAHs) and rural hospitals. It focuses on organizational culture change for patient safety. Each hospital that volunteers to participate in this project's Identified Participant Group (IPG) will use the *Hospital Survey on Patient Safety Culture* to identify its area of focus to improve its patient safety climate.

ELIGIBILITY

All hospitals located in a rural county, as defined by CMS, are eligible. In Arizona, this includes any hospital located in the counties of Apache, Cochise, Gila, Graham, La Paz, Mohave, Navaho, Santa Cruz, and Greenlee. In addition, all CMS-designated CAHs (as of January 2005) are eligible, regardless of county location.

QUALITY INDICATORS

Each hospital will determine its area for improvement.

METHODOLOGY

The *Hospital Survey on Patient Safety Culture* will be administered by each hospital for a baseline assessment to determine an area of focus for improvement.

After obtaining its survey results, each hospital will implement organizational interventions for improvement.

Each hospital will reassess its safety culture via the survey to determine improvement.

Note: Health Services Advisory Group (HSAG) will offer and provide assistance in the above areas.

PARTICIPATION PROCESS

The chief executive officer (CEO) of each hospital eligible to participate has been sent an invitational letter inquiring as to the hospital's interest. Upon receiving an application that indicates the hospital's interest, HSAG will send a ROSC information packet. This packet will include HSAG's and the hospital's role and general timeline. HSAG will contact each interested hospital as to its selection status. Upon being selected, the hospital will receive a Participation Agreement to be signed by the CEO.

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CMS Rural Organizational Safety Culture Change (ROSC) Project

— Frequently Asked Questions (and Their Answers) —

1. What is the CMS Rural Organizational Safety Culture Change (ROSC) Project?

In this project initiated by the Centers for Medicare & Medicaid Services (CMS), a select group of critical access hospitals and rural hospitals will work intensively as an Identified Participant Group (IPG) to improve the patient safety culture within their facilities.

2. What is a hospital culture of patient safety?

A hospital culture of patient safety is the foundation of its staff's values, norms of behavior, perceptions, communications, attitudes, and actions—in which the safety of patients prevails within all activities.

3. What does ROSC entail for participating hospitals?

Each participating hospital will assess its culture as it pertains to patient safety, determine an area of focus for improvement, implement and monitor interventions, and reassess to ascertain improvement.

4. How can a hospital's safety culture be assessed?

The Agency for Healthcare Research and Quality (AHRQ) sponsored the development of the *Hospital Survey on Patient Safety Culture (HSOPSC)* to assess employees' perceptions of the safety climate within a health care facility. The *HSOPSC* is available for use via http://ahrq.gov/qual/hospculture.

5. Why should a hospital conduct a safety culture survey?

Safety culture surveys are useful for measuring organizational conditions that can lead to adverse events and patient harm in health care organizations. Organizations that want to assess their existing culture of patient safety should consider conducting a safety culture survey. Safety culture surveys can be used to:

- Raise awareness about patient safety issues.
- Diagnose the current status of safety culture.
- Evaluate specific patient safety interventions or programs.
- Conduct internal and external benchmarking.

- Track change over time.
- Fulfill directives or regulatory requirements.

6. There are other organizational culture and patient safety surveys; why should a hospital use the AHRQ *HSOPSC*?

There are several advantages of the *HSOPSC*. It is:

- **Free—available to the public.** The survey was developed by AHRQ and is available free of charge.
- **A hospital-wide instrument.** The survey was designed to be administered to all types of hospital staff, including clinical and nonclinical. It can be used to assess individual hospital units or departments, or it can be administered hospital-wide.
- **Reliable and valid.** The survey development process was careful and rigorous, based on a review of the existing research and other culture surveys. More importantly, the survey items have demonstrated reliability and validity (for more details, refer to the survey Toolkit materials available on the AHRQ Web site at http://www.ahrq.gov/qual/hospculture/).
- **Comprehensive and specific.** The survey covers over a dozen areas of patient safety, providing a level of detail that helps hospitals identify specific areas of strength and areas for improvement at both the unit and hospital levels.
- **Easy to use.** The survey has an accompanying Toolkit that contains the following support tools:
  - **A Survey User's Guide—**Gives step-by-step instructions on how to select a sample, administer the survey and obtain high response rates, and analyze and report results.
  - **A template to display survey results—**A PowerPoint presentation template is included that can be customized to display survey results to administrators and staff throughout the hospital.

In addition to these support tools, the Safety Institute of Premier Inc. has developed an Excel data entry and survey analysis tool that is downloadable for free on its Web site (http://www.premierinc.com/safety/culture/index.jsp). The tool enables hospitals to automatically produce graphs and charts of their survey results when they enter their survey data.

7. What areas of patient safety does the *HSOPSC* cover?

The survey measures staff perceptions of patient safety in their work area/unit, as well as perceptions about patient safety in the hospital as a whole. The following 12 areas of patient safety are included, with each area measured by three or four survey questions:

- Unit-level Safety Areas Covered
  - Overall perceptions of safety
  - Frequency of events reported
  - Supervisor/manager expectations and actions promoting patient safety
  - Organizational learning—continuous improvement
  - Teamwork within units
  - Communication openness
  - Feedback and communication about error
  - Nonpunitive response to error
  - Staffing
- Hospital-wide Safety Areas Covered
  - Hospital management support for patient safety
  - Teamwork across hospital units
  - Hospital handoffs and transitions
- There are also two other questions concerning the following:
  - The patient safety “grade” the respondent would assign his or her work area/unit
  - The number of events the respondent has reported in last 12 months

8. How long is the survey?

There are 51 items in the survey, and it takes approximately 10–15 minutes to complete. Most of the items use Agree/Disagree or Never/Always response categories, so it is easy to answer. There is room for written comments at the end of the survey.

9. Can I benchmark or compare my hospital's survey results against other hospitals?

Currently, there is no central repository for hospitals to send data for benchmarking purposes. However, AHRQ is planning to support a national benchmarking database. In the meantime, hospitals can compare their results against preliminary benchmarks based on data from over 1,400 respondents from 20 hospitals that

participated in a pilot test of the survey in 2003. These preliminary benchmarks are available online at http://www.ahrq.gov/qual/hospculture/prebenchmk.htm.

10. Can I modify the survey or do I need to use it as is?

To benchmark or compare your hospital's results against other hospitals, you should not modify the survey. In general, it is recommended to make only those changes or additions to the survey that are absolutely necessary, because any changes may affect the reliability and overall validity of the survey and make comparisons with other hospitals difficult. For more specific suggestions regarding modifications, such as adding or removing items from the survey, refer to Chapter 1 from the *Survey User's Guide* in the Toolkit.

11. Who is eligible to participant in ROSC?

Critical access hospitals (CAHs) and rural hospitals are eligible to participate.

12. How is "rural hospital" defined?

The U. S. Census Bureau definition of urban and rural will be used. The Census Bureau defines a set of urban areas, known as Metropolitan Statistical Areas (MSAs), as areas consisting of one or more counties that contain a city of 50,000 or more inhabitants and having a total population of at least 100,000 (75,000 in New England). The counties that make up MSAs are defined as urban. Those counties not within an MSA are considered rural. Hospitals located within an MSA will be defined as urban facilities, and hospitals located outside of MSA counties will be defined as rural.

In Arizona this definition classifies the following counties as rural: Apache, Cochise, Gila, Graham, La Paz, Mohave, Navaho, Santa Cruz, and Greenlee. If your facility is located in one of these counties, you are eligible for the ROSC. In addition, all Arizona CAHs are eligible, regardless of where they are located.

13. Is participation in ROSC mandatory?

Participation in ROSC is voluntary at this time.

14. What national organizations are supporting a culture of patient safety?

- Agency for Healthcare Research and Quality (AHRQ)
- American Hospital Association (AHA)
- Centers for Disease Control and Prevention (CDC)

- Centers for Medicare & Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- Institute of Medicine (IoM)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

15. What support will HSAG provide to hospitals participating in ROSC?

HSAG will assist each hospital to:

- Determine its data collection method (e.g., Web-based or paper tool) and survey distribution (e.g., all hospital staff, a sample, a subset of providers, or a combination of strategies).
- Ensure that each hospital will have its own database of baseline and remeasurement from the *HSOPSC*.
- Have a working knowledge of how to resurvey, enter results, analyze the data, and report and interpret results.
- Understand the principles of patient safety culture, clinical education, and intervention design to promote a culture of patient safety.
- Select and implement change models that will require direct involvement from senior leaders.

HSAG will also:

- Facilitate, among ROSC participants, telephone and videoconferences designed to address issues of survey administration, results, and interventions.
- Assist with technical support for data collection.
- Provide references, tools, and consultative services.

16. What will be expected of hospitals participating in ROSC?

In collaboration with HSAG, each hospital will:

- Form a ROSC team to plan the methodology for survey dissemination, follow-up reminders, collection of surveys, and data clean-up.
- Enter the data and obtain and interpret results.
- Share results will hospital staff.
- Determine areas for improvement.
- Devise top-down interventions that will demonstrate commitment to establishing an improved culture of safety at the hospital.
- Implement and monitor interventions.
- Resurvey to determine improvement.

17. What is the time frame for ROSC?

Although subject to change, the general timeline is as follows:

December 2005	Completion of baseline survey
Jan.–Mar. 2006	Interpret results for areas of improvement and determine and implement interventions
April 2006–July 2007	Monitor interventions and track progress
August 2007	Re-survey

18. Who can I contact if I have additional questions?

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